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Practical Matters

Taking the copay out of staying healthy

Many in the U.S. — including those on Medicare and Medicaid — have gained access to free diabetes screenings, mammograms and other preventive services.

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Being healthy is starting to cost a lot less.

Americans get only about half the preventive services recommended by their physicians, according to a 2003 report in the New England Journal of Medicine. The consequences are significant: A 2007 study by the Partnership for Prevention found that more than 100,000 lives could be saved annually by increasing the use of just five services: aspirin to prevent heart disease, smoking cessation assistance, screenings for breast and colorectal cancers, and flu shots.

There are many reasons why patients may not be getting preventive services. But the Patient Protection and Affordable Care Act, the sweeping health reform law passed this year, is attempting to remedy at least one of them: cost.

For a growing number of health plans, financial barriers to preventive care will be a thing of the past. No longer will insurance providers be able to charge a copay, deductible or coinsurance for preventive services.

For now, the rule applies only to group and individual health plans established since Sept. 23. As of Jan. 1, it also applies to those covered by Medicare and Medicaid.

In addition, private plans created before Sept. 23 will have to comply if they make "significant" changes that reduce benefits or increase costs. The changes aren't spelled out in the law but would certainly include major adjustments in copays, provider networks or drug benefits.

The U.S. Department of Health and Human Services expects that nearly 70% of those older plans will lose their exemption by 2013; by then, an estimated 88 million Americans will have access to free preventive services.

"This tries to rebalance a system that has been largely focused on acute care instead of on being healthy," said Dr. Roland Goertz, president of the American Academy of Family Physicians, which supports the changes.

The new rule applies to services that are rated A or B by the U.S. Preventive Services Task Force, a division of the Department of Health and Human Services that advises the government on health matters. These ratings mean that the services have a high likelihood of providing benefits to the patients. Screenings and treatments recommended by other government agencies or independent groups — such as the national Centers for Disease Control and Prevention's childhood immunization schedule — also fall under the umbrella of coverage as long as they are backed by clear medical evidence.

The task force alone has more than 40 A and B recommendations, which vary based on the age and health of the patient. For instance, diabetes screenings are now covered for adults with sustained high blood pressure, while folic acid supplementation is free for women planning to become pregnant. (The full list of recommendations can be found at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.)

The services that will affect most people can be condensed to a handful, Goertz said. These include: colorectal screenings for people ages 50 to 75; cholesterol screenings for men over 35 and women over 45; hepatitis and HIV screenings, particularly for at-risk populations; and child and adult immunizations.

Other important services that will be covered include cervical cancer screenings for women, mammograms, smoking cessation and counseling services for tobacco users, and newborn genetic screening for conditions such as sickle cell anemia.

But depending on how consumers use their insurance, they may find themselves footing the bill for some preventive services. For instance, if they go to doctors outside their network, they may have copays or coinsurance fees, said Patrick Johnston, president of the California Assn. of Health Plans.

The task force recommendations often provide guidelines concerning the frequency, method or setting for getting preventive services. But when those aren't specified, insurance companies can use "reasonable medical management techniques" to determine coverage limitations, according to America's Health Insurance Plans, a national lobbying group. For example, the task force recommends breast cancer screening "every one to two years" for women in their 40s. Insurance companies could argue that they are required to pay for a mammogram only once every other year.

There also may be costs to patients if they bundle a group of services into one visit. If you go to the doctor for a sinus infection and get a cholesterol test while you're there, the cholesterol test will be free, but there will still be a copay for the doctor's visit and treatment for the infection.

Free access to preventive services should make for healthier patients, but it's not automatic, Goertz says. He advises people to wrap up their doctor's visits by asking a simple question: "What can I do to be healthier?"

"Being healthy in the long run allows you to be much more productive over your lifetime and lead a life that is much more satisfying," he says. "But it will take time. It's a cultural shift that will have to take place, and it won't necessarily happen just because a law was passed."

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