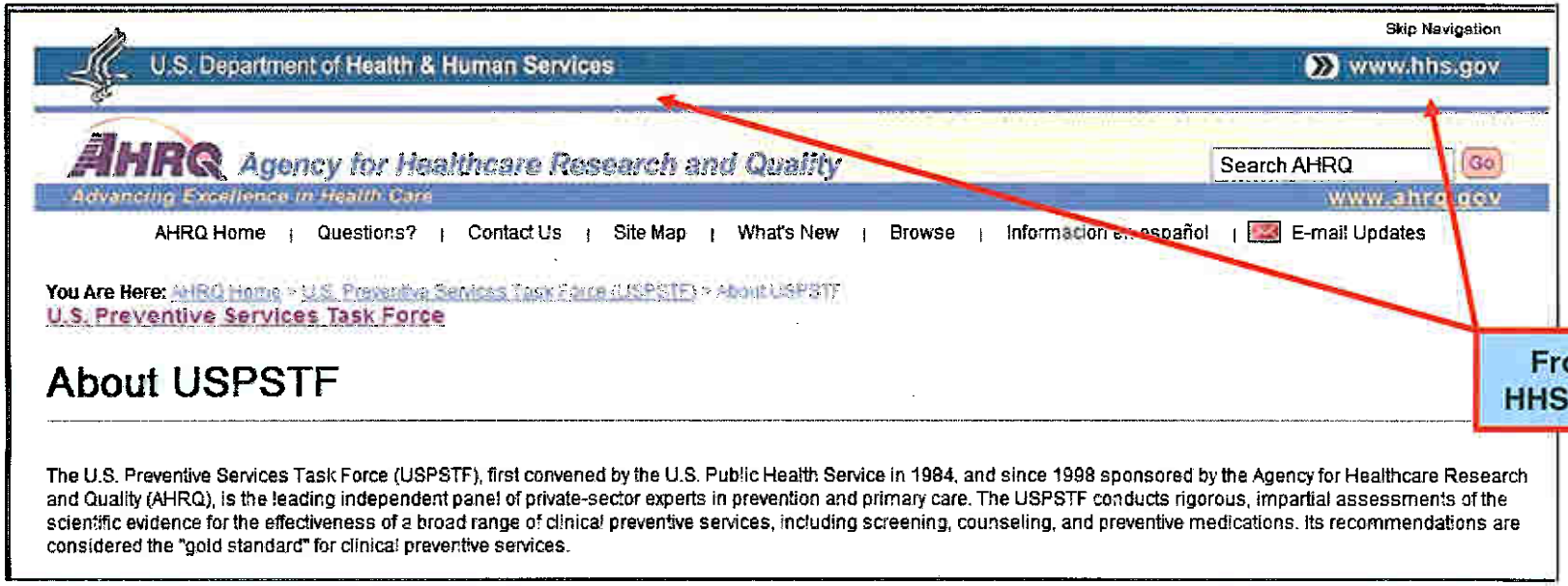
# Connecting The Dots: Preventive Care And Health Reform

Congressman Marsha Blackburn
Tennessee's 7th District
December 4, 2009

**The U.S. Preventive Services Task Force** is an agency within the Department of Health And Human Services…




Their self described mission is to "conducts rigorous, impartial assessments of the scientific evidence for the effectiveness of a broad range of clinical preventive services, including screening, counseling, and preventive medications." They go on to say that their "recommendations are considered the 'gold standard' for clinical preventive services. "

It all sounds like a good idea, a government panel to offer independent assessments of what preventive care does and does not work. But how will these recommendations be treated under Speaker Pelosi's new health care reform plan?

Last month, the **USPSTF** issued new recommendations on mammograms, let's follow those recommendations through the health care bill.

**The Recommendation** says that women under 50 years of age do not need to have regular mammograms to screen for breast cancer. Women between 50 and 74 only need them every other year, and that there is insufficient evidence on the usefulness of mammograms for women over 75…

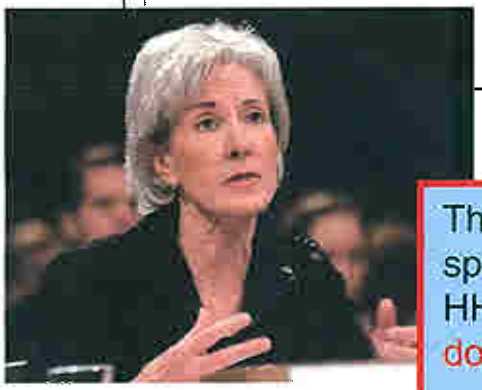


## Screening for Breast Cancer

Clinical Summary of U.S. Preventive Services Task Force Recommendation

**Screening for Breast Cancer Using Film Mammography**

| Population | Women Aged 40-49 Years | Women Aged 50-74 Years | Women Aged ≥75 Years |
|---|---|---|---|
| Recommendation | Do not screen routinely. Individualize decision to begin biennial screening according to the patient's context and values. | Screen every 2 years. | No recommendation. |



The Secretary of Health and Human Services, whose agency sponsored this study, quickly disavowed it. She informed women that HHS "policies remain unchanged," and that women should "keep doing what you're doing."

But as we begin to see on the next page, under government run health care, "recommendations" like these will automatically change HHS policy and will prevent women under 50 from getting regular mammograms.

**H.R. 3962** is a sweeping health care reform bill that has already passed the House. A proposal with similar language is currently before the Senate. H.R. 3962 sets up a Health Insurance Exchange that is administered by a Health Choices Commissioner. Eventually every American will have to buy their insurance through the exchange, one way or another, or face penalties.

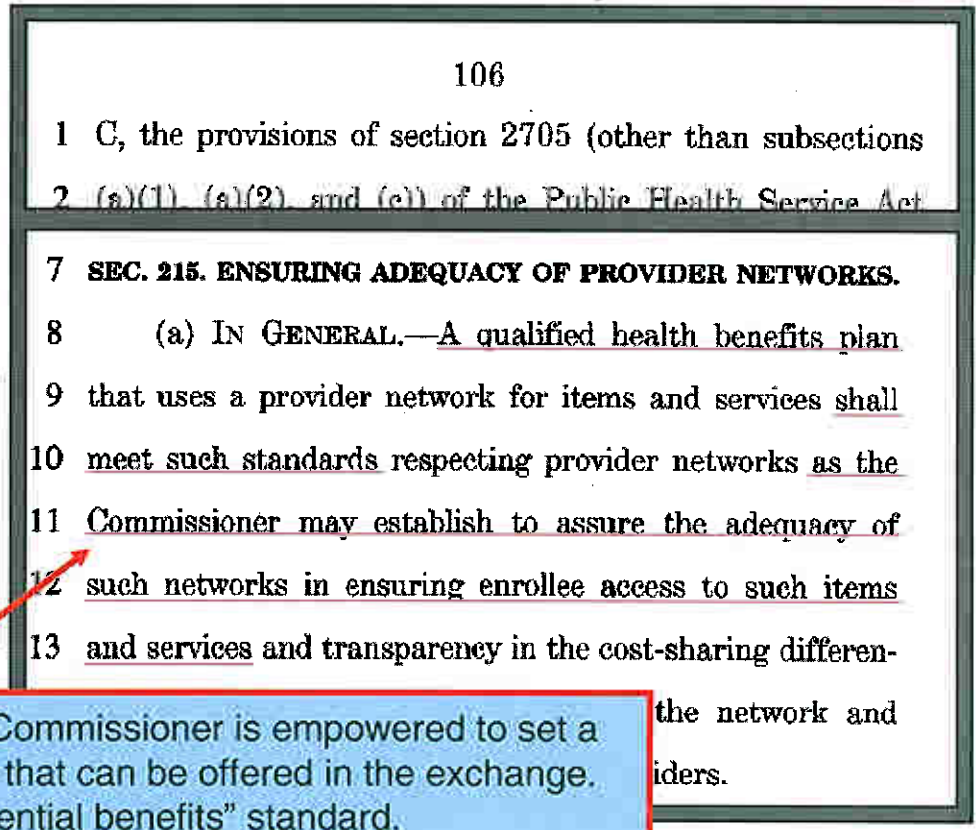
The Commissioner will report to the Secretary of Health and Human Services and is empowered to set the minimum standards that insurance plans must meet to participate in The Exchange.

**The Health Choices Commissioner:**

- Reports to the Secretary of Health and Human Services
- Establishes the minimum "Essential Benefits" plans the Insurance Exchange must offer.

**The Health Insurance Exchange:**

- A pool of health care plans, including a "Public Option" managed by the Federal Government.
- Eventually all Americans, or their employers, will have to buy plans from The Exchange or face penalties.



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1 C, the provisions of section 2705 (other than subsections
2 (a)(1), (a)(2), and (c)) of the Public Health Service Act

7 **SEC. 215. ENSURING ADEQUACY OF PROVIDER NETWORKS.**
8 (a) IN GENERAL.—A qualified health benefits plan
9 that uses a provider network for items and services shall
10 meet such standards respecting provider networks as the
11 Commissioner may establish to assure the adequacy of
12 such networks in ensuring enrollee access to such items
13 and services and transparency in the cost-sharing differen-

the network and

iders.

On page 106 of H.R. 3962 the Health Choices Commissioner is empowered to set a minimum standard of care for health care plans that can be offered in the exchange. The "Public Option" will abide by the same "essential benefits" standard.

**The Essential Benefits** that the Health Choices Commissioner must ensure every plan offers are defined and listed beginning on page 110 of H.R. 3962.

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insurance issuers or insurers for the provision of dental, vision, mental health, and other benefits and services.

**SEC. 222. ESSENTIAL BENEFITS PACKAGE DEFINED.**

(a) IN GENERAL.—In this division, the term "essen-

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(8) Preventive services, including those services recommended with a grade of A or B by the Task Force on Clinical Preventive Services and those vaccines recommended for use by the Director of the Centers for Disease Control and Prevention.

(1) NO COST-SHARING FOR PREVENTIVE SERVICES.—There shall be no cost-sharing under the essential benefits package for—

(A) preventive items and services recommended with a grade of A or B by the Task Force on Clinical Preventive Services and those

**Preventive Services** are included in the list. They are to be provided so long as the Task Force on Clinical Preventive Services grade them as an "A" or "B" priority. In fact, "A" or "B" priority preventive services are to be provided free of charge.

The **"Task Force on Clinical Preventive Services"** gets to decide what preventive services, like mammograms, all Americans can have without a co-pay. If Insurance Exchange plans must cover 100% of the cost of "A" and "B" rated services for every American, what are the chances that they will able, or willing, to afford coverage of "C" rated tests?

So who is this **"Task Force on Clinical Preventive Services?"**

**The Task Force on Clinical Preventive Services'** duties are spelled out in Section 2301 of the bill, starting on page 1301-1302.

**The Task Force** reviews scientific evidence related to preventive services and grades them based on factors set out in the bill.

## SOUND FAMILIAR?

**Mission of the US Preventive Services Task Force**

"conducts rigorous, impartial assessments of the scientific evidence for the effectiveness of a broad range of clinical preventive services, including screening, counseling, and preventive medications."

**Mission of the Task Force on Preventive Services**

"review the scientific evidence related to the benefits, effectiveness, appropriateness, and costs of clinical preventive services."

**"Subtitle C—Prevention Task Forces**

**"SEC. 3131. TASK FORCE ON CLINICAL PREVENTIVE SERVICES.**

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"(2) review the scientific evidence related to the benefits, effectiveness, appropriateness, and costs of clinical preventive services identified under paragraph (1) for the purpose of developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

"(5) pursuant to section 3143(c), determine whether subsidies and rewards meet the Task Force's standards for a grade of A or B;

So what happens once the **Task Force on Clinical Preventive Services** examines a preventive services and rates it as an "A" or "B"?

**The Task Force on Clinical Preventive Services'** ratings are used to determine what services will be considered in the "Essential Benefits" package, according to language that starts on page 1317. As written, this language is problematic for the Secretary of Health and Human Services.

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"(C) populations at high risk of preventable diseases and conditions.

"(c) INCLUSION IN ESSENTIAL BENEFITS PACKAGE.—If, on the basis of the findings of research and demonstration projects under subsection (a) or other sources consistent with section 3131, the Task Force on Clinical Preventive Services determines that a subsidy or reward

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meets the Task Force's standards for a grade A or B, the Secretary shall ensure that the subsidy or reward is included in the essential benefits package under section 222.

When the term "shall" is used in legislation it translates to "must" in the real world. Therefore, this section of the bill constrains the HHS Secretary's discretion where providing preventive services are concerned.

If the **Task Force on Clinical Preventive Services** says that providing a certain screening every other year has a "B" rating while other annual tests are graded "C"; it isn't clear that the Secretary or Health Choices Commissioner has the power to upgrade or downgrade those recommendations.

Thus, under the proposed law, they may not be able to intervene and allow screenings to be offered more or less frequently- or at all.

How does the **US Preventive Services Task Force** recommendations play into this?

**The US Preventive Services Task Force** recommendations are considered to be recommendations of **Task Force on Clinical Preventive Services** according to language on page 1329 of the bill.

According to this passage in the bill, all recommendations of the **US Preventive Services Task Force** will automatically become the standard upon which the Secretary of Health and Human Services **shall** base decisions on what "Essential Benefits" must be provided free of charge to every American.

This takes us back to the beginning, to the mammogram study and the **USPSTF's** recommendation about what women should and should not get them.

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"(4) The term 'tribal' refers to an Indian tribe

(2) RECOMMENDATIONS.—All recommendations of the Preventive Services Task Force and the Task Force on Community Preventive Services, as in existence on the day before the date of the enactment of this Act, shall be considered to be recommenda-

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tions of the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services, respectively, established under sections 3131 and 3132 of the Public Health Service Act, as added by subsection (a).

You Are Here: [illegible] > U.S. Preventive Services Task Force (USPSTF)

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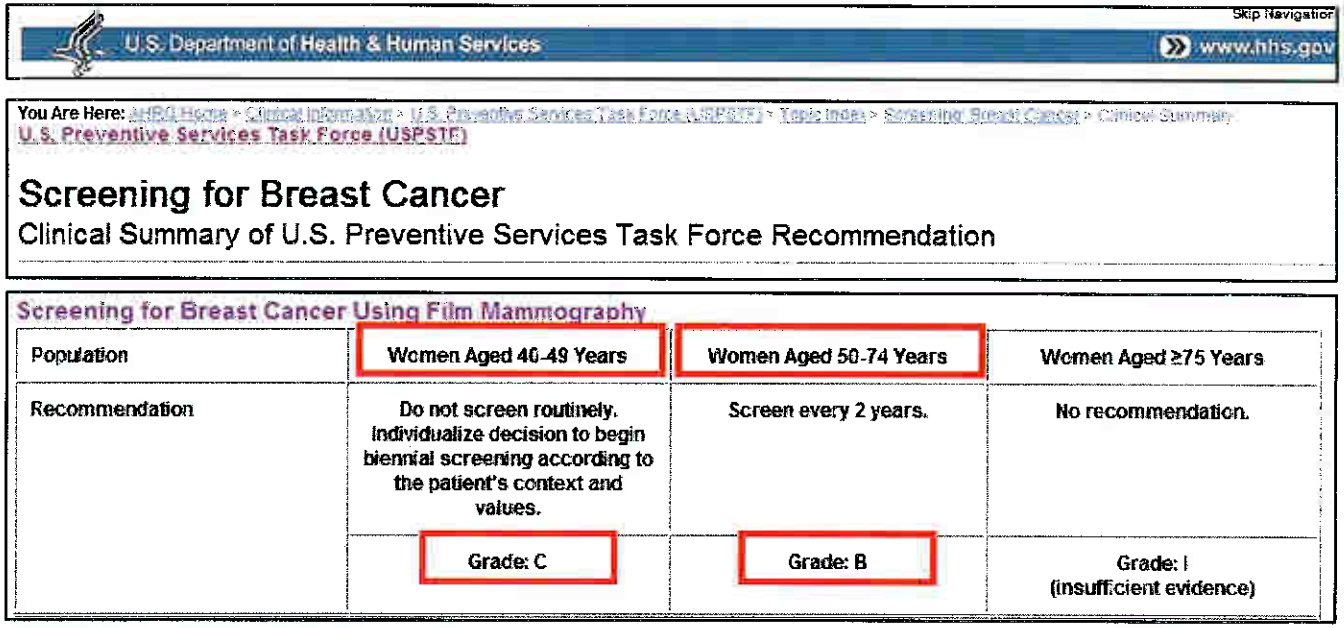
**Screening for Breast Cancer Using Film Mammography**

| Population | Women Aged 40-49 Years | Women Aged 50-74 Years | Women Aged ≥75 Years |
|---|---|---|---|
| Recommendation | Do not screen routinely. Individualize decision to begin biennial screening according to the patient's context and values. | Screen every 2 years. | No recommendation. |

**The US Preventive Services Task Force** recent study on mammograms actually "rated" provision of mammograms for women younger than 50, from 50-75, and older than 75. According to H.R. 3962, those recommendations must be the basis upon which the Secretary of Health and Human Services determines what kind of coverage mammograms will receive in the insurance exchange.



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U.S. Preventive Services Task Force (USPSTF)

## Screening for Breast Cancer

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|---|---|---|---|
| Recommendation | Do not screen routinely. Individualize decision to begin biennial screening according to the patient's context and values. | Screen every 2 years. | No recommendation. |
| | Grade: C | Grade: B | Grade: I (insufficient evidence) |

**USPSTF** rates mammograms for women under 50 a **"C"** ; they rate mammograms for women ages 50-75 a **"B"** but only allow for them every other year; and they find insufficient evidence to recommend mammograms for women over 75 years old. **H.R. 3962 says that these ratings are the basis for the essential benefits all Americans can receive. Therefore women under 50 and over 75 will have to find some other way to get mammograms once this bill becomes law. Women between those ages will be given a mammogram every other year, but that's all.**

C, the provisions of section 2705 (other than subsections (a)(1), (a)(2), and (c)) of the Public Health Service Act shall apply to a qualified health benefits plan, regardless of whether it is offered in the individual or group market, in the same manner as such provisions apply to health insurance coverage offered in the large group market.

**SEC. 215. ENSURING ADEQUACY OF PROVIDER NETWORKS.**

(a) IN GENERAL.—A qualified health benefits plan that uses a provider network for items and services shall meet such standards respecting provider networks as the Commissioner may establish to assure the adequacy of such networks in ensuring enrollee access to such items and services and transparency in the cost-sharing differentials among providers participating in the network and policies for accessing out-of-network providers.

(b) INTERNET ACCESS TO INFORMATION.—A qualified health benefits plan that uses a provider network shall provide a current listing of all providers in its network on its Website and such data shall be available on the Health Insurance Exchange Website as a part of the basic information on that plan. The Commissioner shall also establish an on-line system whereby an individual may select by name any medical provider (as defined by the Commissioner) and be informed of the plan or plans with which that provider is contracting.

(c) PROVIDER NETWORK DEFINED.—In this division, the term "provider network" means the providers with respect to which covered benefits, treatments, and services are available under a health benefits plan.

**SEC. 216. REQUIRING THE OPTION OF EXTENSION OF DEPENDENT COVERAGE FOR UNINSURED YOUNG ADULTS.**

(a) IN GENERAL.—A qualified health benefits plan shall make available, at the option of the principal enrollee under the plan, coverage for one or more qualified children (as defined in subsection (b)) of the enrollee.

(b) QUALIFIED CHILD DEFINED.—In this section, the term "qualified child" means, with respect to a principal enrollee in a qualified health benefits plan, an individual who (but for age) would be treated as a dependent child of the enrollee under such plan and who—

(1) is under 27 years of age; and

(2) is not enrolled in a health benefits plan other than under this section.

(c) PREMIUMS.—Nothing in this section shall be construed as preventing a qualified health benefits plan from increasing the premiums otherwise required for coverage provided under this section consistent with standards established by the Commissioner based upon family size under section 213(a)(3).

insurance issuers or insurers for the provision of dental, vision, mental health, and other benefits and services.

**SEC. 222. ESSENTIAL BENEFITS PACKAGE DEFINED.**

(a) IN GENERAL.—In this division, the term "essential benefits package" means health benefits coverage, consistent with standards adopted under section 224, to ensure the provision of quality health care and financial security, that—

(1) provides payment for the items and services described in subsection (b) in accordance with generally accepted standards of medical or other appropriate clinical or professional practice;

(2) limits cost-sharing for such covered health care items and services in accordance with such benefit standards, consistent with subsection (c);

(3) does not impose any annual or lifetime limit on the coverage of covered health care items and services;

(4) complies with section 215(a) (relating to network adequacy); and

(5) is equivalent in its scope of benefits, as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services, to the average prevailing employer-sponsored coverage in Y1.

In order to carry out paragraph (5), the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Health Benefits Advisory Committee and to the Secretary of Health and Human Services.

(b) MINIMUM SERVICES TO BE COVERED.—Subject to subsection (d), the items and services described in this subsection are the following:

(1) Hospitalization.

(2) Outpatient hospital and outpatient clinic services, including emergency department services.

(3) Professional services of physicians and other health professionals.

(4) Such services, equipment, and supplies incident to the services of a physician's or a health professional's delivery of care in institutional settings, physician offices, patients' homes or place of residence, or other settings, as appropriate.

(5) Prescription drugs.

(6) Rehabilitative and habilitative services.

(7) Mental health and substance use disorder services, including behavioral health treatments.

(8) Preventive services, including those services recommended with a grade of A or B by the Task Force on Clinical Preventive Services and those vaccines recommended for use by the Director of the Centers for Disease Control and Prevention.

(9) Maternity care.

(10) Well-baby and well-child care and oral health, vision, and hearing services, equipment, and supplies for children under 21 years of age.

(11) Durable medical equipment, prosthetics, orthotics and related supplies.

(c) REQUIREMENTS RELATING TO COST-SHARING AND MINIMUM ACTUARIAL VALUE.—

(1) NO COST-SHARING FOR PREVENTIVE SERVICES.—There shall be no cost-sharing under the essential benefits package for—

(A) preventive items and services recommended with a grade of A or B by the Task Force on Clinical Preventive Services and those vaccines recommended for use by the Director of the Centers for Disease Control and Prevention; or

(B) well-baby and well-child care.

(2) ANNUAL LIMITATION.—

(2) SECTIONS 737, 738, AND 739.—Subsections (a), (b), and (c) of section 740 are amended by striking "2002" each place it appears and inserting "2015".

(3) SECTION 741.—Subsection (h), as so redesignated, of section 741 is amended—

(A) by striking "and" after "fiscal year 2003,"; and

(B) by inserting ", and such sums as may be necessary for each subsequent fiscal year through the end of fiscal year 2015" before the period at the end.

(4) SECTION 761.—Subsection (e)(1), as so redesignated, of section 761 is amended by striking "2002" and inserting "2015".

# TITLE III—PREVENTION AND WELLNESS

**SEC. 2301. PREVENTION AND WELLNESS.**

(a) IN GENERAL.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by inserting after title XXX the following:

# "TITLE XXXI—PREVENTION AND WELLNESS

## "Subtitle A—Prevention and Wellness Trust

**"SEC. 3111. PREVENTION AND WELLNESS TRUST.**

"(a) DEPOSITS INTO TRUST.—There is established a Prevention and Wellness Trust. There are authorized to be appropriated to the Trust, out of any monies in the Public Health Investment Fund—

"(1) for fiscal year 2011, $2,400,000,000;

"(2) for fiscal year 2012, $2,845,000,000;

"(3) for fiscal year 2013, $3,100,000,000;

"(4) for fiscal year 2014, $3,455,000,000; and

"(5) for fiscal year 2015, $3,600,000,000.

"(b) AVAILABILITY OF FUNDS.—Amounts in the Prevention and Wellness Trust shall be available, as provided in advance in appropriation Acts, for carrying out this title.

"(c) ALLOCATION.—Of the amounts authorized to be appropriated in subsection (a), there are authorized to be appropriated—

"(1) for carrying out subtitle C (Prevention Task Forces), $30,000,000 for each of fiscal years 2011 through 2015;

"(2) As appropriate, the heads of other Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary).

"(3) As appropriate, nonprofit and for-profit entities.

"(4) The Association of State and Territorial Health Officials and the National Association of County and City Health Officials.

"(5) The Task Force on Community Preventive Services and the Task Force on Clinical Preventive Services.

## "Subtitle C—Prevention Task Forces

### "SEC. 3131. TASK FORCE ON CLINICAL PREVENTIVE SERVICES.

"(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall establish a permanent task force to be known as the Task Force on Clinical Preventive Services (in this section referred to as the 'Task Force').

"(b) RESPONSIBILITIES.—The Task Force shall—

"(1) identify clinical preventive services for review;

"(2) review the scientific evidence related to the benefits, effectiveness, appropriateness, and costs of clinical preventive services identified under paragraph (1) for the purpose of developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

"(3) as appropriate, take into account health disparities in developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

"(4) identify gaps in clinical preventive services research and evaluation and recommend priority areas for such research and evaluation;

"(5) pursuant to section 3143(c), determine whether subsidies and rewards meet the Task Force's standards for a grade of A or B;

"(6) as appropriate, consult with the clinical prevention stakeholders board in accordance with subsection (f);

"(7) consult with the Task Force on Community Preventive Services established under section 3132; and

"(8) as appropriate, in carrying out this section, consider the national strategy under section 3121.

meets the Task Force's standards for a grade A or B, the Secretary shall ensure that the subsidy or reward is included in the essential benefits package under section 222.

"(d) INCLUSION AS ALLOWABLE USE OF COMMUNITY PREVENTION AND WELLNESS SERVICES GRANTS.—If, on the basis of the findings of research and demonstration projects under subsection (a) or other sources consistent with section 3132, the Task Force on Community Preventive Services determines that a subsidy or reward is effective, the Secretary shall ensure that the subsidy or reward becomes an allowable use of grant funds under section 3151.

"(e) NONDISCRIMINATION; NO TIE TO PREMIUM OR COST SHARING.—In carrying out this section, the Secretary shall ensure that any subsidy or reward—

"(1) does not have a discriminatory effect on the basis of any personal characteristic extraneous to the provision of high-quality health care or related services; and

"(2) is not tied to the premium or cost sharing of an individual under any qualified health benefits plan (as defined in section 100(c)).

"(C) populations at high risk of preventable diseases and conditions.

"(b) FINDINGS; REPORT.—

"(1) SUBMISSION OF FINDINGS.—The Secretary shall submit the findings of research and demonstration projects under subsection (a) to—

"(A) the Task Force on Clinical Preventive Services established under section 3131 or the Task Force on Community Preventive Services established under section 3132, as appropriate; and

"(B) the Health Benefits Advisory Committee established by section 223 of the Affordable Health Care for America Act.

"(2) REPORT TO CONGRESS.—Not later than 18 months after the initiation of research and demonstration projects under subsection (a), the Secretary shall submit a report to the Congress on the progress of such research and projects, including any preliminary findings.

"(c) INCLUSION IN ESSENTIAL BENEFITS PACKAGE.—If, on the basis of the findings of research and demonstration projects under subsection (a) or other sources consistent with section 3131, the Task Force on Clinical Preventive Services determines that a subsidy or reward

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"(2) is not tied to the premium or cost sharing of an individual under any qualified health benefits plan (as defined in section 100(c)).

"(4) The term 'tribal' refers to an Indian tribe, a Tribal organization, or an Urban Indian organization, as such terms are defined in section 4 of the Indian Health Care Improvement Act.".

(b) TRANSITION PROVISIONS APPLICABLE TO TASK FORCES.—

(1) FUNCTIONS, PERSONNEL, ASSETS, LIABILITIES, AND ADMINISTRATIVE ACTIONS.—All functions, personnel, assets, and liabilities of, and administrative actions applicable to, the Preventive Services Task Force convened under section 915(a) of the Public Health Service Act and the Task Force on Community Preventive Services (as such section and Task Forces were in existence on the day before the date of the enactment of this Act) shall be transferred to the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services, respectively, established under sections 3131 and 3132 of the Public Health Service Act, as added by subsection (a).

(2) RECOMMENDATIONS.—All recommendations of the Preventive Services Task Force and the Task Force on Community Preventive Services, as in existence on the day before the date of the enactment of this Act, shall be considered to be recommenda-

tions of the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services, respectively, established under sections 3131 and 3132 of the Public Health Service Act, as added by subsection (a).

(3) MEMBERS ALREADY SERVING.—

(A) INITIAL MEMBERS.—The Secretary of Health and Human Services may select those individuals already serving on the Preventive Services Task Force and the Task Force on Community Preventive Services, as in existence on the day before the date of the enactment of this Act, to be among the first members appointed to the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services, respectively, under sections 3131 and 3132 of the Public Health Service Act, as added by subsection (a).

(B) CALCULATION OF TOTAL SERVICE.—In calculating the total years of service of a member of a task force for purposes of section 3131(d)(2)(A) or 3132(d)(2)(A) of the Public Health Service Act, as added by subsection (a), the Secretary of Health and Human Services shall not include any period of service by the