Appendix E: Current Coverage of Clinical Preventive Health Care Services in Public and Private Insurance

To put the debate over insurance for clinical preventive services in context, this appendix describes the extent of current coverage of preventive services in public insurance plans, specifically, Medicaid and Medicare, and in private health insurance plans, specifically, employer-based plans. Within the discussion of private insurance, current Federal and State mandates for coverage within employer-based plans and federally qualified HMOs are also described.

Public Insurance Programs

Medicaid

Federal law requires that all State Medicaid programs provide a standard benefit package to 'categorically needy recipients' [1] (179). Required preventive services include Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT), and family planning services and supplies, EPSDT services consist of screening and diagnostic services to determine physical or mental defects in beneficiaries under age 21, and measures to correct or ameliorate any defects or chronic conditions discovered. At a minimum, screening services must include: comprehensive health and developmental history; comprehensive unclothed physical exam; appropriate vision testing; appropriate hearing testing; appropriate laboratory tests; and dental services for children 3 years of age and older (180). Family planning services include services for women of childbearing age, including minors who can be considered to be sexually active (180). In addition, States that cover medically needy' individuals must reimburse health care providers for prenatal care provided to recipients (179).

States also have the option of covering preventive services not already required (182). Additional preventive services are covered in 3 States for categorically needy individuals and in 20 States for both categorically and medically needy individuals (204). Presumably, the scope of these preventive services in the 23 States is fairly unlimited in the sense that Medicaid permits the health care provider to use his or her own judgment to determine whether to provide the services (55).

Federal requirements prohibit States from charging deductibles or coinsurance for all services provided to children under 18 years old, for services related to pregnancy, or for family planning services.

Medicare

Medicare covers very few clinical preventive services. Federal law prohibits Medicare from offering benefits for preventive services without an amendment to the Medicare Act (Public Law 89-97). Since 1981,

[1] Categorically needy Medicaid recipients are those receiving Aid to Families with Dependent Children (AFDC) benefits and Supplemental Security Income (SSI).

[2] States have the option of offering Medicaid to medically needy people who would be categorically needy for Medicaid but whose income and resources lie above the standards for eligibility. Each State sets its own medically needy resource and income standards up to 133.33 percent of State AFDC income standards.

several screening services and vaccinations have been added to the list of covered services for Medicare recipients. These services are: vaccines for pneumococcal pneumonia and Hepatitis B (for those at high risk for the virus), Pap smears to screen for cervical cancer, and biannual mammographies to detect breast cancer (58).

Private Insurance

Publicly and privately funded surveys of employment-based health plans are the principal source of data on insurance coverage for clinical preventive services; however, these surveys have a number of limitations. First, no one survey provides a completely representative picture of coverage provided to the Nation's workforce. Second, surveys report on only a subset of the clinical preventive services which might be covered, Further, the details of sampling and question construction in privately funded surveys are typically proprietary (i.e., not open to public scrutiny) and may have methodological problems, such as low response rates for specific questions. Fortunately, comparisons across surveys tend to provide a relatively consistent impression of coverage for specific services, thereby giving more confidence to their results.

Surveys of employer-based plans have been completed by the Health Insurance Association of America (HIAA); the U.S. Department of Labor, Bureau of Labor Statistics (BLS); and KPMG Peat Marwick. Each of these organizations uses slightly different survey methods. The BLS survey includes private sector establishments employing 100 workers or more (223). In 1991, BLS contacted 3,246 establishments and 2,144 responded (a 66 percent response rate). Information on benefits was determined from documents provided by each establishment describing their benefits plans.

HIAA surveyed 3,192 public and private firms in the spring of 1990 (excluding self-employed individuals and Federal workers) (173). The sample was nationally representative of small (defined as fewer than 100 employees), medium, and large firms and was stratified and weighted by region and standard industrial classification. Information on plans was collected through interviews.

KPMG Peat Marwick's survey included participants randomly drawn from Dun and Bradstreet's list of the Nation's private or public employers with more than 200 workers (121). KPMG Peat Marwick stratified the sample by industry, region, and number of workers. The sample included 1,057 firms, 744 of which were interviewed in 1991 and the rest in 1990. The overall response rate was 70 percent. Information on benefits was collected through telephone interviews with human resource directors.

The following section reports on the surveys' findings on coverage of preventive services. The first section discusses employer-based traditional indemnity plans. The second section discusses State- mandated benefits laws that could affect the coverage of certain benefits in private insurance plans. The third section discusses health maintenance organizations.

Traditional Indemnity Plans[3]

The surveys which included questions about well-baby care found coverage ranged from one-quarter to one-half of all employees. Peat Marwick found that 46 percent of employees with traditional indemnity insurance had coverage for well-baby care; HIAA found that 48 percent had coverage for well-baby care; and BLS found that 24 percent had well-baby care coverage (see figure E-1).[4]

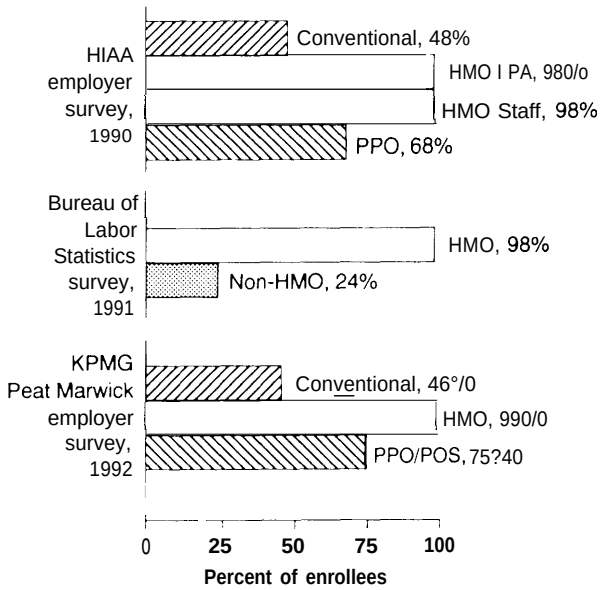
Only two of the surveys asked questions about well-child care. HIAA reported that 39 percent of employees with traditional indemnity insurance had coverage for well-child care, and Peat Marwick reported that 36 percent had coverage for well-child care[5] (see figure E-2). All three surveys asked about coverage of adult physical examinations and results ranged from 16 percent coverage (in the BLS survey) to 32 percent coverage (in the Peat Marwick Survey) (see figure E-3). To summarize, the three studies reported that roughly one-fifth to one-half of employ-

3 In this discussion, a traditional indemnity health insurance plan is a conventional or fee-for-service health plan that typically reimburses the health care provider on a "reasomble and customary' basis or as billed.

4 HIAA and Peat Marwick define well-baby care as care for children less than 1 year of age. In contrast, BLS defines well-baby care as care for children under approximately 2 years of age, excluding newborn care (18). Traditional indemnity plans often do not specify the age limits for well-baby or well-child care; therefore, the distinction is somewhat ambiguous.

5 Peat Marwick and HIAA defined well-child care as care for children between the ages Of 1 and 4.

Figure E-l—Percent of Enrollees Covered for Well-Baby Care in Employer-Based Health Insurance Plans by Plan Type, Various Surveys, Various Years



ABBREVIATIONS: HIAA = Health Insurance Association of America; HMO = health maintenance organization; IPA = independent or individual practice association; POS = point of service plan; PPO = preferred provider organization.

SOURCES: Health Insurance Association of America, Source *Book of Health Insurance Data* (Washington, DC: 1991); **KPMG** Peat **Marwick, *Health Benefits in 7992*** (Washington, DC: October 1992); U.S. Department of Labor, Bureau of Labor Statistics, ***Employee Benefits in Medium*** and ***Large Firms, 7997*** (Washington, DC: U.S. Government Printing Office, 1993).

ees with employer-based traditional indemnity plans had coverage for routine adult physical examinations, well-baby, and well-child care.

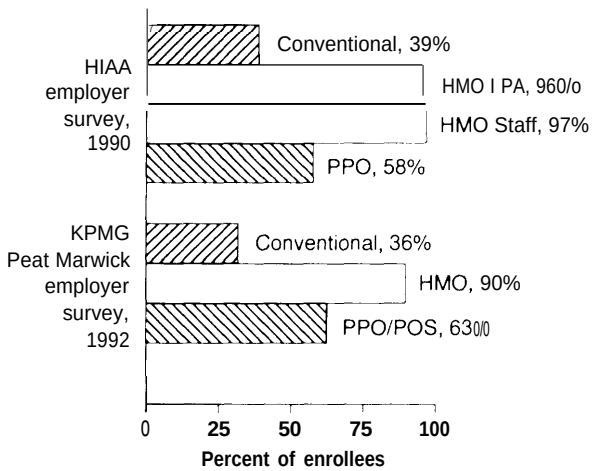
The HIAA survey, which was the only study to report on coverage for screening services, found that about half of all employees with traditional indemnity plans had coverage for Pap smears (55 percent) and mammographies (57 percent). The HIAA survey found that 47 percent of employees had coverage for childhood immunizations.

State Mandates

Many States have adopted mandated health insurance benefit laws for individual or group private insurance plans. The content of these mandates varies from State to State. Some laws may require that insurance carriers make certain benefits available as an option in employer-based plans. Others stipulate that these benefits must be covered in all plans sold to employers. Under the Employee Retirement Income Security Act (ERISA) of 1974, employers that self-fund their insurance plans are exempt from these mandates.

Currently nearly all States report at least one law mandating coverage of at least one clinical preventive service. The most frequently mandated preventive service is mammography screening (43 States) (19). Cervical cancer screening is mandated by 12 States; PKU testing is mandated in 3 States; prostate cancer screening and blood lead screening is mandated in 2 States; and 1 State requires coverage for newborn hearing testing (19), In the area of children's preventive services, 20 States currently require well-child care benefits (19). According to the Blue Cross and Blue Shield Association, States have varying definitions of well-child care; however, most include prena-

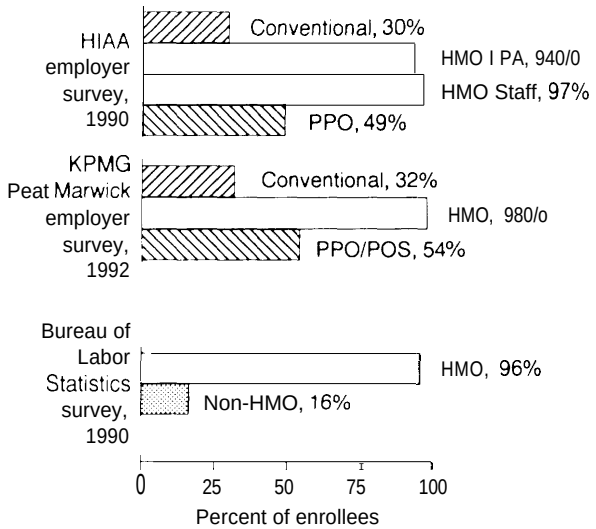
Figure E-2—Percent of Enrollees Covered for Well-Child Care in Employer-Based Health Insurance Plans by Plan Type, Various Surveys, Various Years



ABBREVIATIONS: HIAA = Health Insurance Association of America; HMO = health maintenance organization; IPA = independent or individual practice association; POS = point of service plan; PPO = preferred provider organization.

SOURCES: Health Insurance Association of America, *Source Book of Health Insurance Data* (Washington, DC: 1991)**KPMG** Peat**Marwick, *Health Benefits in 1992*** (Washington, DC: October 1992); U.S. Department of Labor, Bureau of Labor Statistics, ***Employee Benefits in Medium and Large Firms,*** **1997 (Washington,** DC: U.S. **Government** Printing Office, 1993).

Figure E-3—Percent of Enrollees Covered for Adult Physical Examinations in Employer-Based Health Insurance Plans by Plan Type, Various Surveys, Various Years



ABBREVIATIONS: HIAA = Health Insurance Association of America; HMO = health maintenance organization; IPA = independent or individual practice association; POS = point of service plan; PPO = preferred provider organization.

SOURCES: Health Insurance Association of America, *Source Book of Health Insurance Data* (Washington, DC: 1991); KPMG Peat Marwick, *Health Benefits in 1992* (Washington, DC: October 1992); U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1991* (Washington, DC: U.S. Government Printing Office, 1993).

tal services, well-baby care and childhood immunizations as elements of well-child care (127).

Health Maintenance Organizations

Health maintenance organizations are health care organizations that, in return for prospective per capita (cavitation) payments, act as both insurer and provider of specified health services. The Health Maintenance Organization Act of 1973 (Public Law 93-222) requires that most employers include a federally- qualified HMO, if one is available, among its health benefits options. In 1990 about 34 million individuals, or 14 percent of Americans, were enrolled in HMOs (85). About 75 percent of HMO members belong to federally-qualified HMOs (86).

The HMO Act of 1973 also established guidelines for benefit design, rating practices, and operations. Federally-qualified HMOs must provide pediatric and adult immunizations, well-baby and well-child care, periodic health evaluations for adults, abroad range of family planning services, and children's ear and eye examinations, up to age 17, to determine the need for vision and hearing correction (42 CFR 417. 101(a) (8)(i - vi)). Not all HMOs are federally qualified, however, and thus not all offer the full range of 'basic services' specified under Federal law (202).

Partially as a result of Federal requirements, HMOs are far more likely than traditional indemnity plans to cover clinical preventive services. According to four national surveys of employer-based health insurance benefits, the vast majority (over 90 percent) of employees enrolled in HMOs had coverage for routine adult physical examinations, prenatal care, well-baby and well-child care, screening services and immunizations (93,223,121) (see figures E-1, E-2, E-3), The HIAA survey found slight differences between IPA HMOs[6] and staff-model HMOs.[7] The IPA HMOs were slightly less likely to cover adult physical exams (94 percent versus 97 percent), and childhood immunizations (97 percent versus 99 percent) than the staff-model HMOs. Nevertheless, the vast majority of employees in all HMOs had coverage for these services.

Hybrid *Organizations*

During the past decade, various new financing and delivery models have been developed that blur the distinction between pure insurance plans that pay bills for services received and traditional HMOs that combine service delivery systems with a financing organization. These include preferred provider organizations (PPOs) and point of service plans (POS). A PPO refers to a variety of different insurance arrangements under which plan enrollees who choose to obtain medical care from a specified group of ' 'preferred" providers receive certain advantages, such as reduced cost-sharing charges. PPO providers typically

6 Individual Practice Association HMOs are those that contract with a number of individual physicians in independent practices Or with associations of independent physicians, Often independent physicians will contract with more than one HMO (93).

7 A staff-model HMO is one in which the health care providers are employees of the organization. This contrasts with other arrangements where providers or groups of providers contract with an HMO.

furnish services at lower than usual fees in return for prompt payment by the health insurance plan and a certain assured volume of patients. A POS is a hybrid form of managed care plan based on a mixture of cavitation and fee-for-service (FFS) payment arrangements. POS plans permit health plan enrollees to choose a FFS or HMO provider at the time he or she seeks services (rather than at the time they choose to enroll in a health plan).

Two of the three surveys also asked questions about PPOs and POSs. The Health Insurance Association of America and KPMG Peat Marwick surveys both found that PPOs and POSs were more likely than traditional indemnity plans, but less likely than HMOs, to cover clinical preventive services. The KPMG Peat Marwick survey found that in 1992, among PPOs and POSs plans combined, 54 percent offered coverage for routine adult physical examinations, 75 percent covered well-baby care, and 63 percent covered well-child care (figures E-1, E-2 and E-3). The HIAA survey found similar results. About half of employees with PPO plans were covered for adult physicals, **68** percent had well-baby care benefits, and 58 percent had well-child care benefits (figures E-1, E-2 and E-3). Also, about 70 percent had coverage for mammographies and Pap smears.

Summary

The levels of coverage for clinical preventive services within public and private health insurance plans vary by type of health plan. A summary of the discussion follows:

- State *Medicaid* programs are relatively generous in their coverage of preventive services, especially for children and pregnant women; many States offer services in excess of the Federally-defined basic services. Also, Medicaid programs are prohibited by law from imposing patient cost-sharing requirements on most preventive services.
- Since its inception in 1965, *Medicare* has covered very few preventive services, although in the past decade the Medicare Act has been amended to include some screening tests and immunizations.
- The scope of preventive benefits within *private health insurance* plans varies by service and type of plan. Evidence from employer surveys suggests that coverage for preventive benefits in traditional indemnity plans is lower than within HMO plans. Well-baby care and well-child care benefits are covered by about a quarter to half of traditional indemnity plans, while nearly 100 percent of HMOs provide these services, Also, a third, or less, of traditional indemnity plans cover routine screening adult physical examinations, while over 90 percent of HMOs offer this service.