The Preventive Turn in Health-Care Reform

BY PAUL STARR

When health insurance developed in the United States in the 1930s, it covered hospital and later major medical bills, not preventive services. Insurance also had nothing to do with public health. And when Medicare was enacted in 1965, it too made no provision for preventive and public-health services.

The Affordable Care Act is different. Culminating a long shift in thinking, it incorporates preventive care into health insurance and seeks to promote public health through provisions aimed at reducing obesity and smoking and encouraging participation in wellness programs.

The changes in insurance coverage are straightforward to implement. New private insurance policies—that is, all but “grandfathered” plans in existence at the time the president signed the law on March 23—will have to cover 100 percent of the cost of a list of preventive services that have met standards for effectiveness set by the U.S. Preventive Services Task Force. (Clinical preventive services include immunizations, screening tests, and counseling; insurers will now have to cover the services the task force has given a grade of A or B.) Medicare will also now cover the cost of those preventive services as well as an annual wellness visit without any deductible or co-payment. These changes take effect in 2011.

In addition, the federal government will increase matching funds for states that offer the approved preventive services in their Medicaid programs. And it will require Medicaid coverage of smoking-cessation services for pregnant women.

The government has been supporting evaluations of preventive services for years. Established in 1984, the U.S. Preventive Services Task Force is a federally sponsored council of private-sector scientists and health-care practitioners that evaluates the effectiveness of clinical preventive services. A second group, the Task Force on Community Preventive Services, evaluates public-health measures such as tobacco regulations. Besides providing additional funds for both groups, the law also establishes a Prevention and Public Health Investment Fund to support increased training of primary-care providers, scientific research on prevention, public-health education, and other purposes. The total funding for prevention and wellness programs comes to $15 billion over 10 years.

The law also seeks to raise the cost of unhealthy practices. Although it prohibits insurers from charging higher premiums based on an individual’s health risks, it allows them to charge a smoker as much as 50 percent more than a nonsmoker. It also permits employers to increase rewards for participation in wellness and disease-prevention programs from 20 percent to 30 percent of the costs of insurance premiums.

The law’s 10 percent tax on tanning salons falls into the same category of incentives. Since tanning has been linked to skin cancer, the tax is a way both to promote healthier behavior and to recover from tanning salons medical costs that they generate.

Congress, however, did not enact a tax on sugared beverages that some public-health advocates have proposed to fight obesity. But in what will be one of the most visible effects of the legislation, chain restaurants as of next year will have to provide calorie counts on their menus.

Research on such requirements for consumer information indicates that the greatest impact comes when information is conspicuously available at the moment when people make purchasing decisions. The crash-safety ratings for automobiles that buyers see on the windows of cars sold by dealers are a good example. Those safety ratings have affected not just the buying decisions of consumers but the design choices of the manufacturers. If fast-food chains begin adjusting their portions and menu options because of conspicuous calorie disclosure, the new requirements will be working in an analogous way.

By reducing the price for preventive services, raising the price for unhealthy practices, and providing better information about everyday decisions, the government is trying to change the health-care consumer’s menu in a larger sense. Although there are questions about the cost-effectiveness of some clinical preventive measures, the law targets that spending toward services shown to be beneficial by the balance of scientific evidence.

But it may be politically difficult to limit preventive spending where the evidence is weak. At a volatile point in the health-reform debate, the Preventive Services Task Force recommended that mammograms should not be routine for women in their 40s. Instead, the task force stated, “The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient’s values regarding specific benefits and harms.” That recommendation produced a storm of outrage from many people who mistakenly interpreted the decision as evidence of health-care rationing. In fact, the recommendation was based only on an analysis of benefits and risks to the patient and had nothing to do with costs. But it is true that under the Affordable Care Act, because the task force gave mammograms for women under age 50 a grade of “C,” insurers would not be required to pay 100 percent of their cost. We should expect more controversies of this kind in the future.