EBRI FAST Facts
June 22, 2023, #474

Imposing Cost Sharing on Preventive Services Significantly Impacts Expenditures for Eligible Enrollees but Does Not Substantially Reduce Aggregate Employer Health Care Spending: Implications of *Braidwood Management Inc. v. Becerra*

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When the Patient Protection and Affordable Care Act (ACA) passed in 2010, it included provisions requiring that most employers and health plans cover certain preventive services in full.[1] The preventive services come from recommendations by the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), the Health Resources and Services Administration's (HRSA's) Bright Futures Project, and the HRSA-sponsored Women's Prevention Services Initiative (WPSI). The combined list of about 90 preventive services includes, but is not limited to, 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 with no out-of-pocket costs of *some* of these preventive services 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 on *Braidwood Management Inc. v. Becerra* refers to the part of the ACA that requires coverage without cost sharing of preventive services rated "A" or "B" by the USPSTF . The judge ruled that these recommendations are unconstitutional because the USPSTF — a group the Agency for Healthcare Research and Quality has been authorized by the U.S. Congress to convene since 1998 — 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.

On March 30, 2023, the judge ruled on the remedy. The judicial opinion impacts:

- Services receiving an "A" or "B" recommendation after March 2010.
- Services upgraded to an "A" or "B" recommendation after 2010.
- Services receiving an "A" or "B" recommendation in the future.

The list of approximately 50 USPSTF "A"- and "B"-rated services and how the judicial opinion affects them can be found at https://vbidcenter.org/wp-content/uploads/2023/04/Braidwood-USPSTF-Table.pdf. In summary, if the ruling is upheld, there are five services that would no longer require coverage without cost sharing that received an "A" or "B" recommendation after March 2010, and there are 10 services that were upgraded to an

"A" or "B" recommendation after 2010.[2] In addition, there are currently two new recommendations and four updated recommendations in draft form that would not be required to be covered without cost sharing. Moreover, the ruling may also affect as many as 17 additional services that received an "A" or "B" rating prior to 2010, the recommendations for which received significant updates after the signing of the ACA. Overall, about 30 services may be affected by the ruling, though some are not identifiable via claims data, and others may be covered by other provisions in the ACA.

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).

Accordingly, we assessed the impact of imposing cost sharing of the services and prescription drug classes receiving an "A" or "B" recommendation from the USPSTF on enrollee and employer spending.[5] If the judicial ruling stands, employers could impose cost sharing or remove coverage for the 15 services that did not have an "A" or "B" rating before 2010. Of these, 10 of them were measurable in claims data. Furthermore, three of these services (screening for gestational diabetes, HIV, and intimate partner violence/elder abuse) might still require coverage without cost sharing, as they are also recommended by the HRSA.

Our analyses demonstrate two important findings if the Braidwood ruling is upheld and cost sharing is imposed: 1) Enrollees using preventive services may face a substantial increase in their *individual* out-of-pocket spending, and 2) reintroduction of patient cost sharing will have a minimal impact on *overall* employer health care spending, because when spread across the entire pool of covered lives, the costs of covering select preventive services are very low.

Impact on Workers and Their Dependents

If the court decision is upheld and the coverage mandate for the preventive care services receiving an "A" and "B" rating after March 2010 is invalidated, employers and health plans could impose some form of cost sharing for these preventive services. They could also completely drop coverage for these services. For example, if employers were to impose 20 percent coinsurance, the cost of behavioral counseling interventions for healthy weight and weight gain in pregnancy could amount to at least $33 per person on average, the cost of preventive interventions for perinatal depression could amount to at least $91 per person on average, and the cost of HIV PrEP could reach $2,747 per user.[6] The cost of these services could be subject to deductibles as well.

Were employers to not cover these services, the out-of-pocket cost per user could easily exceed the total allowed amounts shown in Figure 1, because some enrollees would no longer benefit from plan-negotiated rates.

If enrollees had to pay out of pocket, use of health care services would likely fall, even for services that were not considered costly, especially among lower-income individuals who may find any cost a barrier to care.[7]

Figure 1

Total Allowed Cost and Possible Cost Sharing of Select "A"- and "B"-Rated Services Receiving Recommendation or Upgrade After March 2010

	Total Allowed Cost per User in 2019	Enrollee Out-of-Pocket If 20 Percent Coinsurance
Screening for Anxiety in Children and Adolescents (ages 8–18)	$10	$2
Behavioral Counseling Interventions for Healthy Weight and Weight Gain in Pregnancy	$163	$33
Preventive Interventions for Perinatal Depression	$454	$91
Pre-Exposure Prophylaxis (PrEP) for Prevention of HIV Infection*	$13,733	$2,747
Screening for Gestational Diabetes+	$20	$4
Screening for Hepatitis B Virus Infection in Adolescents and Adults	$25	$5
Screening for Hepatitis C Virus in Adolescents and Adults	$27	$5
Primary Care Interventions for Tobacco Use in Children and Adolescents	$38	$8
Screening for Human Immunodeficiency Virus Infection (for those not at increased risk) for Pregnant Women+	$38	$8
Screening for Human Immunodeficiency Virus Infection (for those not at increased risk) for Adolescents and Adults (ages 15–64)+	$34	$7

Notes:
* Update being drafted
+ HRSA-Supported Women's Preventive Services.

Impact on Employer Spending

If employers were allowed and chose to impose 20 percent cost sharing on all the "A"- and "B"-rated services and medications that are measurable in claims data for individuals under age 65, employer spending would fall by 0.48 percent. Similarly, in aggregate, "A"- and "B"-rated services account for only 2.4 percent of total spending.

If employers imposed 20 percent cost sharing on those 10 services that either only received the "A"/"B" rating after March 2010 or were upgraded to "A"/"B" after 2010 (Figure 1), employer spending would fall by only 0.10 percent. Pre-exposure prophylaxis (PrEP) for prevention of HIV infection and preventive interventions for perinatal depression account for the overwhelming majority of the potential savings.

In our analysis of PrEP drugs, we found that the cost of these drugs on a per-patient basis is relatively high at $13,733 per year. However, because so few enrollees utilize PrEP medications (about 0.2 percent of all members), the total cost of these drugs account for only 0.38 percent of total spending. Thus, if employers imposed 20 percent cost sharing on patients for PrEP drugs, employer spending would fall by less than one-tenth of 1 percent. Furthermore, now that PrEP is available as a generic, employer savings from imposing cost sharing will be somewhat less. But as mentioned above, the cost to enrollees impacted by the plan design change could be substantial.

Taken together, as enrollees reduce use of "A"- and "B"-rated preventive services, other health care costs may increase. For instance, colorectal cancer screenings are one of the services that have seen a significant update to the original USPSTF recommendation. While employers may realize marginal short-term savings from subjecting colorectal cancer screening to cost sharing, their costs may be higher in the future if enrollees avoid needed health care now, as some enrollees will not prevent the onset of cancer. Employee productivity may also be affected if employees are worried about being unable to get preventive care or the expense of getting that care.

Figure 2

Overall Use and Employer Savings Related to Select "A"- and "B"-Rated Services Affected by the Judicial Ruling, 2019

	Percentage of Members Utilizing Service	Percentage of Total Cost	Employer Savings From 20 Percent Coinsurance
Screening for Anxiety in Children and Adolescents (ages 8–18)	2%	<0.01%	<0.01%
Behavioral Counseling Interventions for Healthy Weight and Weight Gain in Pregnancy	0.04%	<0.01%	<0.01%
Preventive Interventions for Perinatal Depression	1%	0.09%	0.02%
Pre-Exposure Prophylaxis (PrEP) for Prevention of HIV Infection*	0.20%	0.38%	0.08%
Screening for Gestational Diabetes+	1%	<0.01%	<0.01%
Screening for Hepatitis B Virus Infection in Adolescents and Adults	1%	<0.01%	<0.01%
Screening for Hepatitis C Virus in Adolescents and Adults	3%	0.01%	<0.01%
Primary Care Interventions for Tobacco Use in Children and Adolescents	0.20%	<0.01%	<0.01%
Screening for Human Immunodeficiency Virus Infection (for those not at increased risk) for Pregnant Women+	1%	<0.01%	<0.01%
Screening for Human Immunodeficiency Virus Infection (for those not at increased risk) for Adolescents and Adults (ages 15–64)+	3%	0.01%	<0.01%

Notes:
* Update being drafted
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Discussion

Employers may continue to provide these services at no cost to members for at least a few reasons. Employers may not want to cut benefits during a time when unemployment is low, and recruitment and retention of workers is of concern. Employers may continue to offer coverage for these services in full if they believe that incentivizing their use reduces aggregate health spending in the long term. And 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 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 of HSA-eligible health plan deductibles, about three-quarters of them chose to do so, often without cost sharing (Fronstin and Fendrick 2021).[8]

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).

Conclusion

If the Braidwood decision were to be upheld and employers reimposed cost sharing on preventive services that are currently free to enrollees, individuals using those services could face a significant increase in out-of-pocket spending. Although this potentially onerous financial burden could deter care on the individual beneficiary level and likely worsen health inequities, employers would see little impact on their overall spending.

Data and Methods

We analyzed MarketScan® pharmacy and medical claims data on a sample of 14.02 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.

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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, PhRMA, and The Commonwealth Fund.

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Endnotes

[1] Grandfathered health plans are not required to comply with this provision. According to KFF (2023), 13 percent of workers with employment-based health benefits were enrolled in grandfathered plans.

[2] A few of these services might still require coverage without cost sharing as they are also preventive services for women and children recommended by the Health Resources and Services Administration (HRSA).

[3] See "Access to Preventive Services" (2022).

[4] See Kirzinger (2019).

[5] We did not examine 10 services because they were either not measurable from claims data or applied to individuals ages 65 and older, who are generally not covered by employment-based health plans.

[6] Now that PrEP is available as a generic, user out-of-pocket costs will be somewhat less.

[7] According to a recent consumer survey, 37 percent of adults said they "definitely" or "probably" expect to delay or avoid heath care due to potential costs following the ruling, and at least 2 in 5 adults said that they are not willing to pay for preventive services that are currently fully covered by the ACA. See Zipp (2023a)and Zipp (2023b).

[8] Also see "HSA-Eligible Health Plans Embrace Changes" (2021) and Internal Revenue Service (2019).

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