HB09-1204 AND PATIENT PROTECTION AND AFFORDABLE CARE ACT
IMPLEMENTATION SURVEY
Summary Brief

In late summer 2010, the Colorado Department of Public Health and Environment (CDPHE), in collaboration with the Tobacco Cessation and Sustainability Partnership, fielded a survey to Colorado’s eight major health plans. The intent was to learn how Colorado health plans are interpreting recent state and federal legislative changes regarding required health care benefits. Aetna, Anthem, Cigna, Denver Health Medical Plan, Humana, Kaiser Permanente and Rocky Mountain Health Plans responded to the survey; UnitedHealthcare did not.

Generally, the health plans have consistently interpreted and covered major areas of prevention included in state and federal reform. However, some important gaps and inconsistencies were identified.

1. Significant variation exists in the way health plans have interpreted U.S. Preventive Services Task Force (USPSTF) A and B tobacco coverage recommendations. Coverage is inconsistent across plans, particularly with respect to pharmacotherapy coverage for smoking cessation.

2. Obesity screening and counseling are problematic due to a lack of specific reimbursement codes for wellness as opposed to clinical interventions.

3. Health plans have not actively communicated with their members or providers regarding the benefit changes associated with HB 1204.

4. Reimbursement is highly variable for tobacco cessation and alcohol Screening, Brief Intervention and Referral to Treatment (SBIRT), resulting in a lack of certainty for providers that they will be reimbursed for providing these services. Reimbursement uncertainty leads to hesitation to provide the service.

5. Inconsistencies exist, at the plan level, about how to code for reimbursement for preventive colorectal cancer screenings.

Future Implications

The State of Colorado passed legislation (HB09-1204) with the intention of ensuring access to preventive services with documented benefits. A lack of communication to consumers and providers, coupled with inconsistent reimbursement policies, means that it is highly unlikely that the legislation has resulted in any increase in utilization of the benefits by consumers or in payment to clinicians for providing the services.

The low rates of utilization and inconsistencies in implementation of preventive benefits as defined by the USPSTF A and B recommendations will only be exacerbated with the implementation of the federal Patient Protection and Affordable Care Act (PPACA) that mandates similar coverage.
Tobacco: Survey Findings and Call to Action

Tobacco Screening and Cessation Services: Major Survey Findings

1. The most significant area of benefit limitation is coverage for Varenicline and Bupropion SR, both of which receive an A recommendation from the USPSTF.
   - Only one plan reported covering these U.S. Food and Drug Administration (FDA) approved pharmacotherapies for all group policyholders with no restrictions to access.
   - Two of the seven responding plans do not cover these drugs at all, explicitly indicating they do not believe this is part of the mandated benefits – despite USPSTF A recommendations.
   - Five plans have restrictions to access (e.g. annual or lifetime limits, step therapy requirements) either for their group, individual or both product lines.
2. The Colorado Tobacco Cessation Partnership Plan (Partnership Plan) provides an effective option for compliance with HB 1204.
   - Most plans provide no additional counseling for tobacco cessation beyond what is provided by the Colorado QuitLine as part of the Partnership Plan.
   - NRT without member cost-sharing is only available through the Partnership Plan.
3. HB 1204 permits plans to limit screening to primary care providers (PCPs) and three out of seven of the plans have done so. The federal Patient Protection and Affordable Care Act (PPACA) does not have this limitation, creating potential for confusion among providers.
4. Several of the plans have more limited coverage for individual than group policyholders.

Call to Action

1. Create a baseline benefit plan for tobacco cessation that all plans can agree to cover for ALL members in Colorado (those covered by HB 1204, as well as self-insured members in anticipation of the PPACA).
   - Provide telephonic counseling and nicotine replacement therapy (NRT) offered through the Partnership Plan. Explore availability of Varenicline and Bupropion SR through the Partnership Plan.
   - Ensure other counseling and prescription-based drugs are offered as desired through health plans.
2. Work with health plans to create a consistent reimbursement policy (but not payment amounts) for clinician-provided cessation services.
   - All health plans reimburse for the current procedural terminology (CPT) codes specific to tobacco cessation. However, some only reimburse primary care providers and some only reimburse if the services are provided on behalf of a member covered by a group policy, not an individual policy.
3. Launch statewide communication campaigns in collaboration with health plans, the state tobacco program and other stakeholders to promote cessation in accordance with the baseline plan.
   - Educate providers regarding reimbursement opportunities as a means of promoting greater provider engagement.
   - Educate consumers regarding coverage options to drive quit attempts.

For publicly traded insurance companies, the projected cost of the benefit will outstrip the savings in the first three years. We project net savings in the fourth and fifth years...Savings should grow in subsequent years, producing a net gain for the insurers.

Bloomberg Analysis of Tobacco Coverage under Federal Reform, November 2010
Obesity: Survey Findings and Call to Action

Obesity Screening and Counseling: Major Survey Findings

HB 09-1204 does not require obesity screening and counseling for adults and children. The survey queried about these services because of PPACA's requirements and the importance in addressing obesity at both the public and private health levels.

1. The variation in coverage for screening is high.
   - One plan does not cover screening.
   - Three plans cover obesity screening only as part of a primary care exam or visit.

2. There is even greater variation in coverage for obesity counseling.
   - Two plans do not cover counseling.
   - One plan provides counseling only to children.
   - Three plans provide limited counseling, subject to deductibles, co-pays or volume limitations.
     - One plan requires counseling be provided by a dietitian.

3. Payment for services is complicated by a lack of specific CPT codes for obesity screening and prevention.
   - CPT codes currently focus on acute interventions for obesity (e.g. bariatric surgery).
   - The lack of obesity screening and counseling-specific CPT codes is recognized as a barrier to coverage by about half the plans. The other plans assume generic wellness codes will be used, which typically necessitate medical review.

Call to Action

1. Develop a consensus statement regarding the value of all providers screening all patients for obesity.
   - Work with health plans to objectively determine if the benefit of limiting screening services to primary care setting outweighs the confusion and lack of compliance it may create.

2. Until the CPT coding issue is clarified, seek agreement from all health plans to use HealthTeamWorks' clinical guidelines and pediatric coding guidelines as industry standard. For guidance, refer to:

3. Work with Colorado Department of Public Health and Environment, LiveWell Colorado and other obesity prevention and control organizations to launch joint communication campaigns with health plans to promote screening, counseling in accordance with the clinical guidelines and PPACA, and reimbursement codes.

4. Support national efforts to develop obesity-specific CPT screening and counseling codes.

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2 The 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 – December 2003. The USPSTF recommends that clinicians screen children aged 6 years and older for obesity and offer them or refer them to comprehensive intensive behavioral interventions to promote improvement in weight status – January 2010.
Colorectal Cancer Screening: Major Survey Findings

1. All but one plan requires the physician to bill the service as wellness. In other words, the plans defer to the physician in determining if the colonoscopy is wellness or not.
   - One plan expressed concern that if a physician bills a service as preventive, the billing company may change the service to diagnostic if that optimizes reimbursement.
   - A different plan, however, indicated that this is only an issue with mammograms. Only mammography has different diagnostic and screening codes.

2. Two plans indicated that secondary screenings or screenings post-abnormal fecal occult blood test (FOBT) are considered diagnostic, even if the findings are negative.

Call to Action

1. There is considerable confusion among the plans regarding the coding nuances associated with colorectal cancer screening services. Convene an industry work group to educate each other and issue a consensus statement regarding coding and coverage.

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2 The USPSTF recommends 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. The risks and benefits of these screening methods vary.