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 the Health and Human Services department, explains how her agency is implementing this provision of the ACA and how HHS hopes it will affect the behavior of patients and physicians.

FAMILY PRACTICE 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 abdominal aortic aneurysm screening, 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.

FPN: 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?

Before the ACA, Americans used preventive services at about half of the recommended rate.

DR. SESHAMANI

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.

FPN: 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; services for infants, children, and adolescents recommended by the Health Resources and Services Administration, including the Bright Futures guidelines for regular pediatric checkups, and guidelines on newborn screening; and additional preventive services for women that are being developed.

FPN: 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.

FPN: 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.

FPN: Won't these changes raise public and private health care costs, while reform was supposed to control costs?

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

The complete list of preventive services that Medicare and some private plans must offer at no charge to patients is at http://www.HealthCare.gov/center/regulations/prevention.html.

Insurers to Pay 80%-85% of Premium on Medical Care

BY ALICIA AULT

FROM A PRESS CONFERENCE HELD BY THE HEALTH AND HUMAN SERVICES DEPARTMENT

Beginning next year, health insurance companies will be required to prove that they spend at least 80% of premium dollars collected on direct medical care and quality improvement efforts under new federal regulations.

In some markets, insurers spend as little as 60% of the premium dollar on direct care. Under the rule, those companies might have 'to return nearly $3,500 to every family they insure.'

The interim final rule takes effect Jan. 1 and was required by the Affordable Care Act. The so-called medical loss ratio rule was developed by the National Association of Insurance Commissioners, which submitted its recommendations to the Health and Human Services department in late October.

According to the rule, HHS will review insurers' medical loss data at the end of 2010. Companies that spend less than 80%-85% of their premium dollar on direct medical care will be required to issue rebates to consumers, said HHS Secretary Kathleen Sebelius at a press briefing. The rebate checks will begin arriving in 2012.

In some markets, insurers spend as little as 60% of the premium dollar on direct care, said Ms. Sebelius, who added that under the rule, those companies might have "to return nearly $3,500 to every family they insure." Her calculation was based on an average annual premium of $13,250 paid by a family of four.

Ms. Sebelius and other HHS officials said the rule was an important new consumer law. An estimated total of 74.8 million Americans will be protected by the new medical loss ratio requirements, and up to 9 million Americans could be eligible for rebates in the first year, according to HHS.

Timothy Jost, a professor of law at Washington and Lee University, Lexington, Va., who advised the NAIC task force, said he estimated that insurers now spend 12% of the premium dollar on pharmaceuticals and 31% for physician services, and 31% on administrative costs.

The rule "will drive insurers to become more efficient," and "incentivize them to not raise premiums more than necessary," Mr. Jost said during the briefing.

Perhaps in response to opponents who have complained that the passage of the ACA was a closed-door process, HHS and NAIC officials at the briefing said that the medical loss ratio rule had been developed in a very public fashion, with open hearings.

"These rules were carefully developed through a transparent and fair process with significant input from the public, the states, and other key stakeholders," said Jay Angoff, director of the HHS Office of Consumer Information and Insurance Oversight.

Jane Cline, president of the NAIC and insurance commissioner for West Virginia, said there were safeguards in the rule to ensure that it would not destabilize the insurance markets. The HHS Secretary will have the ability to adjust the medical loss ratio on a state-by-state basis to ensure that there is access to insurance, Ms. Cline said.

Four states – Maine, Iowa, South Carolina, and Georgia – have already asked HHS to change the requirements for insurers operating there; others could follow suit, Mr. Angoff said.

Transparency will be required of insurers as well. Starting in 2011 they will have to report publicly how they spend their premium dollars. ■