



The Impact of 2017 Health Reform Proposals on Coverage of Clinical Preventive Services

This issue brief analyzes the potential impact of health reform proposals on public and private health insurance coverage of clinical preventive services. It provides background on current coverage requirements, analyzes the impact of the American Health Care Act (H.R. 1628) passed by the U.S. House of Representatives on May 4, 2017 and outlines the possible impacts of additional legislative proposals and/or administration actions that could be taken to reduce coverage of preventive services.

The potential impact is significant and could affect millions of Americans via:

1. The indirect impact of loss of insurance coverage;
2. Reductions in coverage for evidence-based prevention services due to changes in and/or elimination of essential health
- benefits or other preventive services requirements;
3. Increases in cost-sharing requirements for preventive services; and
4. Delays in implementation of payment policies, e.g., for the Diabetes Prevention Program(DDP).

Current Coverage of Clinical Preventive Services

There are two main Affordable Care Act (ACA) requirements related to coverage of preventive services: Essential Health Benefits (EHB) and Section 2713. These overlapping requirements of the ACA are intended to increase coverage of preventive services and restrict cost-sharing¹ for evidence-based preventive services.

Private Insurance

Preventive Services as a Component

of Essential Health Benefits: Small group and individual plans must cover 10 categories of Essential Health Benefits, including preventive and wellness services and chronic disease management.² The types of preventive services that plans could cover include, for example, blood pressure screening, well visits for babies, children and women, obesity screening and counseling, tobacco cessation interventions, vision screening for children and breastfeeding support and supplies.

The EHB standard does not specify which preventive services states must cover. States have the flexibility to select or default to a specific “benchmark” plan; state, individual and small group health plans must then provide coverage that is substantially equal to the benchmark plan.³

Section 2713 Preventive Services:

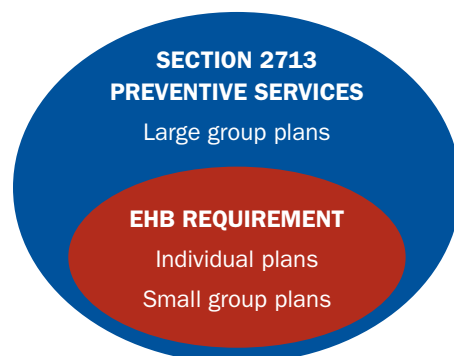
Non-grandfathered⁴ individual, small and large plans (essentially all private insurance plans) must cover certain preventive services without any cost-sharing requirements, including:⁵

- All evidence-based items and services with an A or B grade by the U.S. Preventive Services Task Force (USPSTF);

- All vaccines recommended by the Centers for Disease Control and Prevention’s (CDC) Advisory Committee on Immunization Practices (ACIP); and
- With respect to children and women, evidence-informed preventive care and screenings in guidelines supported by the Health Resources and Services Administration (HRSA).⁶ These are currently based on HRSA’s Bright Futures while women’s services are identified by the National Academies of Medicine and Science (formerly the Institute of Medicine).

In 2015, an estimated 137 million privately insured people were enrolled in private insurance with guaranteed coverage of preventive services without cost-sharing.⁷

FIGURE 1: Applicability of EHB and Section 2713 Requirements to Private Insurance Plans (Non-grandfathered plans)



Medicaid

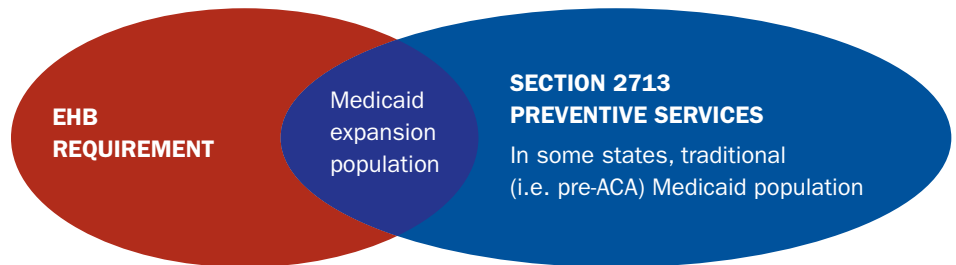
Preventive Services as a Component of Essential Health Benefits:

In states that expanded Medicaid to all adults under 138 percent of the federal poverty level, the 14 million people newly eligible for Medicaid (the “expansion population”) have coverage for 10 categories of Essential Health Benefits, including preventive and wellness services and chronic disease management. Those covered by traditional (non-expansion) Medicaid do not qualify for this same coverage.

Section 2713 Preventive Services: In states that expanded Medicaid to all adults under 138 percent of the federal poverty level, those newly eligible for Medicaid gained coverage for certain preventive services without any cost-sharing requirements, according to the recommendations of the bodies listed above (USPSTF, CDC, ACIP and HRSA).

For the majority of Medicaid enrollees who are covered by traditional (non-expansion) Medicaid, states have the flexibility to determine coverage of preventive services. States have an incentive to cover the full slate of Section 2713 preventive services without cost-sharing – they receive a one percent increase in the federal contribution to Medicaid (FMAP) for those services.⁸ At least 10 states have provided this coverage and have been approved to receive the incentive: California,⁹ Delaware, Hawaii,¹⁰ Kentucky, Montana,¹¹ Nevada,¹² New Hampshire,¹³ New Jersey,¹⁴ New York¹⁵ and Ohio.¹⁶

FIGURE 2: Applicability of EHB and Section 2713 Requirements to Medicaid



Tobacco Cessation Services: As of December 2015, approximately 2.3 million adult smokers were newly enrolled in Medicaid because of Medicaid expansion and thus had access to tobacco cessation services. As of July 1, 2016, all 32 states that have expanded Medicaid eligibility covered some cessation treatments for all Medicaid expansion enrollees.¹⁷

The ACA mandates Medicaid coverage of comprehensive tobacco cessation services for pregnant women, including diagnostic, therapy and counseling services and pharmacotherapy for cessation of tobacco, without cost-sharing. States have flexibility in determining how these services will be provided, including the types of qualified providers and the delivery mode (for example, evidence-based telephone counseling quitlines can be covered).¹⁸

Medicare

The ACA does not require Medicare to cover any specific clinical preventive services. If any USPSTF-recommended services with a grade of A or B are covered by Medicare, however, they must be covered without cost-sharing

to the beneficiary.¹⁹ Medicare covers a Welcome to Medicare Visit and an annual wellness visit (both based on a screening schedule based on USPSTF and ACIP guidelines) and a personalized wellness plan.²⁰

TABLE 1: Summary of Current Preventive Services Coverage Requirements under the Affordable Care Act²¹

Payer	USPSTF A or B recommendations	ACIP recommendations	HRSA recommendations for children	HRSA recommendations for women
Employer-sponsored plans ^b	Required to cover without cost sharing	Required to cover without cost sharing	Required to cover without cost sharing	Required to cover without cost sharing
Individual and small group plans, both inside and outside of Exchanges ^b	Required to cover without cost sharing	Required to cover without cost sharing	Required to cover without cost sharing	Required to cover without cost sharing
Medicare	Not required to cover, but if do, may not require cost sharing ACA requires coverage of an annual wellness visit that includes a screening schedule based on USPSTF and ACIP guidelines.	Varies by vaccine (no new requirements or incentives under ACA) ACA requires coverage of an annual wellness visit that includes a screening schedule based on USPSTF and ACIP guidelines.	Not required to cover, and if do, may require cost sharing (no new requirements or incentives under ACA)	Not required to cover, and if do, may require cost sharing (no new requirements or incentives under ACA)
Traditional Medicaid	Not required to cover. However, under ACA, if all USPSTF and ACIP services are covered without cost sharing, states receive a 1% FMAP boost for these services.	Not required to cover. However, under ACA, if all USPSTF and ACIP services are covered without cost sharing, states receive a 1% FMAP boost for these services.	No new requirements or incentives under ACA (but Medicaid covers key preventive services for children under EPSDT)	No new requirements or incentives under ACA
Expansion Medicaid	Under ACA, required to cover without cost sharing	Under ACA, required to cover without cost sharing	Under ACA, required to cover without cost sharing	Under ACA, required to cover without cost sharing
CHIP	When run separately from Medicaid, not required to cover, and if do, may require cost sharing (no new requirements or incentives under ACA)	When run separately from Medicaid, not required to cover, and if do, may require cost sharing (no new requirements or incentives under ACA)	When run separately from Medicaid, not required to cover, and if do, may require cost sharing (no new requirements or incentives under ACA). When run as extension of Medicaid, must cover EPSDT and may not require cost sharing.	When run separately from Medicaid, not required to cover, and if do, may require cost sharing (no new requirements or incentives under ACA)

Benefits of Insurance Coverage of Preventive Services

Americans with coverage of preventive services are more likely to access these services, particularly if there is no cost to the patient. In one study, young adults with health coverage were more likely to receive preventive services like routine examinations, screenings for blood pressure and cholesterol, and annual dental visits.²² In adults ages 18-65 with coverage, screenings for blood pressure and cholesterol, and flu shots have increased.²³ Medicaid beneficiaries with coverage for preventive services are more likely to get screened for diabetes.²⁴

Providing and promoting evidence-based cessation coverage has been found to be a cost-effective way to help smokers quit. Among the Medicaid population in Massachusetts, an evidence-based, heavily promoted Medicaid cessation benefit was associated with a reduction in smoking prevalence, from 38.3 percent to 28.3 percent over a 3-year period.²⁵ For each dollar spent on the benefit over a 3-year period, an estimated \$3.12 in medical savings occurred from averted cardiovascular hospitalizations alone.²⁶



Potential Changes to Preventive Services Coverage

Loss of Preventive Services Via Current and Potential Legislative Actions

Legislative action, including the American Health Care Act (AHCA) passed by the U.S. House of Representatives on May 4, 2017, would allow states to opt out of the EHB requirements beginning in 2020, when states may apply for waivers to redefine essential health benefits coverage in the individual or small group market.²⁷ AHCA would also repeal the requirement to provide coverage of clinical preventive services and other essential health benefits for Medicaid expansion populations, impacting 14 million people nationwide. AHCA would permit states

to convert Medicaid to a block grant for certain populations, including children. States approved for this block grant option would no longer be required to cover the Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) benefit that ensures that children get access to the services they need – including clinical preventive services.²⁸

The elimination of these standards would affect many Americans with public and private insurance. AHCA would establish a Patient and State Stability Fund for states meeting certain

requirements. Promoting access to preventive services is one of the permitted uses of these funds, along with providing financial assistance for high risk individuals and provide cost sharing subsidies.²⁹ In addition, the House-passed health reform legislative would reduce the numbers of Americans with health insurance by 22 million by 2020,³⁰ which would include losing access to preventive services. Studies show that uninsured individuals are much less likely than those with insurance to receive preventive services.^{31, 32, 33, 34}

Changes the Administration can Make Independent of Congress

The Administration could take a number of actions that would directly or indirectly weaken coverage of preventive services:

1. Changes to the scope of Section

2713: The Administration could change HRSA's endorsement of women's or children's preventive services.³⁵ HHS could also change some of the subregulatory guidance it has issued on specific details of coverage of other preventive services, such as how many FDA-approved smoking cessation medications must be covered to comply with USPSTF's recent recommendation of such medications.³⁶

2. Repeal of Essential Health Benefits:

HHS could weaken the EHB requirement, which was implemented by notice-and-comment rulemaking.

3. Withholding payment for specific

prevention-related programs in Medicaid and Medicare: For example, the National Diabetes Prevention Program is slated to begin providing lifestyle change programs for Medicare beneficiaries with type 2 pre-diabetes and diabetes on January 1, 2018. The final rule, released in November 2016, did not detail reimbursement for provision of these services, with the expectation that CMS would take up the question in 2017. Further, the program is dependent on HHS granting Medicare an innovation waiver under section 1115A of the ACA.³⁷ HHS could postpone reimbursement for the DPP, a program affecting 22 million Medicare beneficiaries who are at risk of developing type 2 diabetes.³⁸

Endnotes

- 1 Including coinsurance, co-payments and deductibles.
- 2 The 10 essential benefits include:
Ambulatory patient services; Emergency services; Hospitalization; Maternity and newborn care; Mental health and substance use disorder services, including behavioral health treatment; Prescription drugs; Rehabilitative and habilitative services and devices; Laboratory services; Preventive and wellness services and chronic disease management; and Pediatric services, including oral and vision care.
- 3 <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html> and <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/ehb-2-20-2013.html>. A chart of benchmark plans by state is available here: <http://kff.org/health-reform/state-indicator/ehb-benchmark-plans/?currentTimeframe=0&sortModel=-%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
- 4 In order to have been classified as “grandfathered,” plans must have been in existence prior to March 23, 2010, and cannot make significant changes to their coverage (for example, increasing patient cost-sharing, cutting benefits, or reducing employer contributions). In 2014, 26% of workers were covered in employer sponsored plans that were grandfathered, however it is expected that over time almost all plans will lose their grandfathered status. See <http://kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/>
- 5 PPACA Sec. 2713.
- 6 PPACA Sec. 2713.
- 7 Department of Health and Human Services. (2015). The Affordable Care Act Is Improving Access to Preventive Services for Millions of Americans. Available at: <https://aspe.hhs.gov/system/files/pdf/139221/The%20Affordable%20Care%20Act%20is%20Improving%20Access%20to%20Preventive%20Services%20for%20Millions%20of%20Americans.pdf>
- 8 PPACA Sec. 4106.
- 9 Department of Health and Human Services. (2013). California State Plan Amendment # 13-014. Available at: <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CA/CA-13-014.pdf>
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- 16 Department of Health and Human Services. (2013.) Ohio State Plan Amendment 13-013. Available at: <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OH/OH-13-013.pdf>
- 18 <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD11-007.pdf>
- 19 PPACA Sec. 4104.
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- 32 CBO estimate <https://www.cbo.gov/publication/52516>
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