EBRI

October 20, 2022, #444

FAST Facts

The Impact of Covering Select Preventive Services on Employer Health Care Spending

When the Patient Protection and Affordable Care Act (ACA) passed in 2010, it included provisions requiring that employers and health plans cover certain preventive services in full.[1] These include services such as screenings for cancer and other health conditions, vaccinations, and birth control. Plan sponsors have been prohibited from imposing any form of cost sharing (i.e., deductible, copayments, or coinsurance) on participants receiving these services. However, a recent federal judicial opinion in Texas may put coverage of some of these preventive services with no out-of-pocket costs in jeopardy. On September 7, 2022, Judge Reed O'Connor of the U.S. District Court for the Northern District of Texas found a key part of the preventive service provision unconstitutional. Specifically, the decision refers to the part of the ACA that requires coverage without cost sharing of preventive services to which the U.S. Preventive Services Task Force (USPTF) assigns a rating of "A" or "B".[2] The judge ruled that recommendations from the USPSTF are unconstitutional because the Task Force is an independent, volunteer panel of national experts in prevention and evidence-based medicine whose members are not appointed by the President and confirmed by the Senate, thereby violating the appointments clause.

This ruling has important clinical, equity, and cost implications, as preventive care is important for individuals and public health. The U.S. Department of Health and Human Services has estimated that in 2020, 151.6 million people had access to free preventive care under the ACA.[3] This ACA provision is very popular, favored by 62 percent of Americans.[4] A recent review reported that removing cost sharing boosts the use of preventive services, which helps reduce disparities and save lives (Norris et al. 2021).

If this court decision is upheld and the coverage mandate of USPSTF "A"- and "B"-rated services is invalidated, employers and health plans could impose some form of cost sharing for these preventive services. Yet, employers may continue to provide these services at no cost to members for at least a few reasons, including:

1. **Employers may not want to cut benefits during a time when unemployment is low** and recruitment and retainment of workers is of concern.

2. Employers may believe that **incentivizing their use reduces aggregate health spending in the long term**.

3. There is **precedent for covering these services without cost sharing in the absence of the ACA mandate**. When health reimbursement arrangements (HRAs) were introduced in the early 2000s, some employers provided first-dollar coverage for preventive services (Fronstin 2002). Comparable generous

[1] Grandfathered health plans are not required to comply with this provision.

[2] The USPTF is a group the Agency for Healthcare Research and Quality (AHRQ) has been authorized by the U.S. Congress to convene since 1998.

[3] https://aspe.hhs.gov/sites/default/files/documents/786fa55a84e7e3833961933124d70dd2/preventive-services-ib-2022.pdf.

[4] https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-july-2019/.

© 2022, Employee Benefit Research Institute, 901 D St. SW, Suite 802, Washington, DC 20024, 202/659-0670 www.ebri.org

coverage was implemented when health savings account (HSA)-eligible health plans were introduced (Fronstin, Sepulveda, and Roebuck 2013). Similarly, recent research has found that when the IRS allowed employers and health plans to cover certain preventive services outside HSA-eligible health plan deductibles, about three-quarters of them chose to do so, often without cost sharing (Fronstin and Fendrick 2021).[5]

Given the current uncertainty surrounding the ACA's preventive care coverage mandate, we examined the extent to which these health services impact costs. Accordingly, we conducted an analysis of claims data on over 2.4 million enrollees to quantify spending on five commonly used services and all prescription drug classes receiving an "A" or "B" recommendation from the USPSTF.

Our findings demonstrate that the costs of covering select preventive services are very low (Figure 1). Moreover, any reintroduction of patient cost sharing will have a minimal impact on overall employer health care spending. If employers imposed 20 percent cost sharing on these medications, employer spending would fall by 0.3 percent.

The case before the U.S. District Court for the Northern District of Texas challenged the requirement that employers had to provide coverage for Pre-Exposure Prophylaxis (PrEP) medications that prevent human immunodeficiency virus (HIV) without cost sharing. The court concluded that the requirement to cover PrEP drugs violates the federal Religious Freedom Restoration Act. In our analysis of PrEP drugs, we found that the cost on a per-patient basis of these drugs is relatively high at $13,814 per year. But because so few enrollees utilize PrEP medications (about 0.17 percent of all members), the total cost of these drugs accounts for only 0.41 percent of total spending. If, for example, employers imposed 20 percent cost sharing on patients for PrEP drugs, employer spending would fall by less than one-tenth of 1 percent.

Figure 1
Cost of "A" and "B" Rated Medications, 2019

	Total Cost Per User	Percentage of Members Utilizing Service	Percentage of Total Cost	Employer Savings From 20 Percent Coinsurance
HIV PrEP Medication	$13,814	0.20%	0.40%	0.08%
Statins (Ages 40–64)	$151	8%	0.20%	0.04%
Breast Cancer Preventive Drugs (Ages 35–64)	$237	1%	0.02%	0.00%
Contraceptives	$470	9%	0.70%	0.14%
Total	$454	17%	1.30%	0.30%

Notes: HIV=Human Immunodeficiency Virus; PrEP=Pre-Exposure Prophylaxis.

Other selected preventive services are similarly low cost. For instance, screening for breast cancer, cervical cancer, and colorectal cancer are perhaps the most well-known "A"- and "B"-rated preventive services. In 2019, 10 percent of enrollees received breast cancer screening, 9 percent received cervical cancer screening, and 4 percent received colorectal cancer screening (Figure 2). (It is important to note that each of these cancer screenings are not performed annually for recommended patient populations). They account for 0.5 percent, 0.1 percent, and 0.7 percent of total costs, respectively. Following on the prior example, if employers were to introduce 20 percent member cost sharing for these screenings, they would reduce their spending by 0.27 percent.

[5] Also see https://ahiporg-production.s3.amazonaws.com/documents/202109-AHIP_HDHP-Survey.pdf and https://www.irs.gov/pub/irs-drop/n-19-45.pdf.

Figure 2
Cost of Select Preventive Services, 2019

	Total Cost Per User	Percentage of Members Utilizing Service	Percentage of Total Cost	Employer Savings From 20 Percent Coinsurance
Breast Cancer Screening	$332	10.00%	0.50%	0.11%
Cervical Cancer Screening	$39	9%	0.10%	0.01%
Colorectal Cancer Screening*	$990	4%	0.70%	0.15%
HPV Vaccination†	$297	3%	0.10%	0.03%

Notes:
HPV=Human Papillomavirus.
* Not including facility fees, pathology, or anesthesia.
^ Not including sterilization.
† Including administration.

The Texas case may also raise questions about contraceptive coverage. Our analysis finds that total average spending per user was $470, and 9 percent of enrollees used some form of contraceptives, accounting for 0.7 percent of total spending. If employers were to introduce 20 percent member cost sharing on contraceptives, they would reduce their spending by 0.14 percent.

We expect the spending on other preventive services receiving a USPSTF "A" or "B" rating to be similarly low. Moreover, certain recommended services do not impose incremental costs, as they are often provided as part of a routine office visit, such as screening for hypertension, tobacco use, and unhealthy weight.

Employers could realize more measurable cost reductions if the addition of cost sharing reduced use of these preventive services. However, imposing cost sharing for preventive services would reverse a growing movement among employers in recent years to expand coverage of clinically effective care without deductibles or copays (Fronstin and Fendrick 2021). It also could hamper intensifying efforts to reduce health disparities for lower-income Americans, people of color, and the LGBTQ+ population.

Data and Methods

We analyzed MarketScan® pharmacy and medical claims data on a random sample of 2.4 million members continuously enrolled during 2019 in a non-capitated private health plan (including employer-sponsored and other commercial insurance). No further sample restrictions were applied. Therefore, the study cohort included individuals under age 65, residing in all U.S. geographic regions, and enrolled in a variety of plan types. Using relevant procedure codes and financial fields from claims, we derived mean per-member per-year (PMPY) plan, member, and total cost measures for the "A"- and "B"-rated preventive services examined. We also captured the percentage of members with any utilization of each of the services, as well as the share of total costs represented by each service. We replicated the analysis using 2020 data and found nearly identical results.

About EBRI: The Employee Benefit Research Institute is a private, nonpartisan, nonprofit research institute based in Washington, DC, that focuses on health, savings, retirement, and economic security issues. EBRI does not lobby and does not take policy positions. The work of EBRI is made possible by funding from its members and sponsors, which include a broad range of public, private, for-profit and nonprofit organizations. For more information go to www.ebri.org or connect with us on Twitter or LinkedIn.

A Thank You To Members: This study was conducted through the EBRI Center for Research on Health Benefits Innovation (EBRI CRHBI), with the funding support of the following organizations: Aon, Blue Cross Blue Shield Association, ICUBA, JP Morgan Chase, Pfizer, and PhRMA.

References

Fronstin, P. (2002, July). Can "Consumerism" Slow the Rate of Health Benefit Cost Increases? *EBRI Issue Brief no.247*.

Fronstin, P., & Fendrick, A. M. (2021, October). Employer Uptake of Pre-Deductible Coverage for Preventive Services in HSA-Eligible Health Plans. *EBRI Issue Brief*, no. 542.

Fronstin, P., Sepulveda, M. J., & Roebuck, M. C. (2013, June). Consumer-Directed Health Plans Reduce The Long-Term Use Of Outpatient Physician Visits And Prescription Drugs. *Health Affairs, 32*(6), 1126-1134.

Norris, H. C., Richardson, H. M., Benoit, M.-A. C., Shrosbree, B., Smith, J. E., & Fendrick, A. M. (2021). Utilization Impact of Cost-Sharing Elimination for Preventive Care Services: A Rapid Review. *Medical Care Research and Review*, 1-23.

###