

# HEALTH REFORM ISSUE BRIEF

## ESSENTIAL HEALTH BENEFITS (EHB)

### Overview

This issue brief will focus on the Affordable Care Act's (ACA) Essential Health Benefits (EHB) provisions and how they will affect access to care for people living with HIV and viral hepatitis who will be moving into private insurance or Medicaid expansion coverage in 2014. It will be important for HIV/AIDS programs, providers and benefits counselors to review plans to assist clients in finding plans that meet care, treatment and affordability needs. The ACA includes ten broad categories of benefits that private insurance plans sold in the individual and small group markets as well as Medicaid packages for newly eligible beneficiaries must provide in 2014.<sup>1</sup>

#### EHB Categories

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral & vision care

The Secretary of the Department Health and Human Services (HHS) was charged with defining the broad categories listed above. However, instead of setting a national federal standard for what services private insurance plans and Medicaid programs must cover, HHS has given considerable discretion to states to define the EHBs. This flexibility and what it means for the scope of services that will be available to people living with HIV and viral hepatitis who will transition to new ACA coverage options in 2014 is discussed in detail below. For questions, please contact [Amy Killelea](#).

### ACTION STEPS

As state HIV/AIDS and viral hepatitis programs prepare for health reform, there are three things to keep in mind when planning for EHB implementation:

- 1. Find your state's private insurance EHB benchmark plan.**  
[State private insurance benchmark plan selections](#) are final. Assess the plan's coverage of HIV and viral hepatitis medications, case management, and mental health and substance use disorder services, including limits on these services.
- 2. Monitor exchange/marketplace implementation and certification of plan issuers and report discriminatory plan designs.**  
Over the coming weeks and months states and the federal government will be assessing applications from issuers to sell Qualified Health Plans in the state-based and federally facilitated exchanges/marketplaces. The plan designs will have to meet EHB standards, but given the lack of specificity with regard to definition of the EHB categories, plans sold through the exchanges/marketplaces could vary. It will be important for HIV/AIDS programs, providers, and benefits counselors to review plans to assist clients in finding plans that meet care, treatment, and affordability needs. Things to look for include: formulary inclusion of HIV and viral hepatitis medications and service limits and utilization management techniques (e.g., prior authorization). Report plans that discriminate against people with HIV or viral hepatitis – by excluding essential services, charging significantly more for those services, or putting in place other barriers to meaningful access – to the exchange/marketplace.
- 3. Monitor your state's decision with regard to benefits for the Medicaid expansion population.**  
States that are expanding Medicaid in 2014 are making decisions with regard to the scope of that coverage. State plan amendments are subject to public notice and comment periods, and HIV/AIDS and viral hepatitis programs should be prepared to weigh in on proposed benefits plans for this population. This includes supporting protections to ensure that medically frail and other vulnerable populations have access to the care and treatment they need to stay healthy.

## How the EHB Requirements Work

### *Private Insurance*

The EHB requirements are different for private insurance than they are for Medicaid. For private insurance, HHS allowed states to choose a “benchmark” plan, which will be the standard for the scope of coverage required in each state. States chose their benchmark plans from a list of ten existing private insurance plans (if states did not choose a plan, HHS set a default option).<sup>2</sup> The [state benchmark plan selections](#) are now final, and most states chose a small group plan as their benchmark. The benchmark plan must cover the ten EHB categories listed above.<sup>3</sup> Starting in 2014, any plan sold in the individual and small group market (including those sold through the exchanges/marketplaces) must be compared to the state’s benchmark plan to ensure that it meets the level and scope of coverage for the ten categories of EHB. This does not mean that all plans will be identical. Plans must provide coverage for the EHB categories that is “substantially equal” to the coverage (and limits) provided by the benchmark plan. For example, all plans must provide prescription drug coverage, but not the exact drugs covered in the benchmark plan. The effect of the EHB standards on certain benefits requirements that are particularly important for people at risk for and living with HIV and viral hepatitis are discussed in more detail below.

### *Medicaid*

The EHB requirements work differently as applied to Medicaid. For states that opt to expand their Medicaid programs to individuals with income up to 138% FPL under the ACA, states are required to provide the Medicaid expansion population with an “Alternative Benefits Package” (ABP) that includes the same ten categories of EHB as required in the private insurance market.<sup>4</sup> Federal rules will allow states to offer a Medicaid benefits package for the expansion population that could be very similar to the state’s private insurance benchmark plan or could be very similar to the state’s traditional Medicaid benefits package.<sup>5</sup> Whichever plan a state chooses as its ABP will have to be measured against the private insurance benchmark discussed above to ensure that the ten EHB categories are included. However, certain benefits categories will be defined differently for Medicaid and these distinctions are discussed in more detail below.

There is an additional protection for vulnerable populations in Medicaid. States are required to give Medicaid beneficiaries defined as “medically frail”

the option to enroll in a traditional Medicaid benefits package instead of the new ABP for newly eligible beneficiaries. The federal definition of medically frail should encompass people living with HIV, viral hepatitis or other chronic conditions. This protection will ensure that in states where the ABP for the Medicaid expansion population may not be as robust as traditional Medicaid, vulnerable populations with greater health care needs will have the choice to enroll in traditional Medicaid instead of the ABP.

## How the EHB Requirements Affect Vital HIV and Viral Hepatitis Services

The framework the federal government has adopted for defining the EHB means that the scope of coverage in each benefits category will vary state-by-state and plan-by-plan. Several key benefits categories that are particularly significant for people living with and at risk for HIV and viral hepatitis are discussed below.

### 1. PRESCRIPTION DRUGS

#### *Private Insurance*

To comply with prescription drug EHB coverage requirements, private insurance plans must cover **the greater of:**

1. One drug in every category and class (as defined by the U.S. Pharmacopeia classification system); or
2. The same number of drugs in each category and class as the EHB-benchmark plan.

Analysis of prescription drug coverage within the benchmark plans indicates that most plans go well beyond one drug per class and cover the vast majority of anti-retroviral medications. **Plans may cover different drugs than are covered by the benchmark plan, as long as they cover at least the same number of drugs in each category.** Based on analyses conducted by NASTAD and others, benchmark plans cover the majority of anti-retroviral medications (and a number of hepatitis medications). However, these medications are often placed on specialty or preferred-drug tiers, meaning that the cost-sharing associated with each drug could be quite high. It will be essential for AIDS Drug Assistance Programs (ADAPs) that are paying for premiums and cost-sharing obligations of clients to compare

## STATE CASE STUDY: TEXAS

USP Class/Category <sup>6</sup>		Benchmark Plan <sup>7</sup> (# of Drugs Covered)	ADAP <sup>8</sup> (# of Drugs Covered)
Antiviral	Anti-HIV-agents, non-nucleoside Reverse Transcriptase Inhibitors	5	5
Antiviral	Anti-HIV-agents, nucleoside Reverse Transcriptase Inhibitors	11	10
Antiviral	Anti-HIV-agents, protease inhibitors	9	9
Antiviral	Anti-HIV agents, other*	3	3
Antiviral	Anti-Cytomegalovirus (CMV) agents	2	1
Antiviral	Anti-Hepatitis agents	12	0

\*Anti-HIV agents other includes Selzentry, Isentress, and Fuzeon

the ADAP formulary to the plan options in 2014, including the cost-sharing associated with each drug. **Importantly, plans must have procedures in place to ensure that enrollees have access to clinically appropriate drugs that are prescribed by providers but not included on the plan’s drug list.**

### Medicaid

Recent final regulations implementing the Medicaid EHB requirements apply the same prescription drug requirements as the private insurance EHB requirements.<sup>9</sup> This means that private insurance EHB requirements (i.e., the requirement that formularies include the greater of one drug per United States Pharmacopeia category/class or the same number of drugs per category/class as the chosen “benchmark” plan) will apply. The final rule explicitly allows states a great deal of flexibility with regard to use of utilization management techniques for prescription drug coverage, including explicitly allowing states to offer prescription drug coverage that is closely aligned to the private insurance market as well as utilize monthly drug limits or other formulary restrictions. However, states will need to adhere to non-discrimination requirements and ensure that there are procedures in place to allow beneficiaries to access clinically appropriate drugs not otherwise covered. In addition, Medicaid protections – such as a requirement that prior authorization requests be processed within 24 hours and at least a 72-hour supply of a covered outpatient prescription drug be dispensed in an emergency situation – apply to ABPs. HIV/AIDS and viral hepatitis programs, providers and advocates are urging states to put in place protections that ensure people living with chronic conditions have access to the medications they need to stay healthy (e.g., exceptions for exceptions to monthly limits for people living with HIV, viral hepatitis and other chronic conditions).

## 2. PREVENTIVE SERVICES

### Private Insurance

The ACA includes a number of new benefits requirements for preventive services that will expand access to HIV and viral hepatitis screening. All non-grandfathered<sup>10</sup> private insurance plans must cover preventive services with a [United States Preventive Services Task Force \(USPSTF\)](#) Grade A or B rating, [Advisory Committee on Immunization Practices \(ACIP\)](#) recommended immunizations, as well as specified [women’s preventive services](#). These services must be covered without cost sharing.

Importantly, the recent [final USPSTF recommendation for HIV screening](#) means that routine HIV testing for everyone between the ages of 15-65 must be covered without cost sharing. The USPSTF also published a [final recommendation on screening for hepatitis C Virus \(HCV\)](#): USPSTF now recommends that all baby boomers receive a one-time screening for HCV with a B grade, at-risk populations (e.g. people who inject drugs and those who received a blood transfusion prior to 1992) are also recommended to be screened for HCV with a B grade.

### Medicaid

This same set of preventive services is also required for the Medicaid expansion population without cost sharing. States may choose to cover these services for their traditional Medicaid populations, and if they do so, they will be eligible for a one percent increase in federal matching funds. Importantly, the final Medicaid EHB rule also expanded the scope of non-physician providers that can be reimbursed by Medicaid for providing preventive services. The final rule allows preventive services to be provided when “recommended by a physician or other licensed practitioner of healing arts within the scope of their practice under State law.” This shift in policy could increase the ability of non-physician providers to be reimbursed for providing HIV tests. Finally, the ACA requires Medicare to cover the preventive services listed in the chart below without cost sharing.

## ACA PREVENTIVE SERVICES REQUIREMENTS

Private Insurance	Medicaid Expansion	Medicare
<p>USPSTF A and B rated services including:</p> <ul style="list-style-type: none"> <li>▪ Routine HIV screening</li> <li>▪ Hepatitis C screening for baby boomers and for at-risk individuals (e.g., people who inject drugs)</li> </ul> <p>Women’s preventive services, including:</p> <ul style="list-style-type: none"> <li>▪ Routine HIV screening and counseling</li> <li>▪ HPV screening</li> <li>▪ Well woman visits</li> <li>▪ Contraception and counseling</li> <li>▪ Domestic violence screening and counseling</li> </ul> <p>➤ <i>No cost-sharing for these services</i></p>	<p>USPSTF A and B rated services including:</p> <ul style="list-style-type: none"> <li>▪ Routine HIV screening</li> <li>▪ Hepatitis C screening for baby boomers and for at-risk individuals (e.g., people who inject drugs)</li> </ul> <p>Women’s preventive services, including:</p> <ul style="list-style-type: none"> <li>▪ Routine HIV screening and counseling</li> <li>▪ HPV screening</li> <li>▪ Well woman visits</li> <li>▪ Contraception and counseling</li> <li>▪ Domestic violence screening and counseling</li> </ul> <ul style="list-style-type: none"> <li>▪ <i>States may provide these services to traditional Medicaid beneficiaries and will get increased federal funding if they do so.</i></li> </ul> <p>➤ <i>No cost-sharing for these services</i></p>	<p>Annual wellness visit</p> <p>HIV screening for those at increased risk and for those who request a test*</p> <p>➤ <i>No cost-sharing for these services</i></p>

\* The ACA gives authority to the Centers for Medicare and Medicaid Services (CMS) to align required preventive services with USPSTF recommended services, meaning that now that the USPSTF draft recommendations for HIV and hepatitis C screening are final, CMS may add them as required Medicare preventive services.

### 3. CHRONIC DISEASE MANAGEMENT

#### Private Insurance

Chronic disease management is included as one of the EHB categories; however, HHS has not defined what specific services make up this category. Without federal standards defining this category, the scope of coverage for chronic disease management will vary depending on the benchmark plan. Many small group private insurance plans (which make up the majority of the state private insurance benchmark plans) have little coverage for the types of case management services covered by the Ryan White Program. For instance, private insurance plans may cover periodic phone calls to discuss appointments and assist in finding services but may not cover the more intensive treatment adherence services that Ryan White Program case managers often provide.

#### Medicaid

Again, because HHS has not defined the services that make up the chronic disease management category, the scope of coverage for this category of benefits for the Medicaid expansion will also vary depending on the state’s benchmark plan. However, traditional Medicaid has more options for coverage of chronic disease management services than the private market. Many states provide targeted case management services to high-need Medicaid beneficiaries, including people living with HIV. The ACA also allows states to implement Health Home Programs to cover a range of care coordination services – such as peer counseling, targeted social services referrals and treatment management – for people with multiple chronic conditions, including HIV.

**Case management**

Periodic phone calls to discuss appointments and assist in finding services.

**Counseling**

HIV screening and counseling for adults and adolescents “at higher risk.”

**Education**

Education conducted by participating providers about managing chronic disease states.

**Targeted Case Management**

Targeted case management services are available to children with serious emotional disturbance, adults with serious mental illness, persons with a developmental disability, and those with co-occurring substance use disorders. Services include assessment addressing needs, coordinating services and supports with all providers, making referrals, and assisting in accessing health and social services programs.

**Medical case management**

Services include coordination and follow-up of medical treatments, ongoing assessment of the client’s and other key family members’ needs and personal support systems, development of a service plan, coordination of services, provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments.

**Non-medical case management**

Services include the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services (does not include coordination and follow-up of medical treatments).

## 4. MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

### *Private Insurance*

Coverage for mental health and substance use disorder services is a required component of the EHBs. In addition, HHS regulations implementing the Mental Health Parity and Addiction Equity Act of 2008 (which are not yet finalized) will complement EHB requirements. This means that may not impose cost sharing and treatment limitations on mental health and substance use disorder benefits that are more restrictive than the cost sharing and treatment limitations for medical and surgical benefits. Like the other EHB categories, HHS has not specified the scope of services that must be included in mental health and substance use disorder coverage.

### *Medicaid*

The parity requirements discussed above will also apply to benefits available to the Medicaid expansion population in 2014. In many states, coverage for mental health and substance use disorder services is often more robust in Medicaid programs than in the private insurance market. Because states will have flexibility to design a Medicaid package for the expansion population that looks more like the private insurance market, it will be important to ensure that people who have mental health and substance use treatment needs

have access to the traditional Medicaid coverage of these services. The Medicaid Health Home program discussed above will also allow states to broaden the scope of coverage for care coordination services for people with a mental health and/or substance use disorder (which is an eligible chronic condition for the program).

### **NASTAD Resources on Health Reform**

- [NASTAD Health Reform Website](#) includes NASTAD’s presentations, issue briefs, fact sheets and other resources on health reform.
- [NASTAD Blog](#) provides timely updates and breaking news with regard to federal and state health reform implementation.

### **Other EHB Resources**

- TARGET Center, [Health Reform Resource Bank](#)
- [HIV Health Reform](#)
- [State Refo\(ru\)m](#)
- [Center for Consumer Information and Insurance Oversight \(CCIIO\)](#)

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<sup>1</sup> ACA, § 1302.

<sup>2</sup> States could choose: one of the three largest small group plans in the state by enrollment; one of the three largest state employee health plans by enrollment; one of the three largest federal employee health plans by enrollment; or the largest HMO plan in the state's commercial market by enrollment.

<sup>3</sup> If a state's chosen benchmark plan did not cover all of the ten categories, states were required to supplement coverage with a benefits category from another benchmark plan option.

<sup>4</sup> CMS, Final Rule: Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, available at [http://www.ofr.gov/OFRUpload/OFRData/2013-16271\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2013-16271_PI.pdf).

<sup>5</sup> Some states are also considering using federal Medicaid money to purchase private insurance for the Medicaid expansion population through the exchanges/marketplaces. Federal guidance indicates that if states move forward with that option, the Medicaid EHB requirements still apply as well as existing Medicaid protections with regard to cost sharing. CMS, Medicaid and the Affordable Care Act: Premium Assistance (March 2013), available at [http://content.govdelivery.com/attachments/USCMS/2013/03/29/file\\_attachments/200058/Premium%2BAssistance%2BFAQ%2B03-29-13.pdf](http://content.govdelivery.com/attachments/USCMS/2013/03/29/file_attachments/200058/Premium%2BAssistance%2BFAQ%2B03-29-13.pdf).

<sup>6</sup> Prescription drug categories and classes are those used by the United States Pharmacopeia. The USP classification system does not appear to separately count combination drugs.

<sup>7</sup> Blue Cross and Blue Shield of Texas Preferred Drug List, Prime Therapeutics, available at [http://www.bcbstx.com/pdf/drug\\_list.pdf](http://www.bcbstx.com/pdf/drug_list.pdf); Center for Consumer Information and Insurance Oversight, Texas EHB Benchmark Plan, available at <http://cciio.cms.gov/resources/EHBBenchmark/texas-ehb-benchmark-plan.pdf>.

<sup>8</sup> Texas HIV Medication Program Formulary (November 2012), available at <http://www.dshs.state.tx.us/hivstd/meds/document.shtml>.

<sup>9</sup> CMS, Final Rule: Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, available at [http://www.ofr.gov/OFRUpload/OFRData/2013-16271\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2013-16271_PI.pdf).

<sup>10</sup> Grandfathered health plans are those plans that were in existence prior to enactment of the ACA (March 2010). Grandfathered plans are exempt from certain ACA provisions, such as requirements to cover EHBs and certain preventive services without cost sharing. Grandfathered plans lose their status if they make significant changes to their plan designs. For more information, see [Healthcare.gov](http://Healthcare.gov), [Grandfathered Health Plans](#).

<sup>11</sup> Priority Health, Priority Health HMO Member Handbook, available at

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[http://www.priorityhealth.com/member/handbook/~/\\_media/documents/member/priorityhmo-member-handbook.ashx](http://www.priorityhealth.com/member/handbook/~/_media/documents/member/priorityhmo-member-handbook.ashx).

<sup>12</sup> Michigan Department of Community Health, Medicaid Provider Manual (January 2013), available at <http://www.mdch.state.mi.us/dch-medicaid/manuals/medicaidprovidermanual.pdf>.

<sup>13</sup> Michigan Department of Community Health Division of Health, Wellness and Disease Control, Standards of Service for HIV Case Management in Michigan Medical and Non-Medical (2008), available at [http://www.michigan.gov/documents/mdch/Standards\\_-\\_Medical\\_Non-medical\\_225818\\_7.pdf](http://www.michigan.gov/documents/mdch/Standards_-_Medical_Non-medical_225818_7.pdf).