Paying for Prevention: Recent Developments and Future Strategies

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Today's conscientious physician is justifiably frustrated by a reimbursement system that denies payment for preventive screening, counseling, and immunizations. Health insurance generally does not (and many contend that it should not) cover low, predictable-cost preventive interventions. The past decade has witnessed three major developments that are changing this traditional view: (1) a dramatic and unsustainable rise in health care costs; (2) increasing legislative and patient demand for "prevention," and (3) a growing body of evidence demonstrating the health benefits, and to a lesser degree, cost-effectiveness, of preventive services.

Frustrated by annual medical care cost and health insurance premium increases of 20% to 35% that consume more than 50% of pretax corporate profits,[1] employers are seeking to decrease expenditures and restrict benefits. Currently, only about 45% of employment-based health plans offer coverage for basic childhood vaccinations[2]; packages that include screening services or counseling are covered even less routinely. Screening tests and immunizations are more likely to be reimbursed in the office setting than are counseling services. Payment for smoking cessation is provided rarely, and even then, only in conjunction with the treatment of a smoking-related disease.[3] Some companies and health insurance plans are experimenting with offering a capped amount for preventive services, including smoking cessation. Direct medical cost savings are difficult to demonstrate for the vast majority of preventive interventions, with the exception of selected immunizations. The promise of indirect benefits (increased productivity, less absenteeism, improved morale, etc) more than likely constitutes the major rationale for expanding preventive coverage.

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Medicare, prohibited by statute from paying for preventive services, now covers specific immunizations and screening tests (pneumococcal and hepatitis B vaccinations, Papanicolaou smears, mammography) based on either demonstration of future direct medical cost savings or, increasingly, on congressional mandate. There is no specific reimbursement for smoking cessation interventions, for either physician counseling or group classes. However, new evidence that smoking cessation at any age, even after 65 years,[4] decreases mortality may move insurers to review this policy. Major demonstration projects to study the effectiveness of preventive services in the elderly are not expected to yield definitive information on whether the Medicare program should expand benefits, chiefly because of delayed enrollment periods and short follow-up.[5]

Premium costs for providing preventive services are quite modest, primarily based on historically low levels of utilization rates in the range of 40%, even when no deductible or copayment is required.[6] It is estimated that to offer the screening and immunization services as recommended by the US Preventive Services Task Force[7] would increase the typical annual health insurance premium by $24 for individual and $84 for family coverage. Total lifetime preventive costs incurred by age 85 years would range from $2900 to $4300 for men and from $4700 to $6600 for women, based on whether services were received in accordance with the "less frequent" or "more frequent" schedule of the task force.[8]

A Plan of Action

If reimbursement for preventive services is to be expanded in today's difficult health-care economic climate, a multiple-front approach by physicians, payers, and patients will be required, as follows.

Increase demand for preventive services coverage by providers, patients, and employers. Physicians can directly and indirectly stimulate such demand through professional negotiations with employers and insurers, by speaking out frequently and visibly before interested groups, and by urging patients in their office practices to inquire about and demand better coverage for services. Preventive interventions should be covered without deductibles or copayments. Innovative approaches such as the use of "preventive services accounts" with annual or lifetime capped dollar amounts may represent a promising mechanism to increase coverage for prevention, particularly for behavioral risk factor counseling. Information about the low actuarial costs of covering preventive services should be disseminated widely.

Revise CPT and ICD-9-CM coding systems to reflect current scientific knowledge and practice in preventive medicine and encourage their appropriate use and reimbursement. While the existence of a CPT code does not ensure reimbursement, the deliberate miscoding of preventive services as diagnostic procedures or the absence of appropriate codes for clinically effective services undermines the practice of and payment for preventive medicine. Physician specialty societies should endorse changes to these coding systems that reflect our knowledge about the efficacy of primary and secondary prevention and the existence of well-described "high-risk conditions" that mandate intervention.

The American College of Preventive Medicine (ACPM), in consultation and coordination with the American Academy of Family Practice and other primary care specialties, is proposing a major revision and expansion of CPT-4 codes based generally on the *Guide to Clinical Preventive Services.* The *Guide* represents the consensus of a 5-year effort by the US Preventive Services Task Force to evaluate, using an explicitly documented methodology, the efficacy and effectiveness of preventive interventions. New codes are proposed for the periodic medical examination of "new" and "established" patients based upon age, sex, and high-risk groups. Time-based "counseling/risk factor reduction" visit codes and a specific code for the administration and interpretation of health risk appraisals are also proposed. The existing code for counseling in a group setting would be maintained.

Support continuing research and demonstration projects for the health and cost-effectiveness of preventive services. Many decry the "double standard" used to justify the nonpayment for preventive as opposed to "curative" medical services. Nevertheless, such evidence is critical to expand further payment for prevention, particularly for public health insurance. Physicians and their specialty organizations should actively support extending existing Health Care Financing Administration demonstration projects on preventive services.

Support and participate in the resource-based relative value scale (RBRVS) process to evaluate preventive services. Screening, counseling, and immunizations, as the cornerstones of effective primary and secondary disease prevention, should receive the same degree of scrutiny as other medical care. Through testimony before the Physician Payment Review Commission, ACPM and other groups have successfully argued that preventive services be studied by the RBRVS panel.

A consistent, coordinated approach to the individual patient, employers, insurers, and specialty organizations that builds on the scientific evidence of clinical effectiveness, consumer demand, and direct and indirect cost-savings/effectiveness is necessary to effect change in the current reimbursement system. Individual physicians, through both their daily patient interactions and their professional relationships with the lay and medical community, can and should be important "change agents" in moving us toward equitable payment for effective preventive services.

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