Health Plan Implementation of U.S. Preventive Services Task Force A and B Recommendations — Colorado, 2010

The Patient Protection and Affordable Care Act (PPACA) is aimed at expanding access to health care and lowering cost barriers to seeking and receiving care, particularly high-value preventive care. The legislation requires Medicare and all qualified commercial health plans (except grandfathered individual and employer-sponsored plans) to cover routine preventive services graded A and B by the U.S. Preventive Services Task Force (USPSTF) at no cost to the consumer, along with recommended immunizations and additional preventive care and screenings for women (*1*). In 2009, Colorado passed a law with similar USPTF A and B service coverage requirements (*2*). To determine how Colorado health plans had interpreted the state and federal law, the Colorado Department of Public Health and Environment (CDPHE) interviewed representatives of commercial health plans serving Colorado residents. The results of those interviews indicated that different health plans interpreted certain USPSTF recommendations differently, including tobacco screening and pharmacotherapy, colorectal cancer screening, and obesity screening and counseling. One health plan communicated the scope, eligibility criteria, and content of the new preventive services coverage to its members or providers. The differences in interpretation of the USPSTF recommendations and limited communication to consumers or health-care providers in Colorado might be repeated in other states. To ensure optimal consumer and health-care provider utilization of preventive service benefits, the preventive services supported by USPSTF A and B recommendations should be clearly defined in health plan benefit language, with processes put in place for consistent implementation and eligibility criteria communicated to both consumers and providers. The experience in Colorado shows that public health organizations can play a key role in successfully implementing PPACA prevention services provisions.

During June–July 2010, CDPHE staff members used a standardized survey protocol to interview seven of the eight local medical directors or quality improvement directors of each of the major commercial health plans in Colorado about their coverage of USPSTF recommended services. USPSTF reviews the most current evidence of effectiveness of clinical preventive health-care services and grades the strength of the evidence. USPTF recommends that primary-care practitioners and health systems offer or provide their clients preventive services when there is high certainty that the net benefit is substantial (grade A recommendation) or when there is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial (grade B recommendation) (*3*). The survey questions focused only on those USPSTF recommendations pertaining to chronic disease prevention, screening, and management. The survey inquired about cardiovascular disease and cancer screening, obesity screening and intervention, and tobacco screening and cessation. Medical directors were questioned about benefit availability across each coverage type provided by the health plan (i.e., individual versus group market) and limits on coverage (i.e., age, frequency, annual or lifetime limits). In addition, directors were questioned regarding how they had communicated these benefit changes to their consumers and providers.

The vast majority of A and B recommendations addressed in the survey were interpreted consistently across all health plans. However, health plans interpreted and designed their coverage around some A and B recommendations differently. One USPSTF A recommendation encourages clinicians to ask all adult patients about tobacco use and provide tobacco cessation interventions for adults who use tobacco products (*4*). Colorado health plans reported some restrictions and variability in the provided coverage for tobacco screening and pharmacotherapy. Three of the eight plans restricted reimbursement for tobacco use screening to primary-care providers. One plan restricted the frequency that providers could be reimbursed for screening to the annual visit plus one other visit per year. Only one heath plan offered all Food and Drug Administration–approved tobacco cessation medications with no restrictions. The most consistent areas of pharmacotherapy benefit limitation were with varenicline and buproprion SR. Two plans did not cover these medications, and five plans offered the medications with restrictions, such as frequency (annual or lifetime limits), step therapy requirements, copays, deductibles, or coinsurance.

In addition to the different interpretations regarding tobacco cessation and counseling, the benefit design for colorectal cancer screening reflected different interpretations of how coverage for such benefits should be structured. USPSTF advises, as an A recommendation, screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years (*4*). Not all health plans consistently interpreted colonoscopies as a preventive benefit rather than a diagnostic service when performed either as a primary screening or secondary screening after an abnormal fecal occult blood test. Four health plans

What is already known on this topic?

The Patient Protection and Affordable Care Act requires commercial health plans to cover services recommended for routine use (A and B recommendations) by the U.S. Preventive Services Task Force (USPSTF) at no cost to the consumer.

What is added by this report?

Interviews conducted by the Colorado Department of Public Health and Environment with representatives of seven of eight health plans operating in the state determined that USPSTF recommendations are not written in health plan language and certain A and B recommendations are not being uniformly interpreted by health plan administrators. This can create confusion for the consumer and health-care provider and might result in underuse of the recommended services.

What are the implications for public health practice?

Public health organizations can assist health plans in interpreting federal health-care reform regulations and can work with health plans to define minimum baseline standards for all USPSTF recommended services required by the Patient Protection and Affordable Care Act.

defined a colonoscopy after an abnormal fecal occult blood test as diagnostic rather than preventive, making colonoscopy subject to all applicable copays and deductibles. Three of the health plans indicated that the cost to the patient would depend on whether the clinician coded the service as preventive or diagnostic. One plan indicated that colonoscopies were covered with no cost sharing only so long as consumers used the preferred facility within their plan.

Obesity screening and counseling was the last area where plans reported the greatest variations in eligibility requirements and in how provided services would be covered. USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. In addition, USPSTF recommends that clinicians screen children aged ≥6 years for obesity and offer or refer them to comprehensive, intensive behavioral interventions for weight control (*4*). Both are B recommendations. All health plans identified the lack of specific Current Procedural Terminology (CPT) codes for obesity screening as a barrier. Two health plans indicated no restrictions on the type of clinician that could be reimbursed for screening and counseling for obesity and also reported no limits on how often clients could be screened or counseled. Two health plans indicated that the counseling CPT code could be used only by a registered dietitian. One health plan responded that the consumer could receive two counseling sessions within the year unless a determination of medical necessity such as an obesity-related comorbidity (e.g., diabetes or cardiovascular disease) was made. One plan indicated use of an authorized but unlisted CPT code. To request reimbursement, providers would have to call the health plan directly for the CPT code to bill and, when the claim form was submitted, the claim was subject to an automatic review by health plan staff, increasing the likelihood of denial.

When asked whether health plans had communicated the new, no-cost, covered benefits to consumers or health-care providers, one plan indicated such communication occurred via e-mail and letters. The rest indicated that they had not promoted the benefit plan changes to their members.

Reported by

Sara Russell Rodriguez, MSN, MPH, Deb Osborne, MPH, Prevention Svcs Div; Jillian Jacobellis, PhD, Colorado Dept of Public Health and Environment. ***Corresponding contributor:*** *Jillian Jacobellis, jillian.jacobellis@state.co.us, 303-692-2504.*

Editorial Note

Health-care reform advances individual and population prevention goals by requiring coverage of services supported by evidence. Variance in health plan interpretation of the USPSTF recommendations coupled with health-care provider uncertainty regarding coverage and coding and lack of clarity among consumers regarding benefits might affect their use of services and impinge on optimal health outcomes.

Although USPSTF provides clinical guidance on how to implement recommendations within health-care provider practices, it does not define the recommendations in language that can be applied readily to the delivery of health insurance benefits (*4*). To ensure optimal consumer and health-care provider utilization of preventive benefits, implementation of these benefits must be consistent across health plans and understood by both health-care providers and consumers. The A and B recommendations should be translated clearly into health plan benefit language, and processes should be put in place for consistent implementation; public health agencies can assist in this effort. CDPHE has taken the lead in identifying gaps in preventive services and addressing these inconsistencies through collaboration with the major commercial and public health plans in Colorado.

Colorado has formed a prevention council, where health plan representatives can share best practices and come to agreement on minimum benefit standards for the A and B recommendations. Colorado has had previous success in working with health plans on tobacco cessation coverage and counseling and was able to gain agreement on minimum benefits. Creating constructive relationships with health plans

will be critical to successful implementation of federal health-care reform. Public health agencies also can provide useful data regarding the return on investment from many public health initiatives and can connect health plans with population-based strategies to increase preventive service use.

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