Introduction

This OTA background paper describes the preventive Services provisions of selected Congressional and private health care reform proposals. This paper was prepared as an internal OTA document as background for OTA's assessment, Technology, Insurance, and the Health Care System.[1,2] As part of the assessment, OTA is addressing issues surrounding the use of effectiveness, cost-effectiveness, and appropriateness information to design **a** minimum benefit package for individuals who are currently uninsured. **A** key question is the extent to which the evidence on effectiveness and cost-effectiveness might support the inclusion of some or all preventive services in a minimum health benefit package, should one be specified in a reform initiative.[3] This paper is limited to providing a descriptive overview **of current** proposals for the inclusion of preventive services; we main report for **OTA's full assessment**-- to be published in 1993-- will place the proposals in the context of available **evidence** about effectiveness and cost-effectiveness, and discuss policy implications.

1 In this assessment, the term "health insurance" is defined broadly to include various types of health plans that are designed to reimburse or indemnify individuals or families for the costs of medical care, including traditional private indemnity fee-for-service coverage, prepaid health plans such as health maintenance organizations, self-finded employment-based health plans, Medicaid, and Medicare.

2 The overall assessment was requested by the Senate Committee on Labor and Human Resources, the House Committee on Energy and Commerce, the House Committee on Ways and Means Subcommittee on Health, and Senator Charles E. Grassley.

3 OTA is also analyzing two other specific aspects of health services (mental health and substance abuse treatment services; the health effects of patient cost-sharing for acute care services) in terms of evidence for effectiveness and cost-effectiveness.

DEFINITIONS AND TYPES OF PREVENTION

"Prevention" in health is both a popular and ambiguous concept. Prevention is regarded as both a humane and cost-saving approach to improving health in the United States, but the term prevention is often left undefined. The use of the three "traditional" levels of prevention--primary, secondary, and tertiary (U.S. Preventive Services Task Force, 1989) -- may not be helpful, because the three levels may be difficult to operationalize, are often used interchangeably in popular discourse, and all have implications for preventive services benefit design. For example, to the emergency room physician, a patient's stroke may have been prevented by the patient's compliance with a prescription drug regimen for hypertension; in a televised discussion the physician may say that improved prevention (meaning better coverage of prescription drugs for elderly or low-income patients) is an essential part of health care reform. To a pediatrician, on the other hand, "prevention" may mean the combination of medical and "cognitive" services that he or she delivers (e. g., appropriate immunizations, health education for parent and child). To a radiologist, internist, gynecologist, or obstetrician, preventive services may mean the tests that detect abnormalities (e.g., mammograms, digital rectal examinations, or Pap smears) so that early treamtment may begin. To some observers, the focus of preventive interventions is on personal behaviors not related to health care (e. g., refraining from smoking, abstinence from sex, safer sex, seat-belt use). When the focus is on such personal behaviors, responsibility typically lies with the patient (or potential patient), rather than individual providers or the health services system, and insurance coverage may not be considered an issue (e. g., Sullivan, L. W., 1990).

The issues surrounding concepts of and locus of responsibility for prevention of health problems are complex (e. g., U.S. Congress, OTA, April 1991). For purposes of this and past OTA reports related to coverage decisions for preventive services, OTA focuses on clinical

preventive services; that is, "interventions comprising medical procedures, tests, or visits with health care providers that are undertaken for the purpose of promoting health, not for responding to patient signs, symptoms, or complaints" (U.S. Congress, OTA, Feb. 1990). In general, preventive services in this background paper involve interactions between individual patients or consumers and health care providers. However, OTA includes in this background paper those preventive services that do not fit neatly into this typology. For example, H.R. 3229 introduced in the 102nd Congress[4] by Representative Dellums would cover the "prevention of illness through education and advocacy addressed to the social, occupational, and environmental causes of ill health."

MAJOR APPROACHES TO HEALTH CARE REFORM

Box A contains brief descriptions of the major contemporary approaches to health care reform. These are:

- "Play or pay" (or mandated employment-based coverage with a public backup funded at least in part through a tax on employers);
- "Single payer" (or universal coverage financed with taxes);

4 The 102nd Congress convened in January 1991 and adjourned on October 8, 1992. Any bills that were introduced but not enacted into law during the 102nd Congress (plus an additional period of time past October 8, 1992, for the President to sign a bill into law) should be considered withdrawn from consideration. To be considered by the 103rd Congress (to convene in January 1993), the bills would have to be reintroduced. The only bill with the potential of still being signed by the President as this background paper was being prepared was H.R. 11 (The Enterprise Zone Tax Incentives Act of 1991) (Pianin, 1992). H.R. 11 incorporated some of the Medicaid and Medicare proposals mentioned in the Stark/Gephardt bill (H.R. 5502), as Senate Amendment S. 3318.

- "Market reform" (including tax credits for individual consumers, small group reform, " and managed competition).

In addition, Box A summarizes other proposals introduced in the 102nd Congress that are not so easily categorized (e. g., a single delivery system; a series of incremental changes that would help to establish the framework for more profound changes).

In this background paper, preventive services provisions of Congressional proposals are grouped according to their major strategy for financing and delivery reform (box A; tables 6-1 through 6-4). In general, "play or pay" and single payer proposals (table 6-1 through 6-3[5]) are more likely than the market reform (table 6-3) and the Stark/Gephardt (table 6-4) proposals to designate specific preventive services.

Preventive services provisions of private proposals (summarized in tables 6-5 through 6-8) are grouped according to sponsorship: provider groups (e.g., the American Medical Association) (table 6-5); insurer groups (table 6-6); business groups (table 6-'7); and "think tanks" (table 6-8). The tables related to the private proposals also indicate the financing approach proposed by the sponsor (e. g., "play or pay"). Most, but not all, private proposals specify coverage for specific preventive services.

5 In the tables summarizing preventive services provisions, the Dellums proposal for a single delivery system is grouped with the single payer proposals.