



Health Policy Brief

DECEMBER 28, 2010

Preventive Services Without Cost Sharing. New private health plans must pay for screenings and other preventive services. Will the benefits outweigh the costs?

WHAT'S THE ISSUE?

The Affordable Care Act requires new private health insurance plans to fully cover the costs of 45 recommended preventive services as of September 23, 2010. This means patients pay no deductibles or copayments or otherwise share costs of these services. As of January 1, 2011, the health care law also requires coverage for a new annual wellness visit under Medicare and eliminates cost sharing for recommended preventive services covered by that federal program.

The law also gives state Medicaid programs financial incentives to cover preventive services for adults and supports initiatives to improve public understanding of the benefits of lifetime preventive services. This brief examines the importance of preventive services, the expansion of access to those services required by the new law, and the pros and cons of expanding access to screenings and other tests that might increase costs without necessarily improving health outcomes.

WHAT'S THE BACKGROUND?

The term “prevention” encompasses a wide range of activities, from broad public anti-smoking campaigns to immunizing infants and children against infectious diseases. The term “preventive services” usually pertains to clinical services, such as those typically provided in a health care setting. “Primary”

preventive services, such as vaccinations or prescribing medications to help people quit smoking, are aimed at preventing disease. “Secondary” preventive services are designed to catch disease early so it can be treated; an example is a mammogram. “Tertiary” prevention aims to slow progression of a disease once someone already has it, and to enable him or her to function as normally as possible; an example is lowering the “bad” cholesterol of someone who’s already suffered a heart attack.

BENEFITS AND COSTS: Preventive services have the potential to help people live longer, avoid disease and disability, and be healthier and more productive. However, these improvements may have complex effects on costs. They can redistribute costs across the health care system and may particularly affect Medicare spending. Some preventive services, such as childhood immunizations, may reduce long-term health care spending. However, it is more likely that a preventive service may be considered “cost-effective” rather than cost-saving. “Cost-effective” means that the benefits of improved health outcomes outweigh the costs associated with preventive service and the long-term consequences of getting the service (such as radiation exposure from routine mammograms).

Determining which preventive services should be provided, when, how often, and to whom, can be complicated. In addition to having positive outcomes—for example, when

45

Number of services

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a cancerous breast tumor is found early and treated effectively—preventive services can also have negative consequences, such as risks of excessive radiation from mammograms or computed tomography (CT) scans. Screenings may also be inaccurate, giving “false positives” (meaning that it appears as if disease is present when it really isn’t) or “false negatives” (meaning that no disease appears present when in fact it is). False positives may lead to biopsies or other interventions that may be costly, inconvenient, or even harmful to patients.

Screenings may also identify cases in which disease is present, but would never progress to a level that requires treatment. A classic example is some forms of prostate cancer, which may progress very slowly. Yet individuals in whom such prostate cancer is identified may still undergo surgery or treatment that will have other side effects, even if the cancer itself might never have made them sick. In addition, preventive services themselves can be costly. Resources have to be spent to provide vaccinations or perform screenings on a broad population, even though many of those vaccinated and screened would never have contracted disease in the first place.

COMPLICATIONS AND CONTROVERSIES: The complicated relationship between the costs and benefits of prevention can sometimes lead to controversy. For example, in 2009 the United States Preventive Services Task Force (USPSTF) revised its breast cancer screening recommendations, increasing the age at which routine screening mammograms should begin from 40 to 50 and recommending screening every other year rather than every year. The task force said it worried about recommending routine screening without also making women aware of the harms, such as false positives, unnecessary biopsies, and “overdiagnosis” of cancers that would not otherwise have been identified. The new recommendations conflicted with recommendations by other groups, including the American Cancer Society. As a result, the revised USPSTF recommendations have not been widely adopted. The health reform law mandates coverage based on the recommendations in place before the November 2009 USPSTF revisions.

The mammography screening controversy also has highlighted several fundamental issues surrounding preventive services: Many preventive services have the potential for harm, and the risks and benefits of screening services can be difficult to assess, predict, and

balance. Scientific evidence supporting use of services often has limitations. As the body of evidence grows, it must be reconciled with the practice of medicine in order to encourage doctors to consider and act on the latest science. Also, the evidence must be translated into terms that are understandable to the general public. The controversy also emphasizes the need to weigh the costs of screening people who are not sick with the gain from early diagnosis of individuals who could benefit from early treatment.

In the end, the net benefit of a preventive service is determined by evaluating the prevalence and severity of the disease being identified or prevented, the cost and accuracy of the intervention, and the risks associated with treating individuals falsely diagnosed with the condition or who would not otherwise receive treatment. This analysis may differ for different populations based on complicating factors or limitations in the evidence available. For example, the USPSTF has begun refining its approach to developing recommendations to better address the preventive needs of older people.

MAKING RECOMMENDATIONS: Recommendations issued by the USPSTF are considered to be the “gold standard” for this type of analysis. The USPSTF is a panel of primary care providers, most of them affiliated with major academic medical centers, who are experts in prevention and evidence-based medicine. The panel is convened by the Agency for Healthcare Research and Quality, which is part of the US Department of Health and Human Services (HHS).

When analyzing a particular preventive service, the USPSTF estimates the benefits and harms based on a review of the clinical evidence. It then makes a recommendation about use of the service. The results are shown as one of five letter grades: “A” or “B” means the service is recommended and that the benefit of it is moderate to substantial. A grade of “C” means that the task force recommends against routinely providing the service, although there may be a small benefit for an individual patient. A “D” grade also means the service is discouraged and that there is moderate or high certainty that the service has no net benefit, or that the harms outweigh the benefits. A grade of “I” indicates there is insufficient evidence to determine the balance of benefits and harms. Exhibit 1 shows USPSTF grade and practice recommendations.

A & B

Recommended grades

Preventive services graded A and B by the USPSTF must be covered without cost sharing.

The USPSTF does not consider financial costs when making its determinations, but does summarize available information on costs and cost-effectiveness in its recommendation statements. Recommendations may be based on age, gender, and risk factors. For example, certain routine screenings may be recommended for people age 50 and over, but not necessarily for younger people.

The USPSTF has issued recommendations about preventive services for cancers, such as breast and colorectal cancers; heart disease, including cholesterol screening; diabetes; injury and violence; infectious disease; mental health and substance abuse; obstetric and gynecological conditions; vision and hearing disorders; and sexually transmitted diseases including HIV, syphilis, chlamydia, and gonorrhea. The USPSTF no longer makes recommendations about immunizations for adults and children, as those are now developed by the Advisory Committee on Immunization Practices, a panel of experts advising the Centers for Disease Control and Prevention.

PREVENTION AND HEALTH INSURANCE: Whether a particular individual receives a recommended preventive service often depends on whether the service is covered by health insurance, and how much the individual has to pay toward the service (“cost sharing”). Some states require that certain services be covered by private insurance policies, and may also require that the services be offered without any deductible or cost sharing. Most private plans

cover some preventive services, such as childhood immunizations. However, prior to passage of the Affordable Care Act in 2010, there was no national requirement that private insurance plans cover a basic set of services.

Medicare, the federal health insurance plan for the aged and disabled, does cover a set of preventive benefits, including screening for colorectal, breast, and cervical cancers; bone mass measurement; and certain immunizations. The Centers for Medicare and Medicaid Services (CMS) also has the authority to expand Medicare coverage to services that are recommended by the USPSTF, and has used that process to provide coverage for HIV screening and for tobacco cessation counseling. Since 2005 Medicare also has covered a physical exam for new beneficiaries called the “Welcome to Medicare Physical.”

WHAT'S IN THE AFFORDABLE CARE ACT?

The health reform law expands coverage of preventive services both within private health insurance plans and within Medicare and Medicaid. For private health plans, the new requirements are as follows (see Exhibit 2):

- Effective September 23, 2010, new group and individual plans must cover services recommended by the USPSTF with a grade of A or B, immunizations recommended by the Advisory Committee on Immunization Practices, and other services for which there is strong

EXHIBIT 1

Grade and Practice Recommendations Issued by the US Preventive Services Task Force

Grade	Definition	Suggestions for practice
A	USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service
B	USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service
C	USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small.	Offer or provide this service only if other considerations support offering or providing the service to an individual patient.
D	USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service
I Statement	USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

2013

Medicaid coverage begins

Medicaid programs covering optional adult diagnostic services must cover preventive services and immunizations starting in 2013.

supporting scientific evidence and which are recommended by HHS. This requirement does not apply to “grandfathered” health insurance plans (see the [Health Policy Brief](#) published October 29, 2010, for more information).

- New plans must cover the services listed above without applying deductibles or coinsurance for in-network services. However, they can apply cost sharing to out-of-network services. HHS expects that plans will pass along the cost of providing additional coverage of preventive services in the form of 1.5 percent higher premiums.

MEDICARE REQUIREMENTS: Many recommended preventive services were already covered by Medicare without deductibles and coinsurance for various reasons—including because prior law eliminated cost sharing. But the Affordable Care Act expands Medicare coverage for preventive services considerably as of January 1, 2011. For example:

- The “Welcome to Medicare” physical will now be covered with no cost sharing for beneficiaries.
- An annual “wellness” visit will be covered for beneficiaries with no cost sharing. During the visit, a physician or health team supervised by a doctor will gather information on individual and family medical history; identify the beneficiary’s providers and medications; obtain basic data on height, weight, waist circumference, and blood pressure; and establish a personalized screening schedule for the next 5 to 10 years.
- Certain services, such as depression screening and functional status screening,

will also be covered by Medicare if they are provided in the initial wellness visit.

- A “health risk assessment” during the annual wellness visit will also be covered. The assessment is intended to identify chronic diseases, injury risks, modifiable risk factors, and urgent health needs of the individual. HHS is required to develop guidelines for such assessments by March 23, 2011, and to involve the public in the process.

- Preventive services given A or B recommendations by the USPSTF will be covered by Medicare with no cost sharing.

- Three vaccines will now be covered with no cost sharing: influenza vaccines, the pneumococcal vaccine, and hepatitis B vaccine.

EXCEPTIONS: The Affordable Care Act did not alter existing coverage and cost-sharing arrangements for certain specific services. For example:

- Screening services covered by Medicare but not recommended by the USPSTF—such as digital rectal exams for prostate cancer, glaucoma screening, diabetes self-management training services, and barium enema furnished as a colorectal cancer screening service—are still subject to the deductible and cost-sharing requirements.
- Vaccines other than those for influenza, pneumonia, and hepatitis B that are covered under a different part of Medicare, known as Part D (usually described as the Medicare prescription drug benefit), are still subject to the Part D deductible and cost sharing.

EXHIBIT 2

Preventive Services Required of New Group and Individual Health Plans Without Cost Sharing

Evidence-based preventive services	Preventive services recommended by the the US Preventive Services Task Force based on the strength of the scientific evidence documenting their benefits. Includes breast and colon cancer screenings, screening for vitamin deficiencies during pregnancy, diabetes, high cholesterol, high blood pressure, and tobacco cessation counseling.
Routine vaccinations	Sets of standard vaccines recommended by the Advisory Committee on Immunization Practices, ranging from routine childhood immunizations to periodic tetanus shots for adults.
Preventive services for children	Preventive services recommended under the Bright Futures guidelines developed by the Health Resources and Services Administration and the American Academy of Pediatrics for children from birth to age 21. Includes regular pediatrician visits, vision and hearing screening, developmental assessments, immunizations, and screening and counseling to address obesity.
Preventive services for women	Will also include services recommended under new guidelines expected to be issued by August 2011, in addition to services recommended by the Preventive Services Task Force.

SOURCE US Department of Health and Human Services. **NOTES** Services are required by all new group and individual plans beginning on or after September 23, 2010. Services may be recommended only for certain groups, specific populations, ages, and/or risk factors.

Finally, the Affordable Care Act also gave CMS authority to eliminate coverage or payment for preventive services that are not recommended by the USPSTF. CMS has chosen not to exercise this authority yet but may do so in the future.

MEDICAID: Medicaid is the public health insurance program for low-income people that is jointly funded by the federal and state governments. State governments administer the program and determine which items and services are covered within a broad framework of mandatory and optional services. The federal government provides at least 50 percent of the funding for Medicaid and a higher percentage in poorer states.

States are already required to cover services for children that are considered optional for other populations, including screening and preventive services. Under the Affordable Care Act, and starting in 2013, Medicaid programs that cover optional diagnostic services for adults will also be required to cover preventive services and immunizations recommended by the USPSTF and the Advisory Committee on

Immunization Practices. The federal government will pay an additional 1 percent of the cost of those recommended preventive services if they are provided with no cost sharing.

WHAT'S NEXT?

Improved access and reduced cost sharing for preventive services under the Affordable Care Act are expected to increase the use of these services. Patients who formerly had been paying out of pocket for these services are likely to benefit. The impact of greater use of preventive services is expected to grow over time, as the number of private health insurance plans that are considered grandfathered (and not subject to the coverage requirements) decreases.

HHS is continuing to implement provisions related to the Medicare coverage for preventive services and will hold an open meeting in early 2011 to develop guidelines for the health risk assessment included in the annual wellness visit. ■

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