IMPLEMENTING HEALTH REFORM

New Covered Preventive Care

One goal of the Affordable Care Act was to boost the use of preventive services by all Americans. The law attempts to do this by making those services – health screenings, vaccinations, well-baby visits, and dozens more – free to as many people as possible as soon as possible.

Now, new private health plans must offer the services without patient cost sharing. Although that provision covers only a fraction of the population – existing plans were exempted – as of Jan. 1, all Medicare beneficiaries will be offered a host of new services with no out-of-pocket costs.

Dr. Meena Seshamani, the deputy director of the Office of Health Reform at Health and Human Services, explains how her agency is implementing this provision of the ACA and how HHS hopes it will affect the behavior of patients and physicians.

CLINICAL ENDOCRINOLOGY NEWS: What preventive services will doctors be offering Medicare beneficiaries copayment-free in 2011?

Dr. Seshamani: Medicare beneficiaries with [fee-for-service] Medicare will receive free preventive care services and a free annual wellness visit, or physical. The complete list of preventive services is available in the Medicare & You Handbook, and it includes bone mass measurement, certain colorectal cancer screening tests, immunizations for influenza and hepatitis B, and mammograms. Most Medicare Advantage plans also are offering theses services without cost sharing, so beneficiaries should check with their plan.

Medicare beneficiaries 'will receive free preventive care services and a free annual wellness visit.'

DR. SESHAMANI

CEN: This change went into effect for private insurance plans created after health reform was enacted but not plans existing before then. Will long-existing plans, presumably covering most younger patients, ever have to fully cover preventive services under the law?

Dr. Seshamani: The ACA requires new insurance plans to cover an array of preventive services – those I mentioned above plus additional services including well-baby and well-child visits and routine immunizations – without charging a copay, coinsurance, or deductible. These rules do not apply to grandfathered plans, that is, plans that existed on March 23, 2010, and have not made significant changes since then. If a plan loses its "grandfather status" by making changes that reduce benefits or increase costs to consumers, it will need to comply with the new rules. It's also important to note that many grandfathered plans already cover an array of preventive services with minimal or no cost sharing.

CEN: How were these services chosen?

Dr. Seshamani: The ACA specifies that Medicare beneficiaries will not have to pay cost-sharing for Medicare-covered services that are recommended with a grade of A or B by the U.S. Preventive Services Task Force. The law also requires private plans to cover without cost-sharing all services that are recommended with a grade of A or B by the task force; routine immunizations recommended by the Advisory Committee on Immunization Practices; and services for infants, children, and adolescents recommended by the Health Resources and Services Administration, including the Bright Futures guidelines for regular pediatric checkups.

CEN: How will this change affect primary care physicians? What about specialists?

Dr. Seshamani: Some of the recommended services, like flu shots, are routinely delivered by primary care physicians, while others, like colonoscopies, are more commonly delivered by specialists. All physicians have a role to play in making sure their patients get the preventive care they need to stay healthy.

CEN: What proportion of the preventive services have patients been getting in the past, and what do you expect after these changes?

Dr. Seshamani: Many Americans have not gotten the preventive care they need, often because of cost. Before the ACA, Americans used preventive services at about half of the recommended rate. By eliminating copayments for new plans and for Medicare beneficiaries, the law will make preventive care more accessible for many Americans.

CEN: Won't these changes increase public and private health care costs, while health reform was meant to control costs?

Dr. Seshamani: Chronic diseases, such as diabetes, cancer, and heart disease make up 75% of U.S. health spending. These diseases are often preventable, and by improving access to preventive care, more Americans will get the care they need to stay healthy. This can not only improve the health of Americans, but also prevent the need for costly care later. ■

Cutting Copayments for Drugs Improves Compliance

BY JANE ANDERSON

FROM HEALTH AFFAIRS

Reducing or eliminating copayments for medications to treat common chronic conditions can improve medication adherence by several percentage points, according to a study in one self-employed company.

VITALS

Major Finding: Eliminating the copayment for statin drugs led to a 3.1% increase in medication adherence among employees at self-insured Pitney Bowes.

Data Source: A comparison of medication adherence in employees whose copayments were modified and those whose were not.

Disclosures: The study was supported by the Commonwealth Fund. The authors disclosed grant funding from Aetna Inc. and the Robert Wood Johnson Foundation.

"We observed improvements in adherence that were relatively modest in scale and that are consistent with the findings of other investigators," wrote lead author Dr. Niteesh Choudhry of Harvard Medical School, Boston, and colleagues. "This highlights the various factors involved in nonadherence. Thus, the ability of benefit design and patient financial incentives to address this complex problem completely should not be overestimated."

The investigators manipulated medication copayments for a subset of employees of Pitney Bowes, a self-insured company. For a total of 2,830 employees, copayments for statins were eliminated and the copayment for clopidogrel was significantly reduced. Their medication adherence patterns were compared to 49,801 fellow employees whose copayments were not changed (Health Affairs 2010;doi:10.1377/hlthaff.2010.0808).

To measure medication adherence, the researchers estimated the number of days of medication each patient actually received through the pharmacy benefit manager, compared to the total number of days in each month during 2006-2007.

Adherence to statins rose by 3.1% immediately after the copayment was eliminated, compared to the control group. The number of patients who were fully adherent to their statin regimen rose by 17% immediately, compared with the control group.

Meanwhile, when copayments were reduced for clopidogrel, adherence rates rose by 4.2% in the intervention group compared to the control group, the investigators wrote. The number of patients who were fully adherent rose by 20% immediately, compared with controls.

This type of value-based benefit design can improve compliance, but physicians and policymakers will need to address other compliance factors in order to have a major cost-saving effect, Dr. Choudhry wrote.

Cost plays a role in patient adherence, but it's not the only factor, noted Dr. Melissa S. Gerdes, a family physician at Trinity Clinic Whitehouse, in Texas. "I get people who don't want to pay a $10 copay to see me, but who will go to McDonalds and drop $20," Dr. Gerdes said in an interview. "They – in general – consider anything over $10 as high for a copay."

Decreasing copayments from $50 to $30, for example, wouldn't make much difference, Dr. Gerdes said, because most patients can no more afford the $30 copayment than the $50 one. For a real difference, copayments need to drop to around $4, the price Walmart charges for many generics, she said. ■

VIEW ON THE NEWS

Carrots and Sticks in Health Reform

One possible way to save health care dollars is to use tradeoffs in the form of higher cost-sharing for care deemed less essential, according to Marjorie Ginsburg.

Employers increasingly are using positive incentives to persuade employees to get needed care and stay healthier, Ms. Ginsburg wrote. Few employers have tried raising costs for high-cost, low-value care in order to save money, but that approach might receive more support than insurers and employers might think.

If employers and insurers truly want to employ both the "carrot" of positive incentives and the "stick" of higher costs for services deemed lower-value, they should consider giving employees and patients a voice in the decision-making process.

"There is no substitute for getting people to help design the coverage that will affect them directly," she wrote. "Giving them a voice will make them more supportive of the result, even if some people do not end up with their ideal plan."

MS. GINSBURG *is executive director of the Center for Healthcare Decisions in Rancho Cordova, Calif. Her comments were made in the same issue of the journal (Health Affairs 2010[doi:10.1377/hlthaff.2010.0808]).*