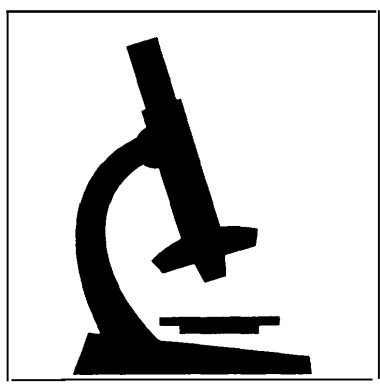
Summary and Policy Options 1

INTRODUCTION AND CONGRESSIONAL REQUEST

As reform of the Nation's health care system has risen to the top of the domestic policy agenda, the issue of what services to cover has increased in importance. Clearly, the scope and depth of services that are covered in any health insurance scheme can have a tremendous impact on how much health care people obtain, on the costs to the system, and, ultimately, on the health of the Nation's people. In order to provide Americans with an optimal level of care, at a reasonable cost to the Nation, policymakers at all levels have been rethinking traditional approaches to benefit design and considering the merits of using explicit scientific criteria to more clearly define the benefit structure.

This report is one of a series of publications on *benefit design in health care reform* being issued as part of the Office of Technology Assessment's (OTA) assessment, *Technology, Insurance, and the Health Care System. The* other publications in the Benefit Design Series are described in box l-A. The overall assessment is being conducted in response to a request from the Senate Committee on Labor and Human Resources (Senator Edward M. Kennedy, Chairman), that was endorsed by the House Committee on Energy and Commerce (Congressman John D. Dingell, Chairman), the House Committee on Ways and Means Subcommittee on Health (then-Ranking Minority Member Willis D. Gradison), and Senator Charles E. Grassley, a member of OTA Technology Assessment Board. Chairman Dingell asked OTA to assess the extent to which a minimum benefit package could be designed based on information about health effects and cost-effectiveness. Other requesters agreed that this was an important question and that OTA should address it by



Box I-A-Other Publications in the Office of Technology Assessment's Series on Benefit Design in Health Care Reform

- *Benefit Design in Health Care Reform: Report #2—Mental Health and Substance Abuse Treatment Services* (U.S. Congress, OTA, in preparation). This report has three goals. First, at the request of Congress, the report addresses the question of whether mental health and substance abuse benefits should be in a core benefit package, should there be such a package. Second, the report describes whether information on effectiveness and cost-effectiveness could be used to select specific types of mental health and substance abuse services for coverage, and the limitations of using such information. And third, the report reviews information on the effectiveness and cost-effectiveness of services for selected mental health and substance abuse conditions.
- *Benefit Design in Health Care Reform: Background Paper—Patient Cost-Sharing* (203). This background paper reviews the evidence on the effects of patient cost-sharing on the uses and costs of personal health services, as well as, to the extent possible, the effects of patient cost-sharing on patients' health.
- *Benefit Design in Health Care Reform: Report #3—General Policy Issues* (U.S. Congress, OTA, in preparation). This report uses the analyses in this report and the two publications listed above, as well as other sources (e.g., U.S. Congress, OTA, Oregon, May 1992), to gain insights into the possibilities and pitfalls associated with trying to design a benefit package based on effectiveness and cost-effectiveness information, in relation to other critical factors, such as public preferences and political considerations.

SOURCE: U.S. Congress, Office of Technology Assessment, 1993.

means of an overall brief on the topic, as well as through examinations of the evidence on clinical preventive services; mental health and substance abuse treatment services; and patient cost-sharing.

This *report-Benefit Design in Health Care Reform: Report #I--Clinical Preventive Services* —addresses issues concerning coverage of clinical preventive services. Preventive services are often portrayed as providing 'good investments' and thus potentially good candidates for health insurance coverage. This report examines this perception and considers the role that information on effectiveness and cost-effectiveness can, and cannot, play in choosing specific clinical preventive services to include in a benefit package.

FOCUS AND ORGANIZATION OF THE REPORT

The focus of this report is on selected clinical preventive services for asymptomatic individuals, that is, individuals who do not exhibit signs of the health condition or disease the clinical preventive service is designed to prevent.

For the most part, the clinical preventive services that have been at greatest contention and subject to the most scrutiny are screening services designed to detect a disease at an early stage (e.g., breast cancer screening, screening for high blood pressure); thus, most of the clinical preventive services reviewed in this report are screening services.

Selected other clinical preventive services have also been debated and subject to some scientific scrutiny because of their assumed potential for preventing unwanted health conditions; several of these clinical preventive services are also reviewed in this report (e.g., immunizations, contraceptives, smoking cessation interventions, some physician counseling).

Not all possible clinical preventive services are reviewed in this report; new clinical preventive services are discovered or introduced into the coverage debate regularly. The purpose of the report is to place the issue of using scientific evidence at the forefront of the health care reform and coverage debates.

The report is organized as follows: chapter 1 summarizes the primary findings of the report and

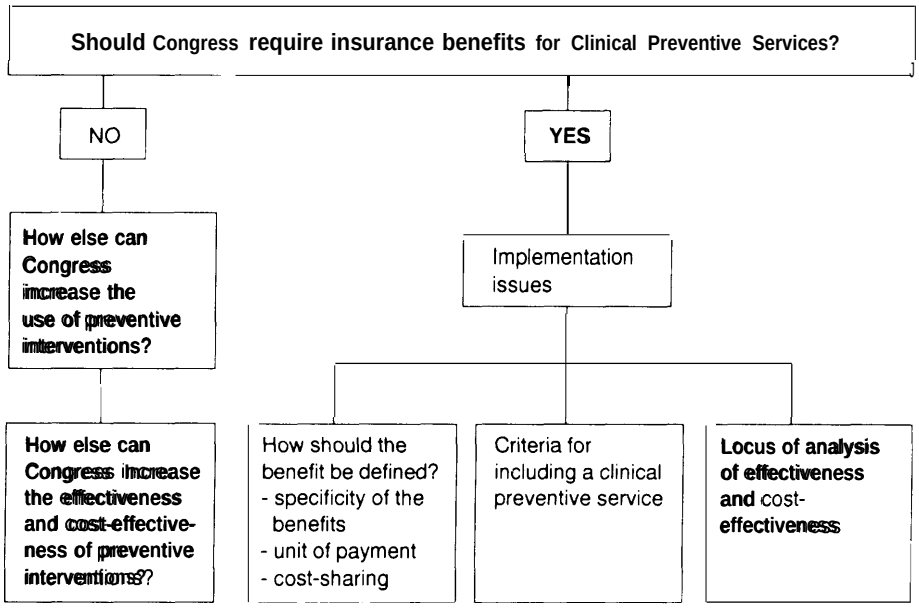
presents issues and policy options. Chapter 2 provides an overview of the issues and discusses: defining clinical preventive services in the context of prevention generally; the use of insurance as a funding source for clinical preventive services; criteria for choosing which clinical preventive services to include in an insurance package; and how insurance benefits for clinical preventive services might be designed once services have been chosen for coverage (e.g., extent of patient cost-sharing, unit of payment, limits on the frequency, limits by patient characteristics). Chapter 3 reviews the evidence on the effectiveness of a select group of clinical preventive services that are frequently proposed for insurance coverage. The last chapter, chapter 4, discusses how information on costs and cost-effectiveness might be used to design benefits for clinical preventive services and the evidence on the costs and cost-effectiveness of selected clinical preventive services.

SUMMARY OF FINDINGS

Below is a brief synopsis of the report's major conclusions:

- Many clinical preventive services have not been evaluated in terms of their effectiveness and cost-effectiveness. Therefore, whether they are effective or relatively cost-effective is simply not known.
- Some, but not all, clinical preventive services for asymptomatic individuals have been found to be effective in reducing, or delaying, the incidence and burden of disease for some patients.
- Very few clinical preventive services have been found to be cost-saving to society in terms of medical care costs when provided to individuals at average risk for the condition.
- An entity's finding that a clinical preventive service is ' 'cost-effective' should not be interpreted to mean that it is ''cost-saving. " Cost-effectiveness is always a statement about the costs of an intervention relative to its effectiveness.
- If policymakers aim to either save money or improve the health of the population, or both, they will need to: a) take care to distinguish among the preventive services that they cause or encourage to be supported; and b) consider the patient characteristics, frequency, and fee schedules for such services. The costs and cost-effectiveness of clinical preventive services may vary greatly depending on the targeted population's underlying risk for the condition and the circumstances under which the intervention is applied.
- Examples of clinical preventive services that evidence shows are effective include: screening for breast cancer (mammography and clinical breast examination) in women 50 years of age and older; screening for cervical cancer (Pap smears) for women who are or have been sexually active; cholesterol screening for certain individuals; selected smoking cessation interventions; hypertension screening for certain individuals; adult immunizations for certain individuals; and screening for sexually transmitted diseases for certain individuals. Although these services are effective—in the sense that they are likely to result in net benefits to health-all have been found likely to increase financial costs to society when applied to populations that are at average risk for the specific condition (with the exception of screening for sexually transmitted diseases which has not been extensively evaluated using cost-effectiveness analysis).
- Examples of clinical preventive *services* that are effective and can reduce aggregate (societal) medical care costs (under certain conditions) include: most childhood immunizations; newborn screening for some congenital disorders (i.e., one-time screen for congenital hypothyroidism and phenylketonuria); and prenatal care for poor women.
- If the aim is to design benefit packages based on effectiveness and cost-effectiveness, the

Figure I-I—Policy Issues Concerning Insurance Coverage for Clinical Preventive Services



SOURCE: U.S. Congress, Office of Technology Assessment, 1993.

specifications of coverage (e.g., which services are covered and under what circumstances), are currently likely to be simpler for clinical preventive services than for therapeutic interventions (i.e., interventions used to treat disease) primarily because, to date, the indications for using preventive interventions have been based on general population characteristics rather than complex signs and symptoms. For example, the indication for mammography is based primarily on the age and gender of the patient. In contrast, selection of a treatment for breast cancer might be influenced by the extent to which the cancer has spread, whether previous treatment has been provided, the number and severity of other diseases, and the patient's tolerance for risks and side effects.

Insurance for clinical preventive services is provided primarily to encourage the use of preventive interventions, rather than to protect against the risk of a catastrophic financial event associated with medical treatment. Evidence suggests that insurance coverage will increase the use of clinical preventive services, but not, by itself, to optimal levels. Whether insurance coverage-or some other means-should be used to help encourage the use of clinical preventive services is only in part a scientific question (e.g., does insurance lead to greater use of services?). It is also a philosophical question and depends on what one considers the purpose of health insurance (e.g., to spread financial risk or to encourage use of services).

ISSUES AND OPTIONS

OTA's analysis of the implications of any of the number of alternative approaches to coverage for preventive services that Congress may or may not pursue suggests that the question is more complicated than "to cover or not to cover. " Figure 1-1 outlines key prevention-related policy issues facing Congress as it considers health care

reform. Each of these issues, and related options, are described in this section.[1]

The first issue Congress must address is whether insurance plans should be required to cover clinical preventive services. If the answer to this question is "yes," several questions follow. One question is: what are the criteria for choosing which specific preventive services to cover? The criteria evaluated in this report were effectiveness, cost-effectiveness, and net costs. A second question is: who should provide the information on effectiveness and costs? A third question is: how should the specifics of the benefit package be determined (e.g., patient cost-sharing; limits on the periodicity of screening)?

Most of the choices related to the issues raised in this report could be adapted to any of a broad range of alternative health care reform schemes. For example, even in a "single payer" system with a global budget, some entity could determine which services would be reimbursed. Some choices related to clinical preventive services may, however, fit better or be associated more with some approaches to reform than others. The following section notes when an alternative related to clinical preventive services is particularly suited or unsuited, or must be adapted to, a particular approach to health care reform.

As the implications of insurance for preventive services and Congressional options are described, it is useful to consider the possible goals of policies regarding insurance benefits for clinical preventive services. Some potential goals are listed in table 1-1.

It is important to recognize that these goals may be addressed through means other than benefit design. The following section discusses options that might aid in pursuing the objectives of greater utilization and effectiveness of clinical preventive services, regardless of decisions concerning insurance coverage. Table 1-2 provides an overview of the options discussed in this report.

Table I-l—Potential Goals of Policies Concerning Insurance for Clinical Preventive Services

1. Increase the use of clinical preventive services.
2. Improve and/or maintain the health of the population.
3. Control or minimize health care costs paid by society, taxpayers, patients, employers, and others.
4. Improve the effectiveness of preventive interventions.
5. Allow flexibility in the provision of services.
6. Allow consumers to exercise their preferences for services.
7. Minimize administrative burden on patients and physicians.
8. Encourage equitable access to services.

SOURCE: U.S. Congress, Office of Technology Assessment, 1993.

Coverage Options

OPTION 1. *Congress could make no statement or requirement pertaining to coverage of clinical preventive services.*

In the absence of a federally mandated benefit package that includes clinical preventive services, choices about which insurance benefits to include may continue to be influenced by *existing* Federal regulations, State mandates, and market forces. A potential disadvantage with this decentralized and non-uniform approach is that it perpetuates variations in benefits. To the extent that clinical preventive services are effective, this approach may result in varying incentives for improving or maintaining health status and may be viewed as inequitable.[2]

An advantage of Congress not requiring benefits for clinical preventive services is that individ-

1 A broad range of health care reform alternatives was being debated while OTA was developing this report (200). This report does not presume that Congress will pass any particular national-level health care reform. To date, there have been few national-level policies related to health care coverage for specific services. Exceptions have been limited to specific subsets of populations or to specific types of insurers and include the HMO Act of 1973, as amended, and coverage for various clinical preventive services under Medicare and Medicaid. For the most pm-t decisions about coverage for specific services have been made in the private sector or legislated at the State level (202).

2 General arguments have been put forth for establishing a uniform benefit package, for example, in the context of some "managed competition' plans (172). Uniform benefits are expected to elucidate price differences between plans thus making it easier for consumers to compare and evaluate insurance plans. In addition, uniform benefits may avoid some of the problems of risk selection (202,172).

Table 1-2—Policy Options for Congressional Consideration

Coverage Options
Option 1: Congress could make no statement or requirement pertaining to coverage of clinical preventive services.
Option 2: Congress could require that all insurance plans include coverage for clinical preventive services, or establish a core benefit package that includes coverage for clinical preventive services.
Option 3: If Congress requires insurance coverage for specific clinical preventive services, coverage decisions concerning specific clinical preventive Interventions could be based on their effectiveness, cost-effectiveness, and/or net costs.
Options Regarding Sources of information on Effectiveness and Cost-Eftectiveness
Option 4: Congress could identify one or more U.S. Executive Branch agencies that would determine whether specific clinical preventive services are effective and the cost-effectiveness of those clinical preventive services.
Option 5: Congress could identify provider organization(s) that would determine whether specific clinical preventive interventions are effective and their cost-effectiveness.
Option 6: Congress could determine whether specific clinical preventive services are effective and evaluate their cost-effectiveness.
Options Regarding Specific Benefit Design Features
Option 7: Congress could identify a Federal agency to determine the specifics of the benefit package (e.g., periodicity schedules, covered populations),
Option 8: Congress could require full insurance coverage for clinical preventive services for those individuals with incomes below a given level.
Option 9: Congress could require full insurance coverage for clinical preventive services for the total insured population.
Access *Options*
Option 10: Congress could encourage the provision of clinical preventive services by directly allocating funding to programs that provide clinical preventive services, such as public clinics, school-based clinics, and work-site programs.
Option 11: Congress could encourage the provision of clinical preventive services by encouraging programs aimed at reducing nonfinancial barriers to access.
Research Options
Option 12: Congress could encourage the provision of effective clinical preventive services by promoting research on the efficacy, effectiveness, and cost-effectiveness of clinical preventive services.
Option 13: Congress could encourage the provision of effective clinical preventive services by promoting the dissemination of information on efficacy.

SOURCE: U.S. Congress, Office of Technology Assessment, 1993.

uals may retain greater control over how their money is spent. For example, in the absence of Federal requirements, individuals, employee organizations, or employers could decide whether they would rather have insurance for clinical preventive services and thus lower out-of-pocket costs if they receive clinical preventive services, or whether they would rather have lower insurance premiums and higher out-of-pocket costs if they receive clinical preventive services. Whether decisions by individuals, or their employers, are "better" than decisions made by government is debatable. On the one hand, government may have greater access to information on effectiveness and cost-effectiveness, and therefore, could better weigh the costs and the benefits of coverage decisions; on the other hand, government may not be able to adequately address individual values and preferences.

OPTION 2. *Congress could require that all insurance plans include coverage for clinical preventive services, or establish a core benefit package that includes coverage for clinical preventive services.*

Congressionally mandated insurance benefits for preventive services may directly, or indirectly, affect the following areas: patients' out-of-pocket costs; the demand for, and use of services; the cost of insurance premiums; total health care costs; and the insured population's health. The impact on each of these areas is reviewed below.

In a private insurance market, one effect of covering clinical preventive services through insurance would be the reduction of the out-of-pocket price to patients of preventive care. Research suggests that reduced out-of-pocket costs tend to increase the demand for clinical preventive services, although a substantial percentage of individuals still do not receive the recommended levels of preventive care, even when covered under insurance plans.

While insurance coverage for clinical preventive services would reduce patients' out-of-pocket costs (relative to no coverage) at the time of service, average insurance premiums will likely increase. Additionally, the increased use of services, due to insurance coverage, is likely to be associated with an increase in total medical expenditures. With few exceptions, these additional costs are unlikely to be offset by savings resulting from avoided treatment.

The ultimate goals of encouraging the use of preventive services are to improve and/or maintain health. A number of clinical preventive services have been found to reduce or delay the probability of mortality and morbidity. Therefore, to the extent that mandated benefits for clinical preventive services increase the use of effective clinical preventive services, they are likely to improve or maintain the insured population's health, and for some interventions (e.g., immunizations, screening for sexually acquired disorders) may also provide health benefits to those not directly receiving the interventions.

OPTION 3. *If Congress requires insurance coverage for specific clinical preventive services, coverage decisions concerning specific clinical preventive interventions could be based on their effectiveness, cost-effectiveness, and/or* ***net*** *costs.*

Effectiveness Criteria

The principal advantage of requiring insurance coverage for clinical preventive interventions based on their net benefits to health is that this approach would deter patients from receiving ineffective or marginally effective clinical preventive services. Preventive interventions are considered effective if they reduce, or delay, the probability of mortality and/or morbidity. However, defining what constitutes effective preventive care is a complex endeavor. In order to use effectiveness as a basis for designing an insurance benefit package, some entity must review the relevant research and determine whether a given preventive intervention is effective, and under what conditions. It is critical that this entity use methods which are as evidence-based as possible. In addition, the rationales and criteria used to evaluate the evidence and draw conclusions concerning effectiveness should be made as explicit as possible.

Cost-effectiveness Criteria

Using cost-effectiveness as a criterion for coverage decisions may invoke greater recognition of the likely tradeoffs between the goals of improving or maintaining health and the goal of limiting aggregate health care costs. In addition, cost-effectiveness analysis may aid in evaluating those societal tradeoffs. Finally, cost-effectiveness analysis may encourage policymakers to consider a broader range of likely consequences of promoting a preventive intervention (e.g., costs associated with follow-up visits to treat conditions found during screening).

Cost-effectiveness analysis has some limitations and weaknesses. Specifically, cost-effectiveness analyses typically do not measure important but less tangible health benefits and do not adequately incorporate equity and political issues. If people rely too heavily on cost-effectiveness, these political concerns and intangibles may be undervalued (183). Despite these problems, on balance cost-effectiveness analysis can be one of several useful tools for making resource allocation decisions, such as those pertaining to insurance benefits.

Net Cost Criterion

Under the criterion of net cost, clinical preventive services would be covered if the costs associated with their provision were less than a given amount. For example, only those services that lead to a net reduction in medical costs might be included. Costs could be defined in several ways, including costs to society, costs to insurance plans, costs to patients, and costs to employers. One problem with this standard is that services with relatively low effectiveness per resource consumed may be covered. For example, a certain intervention may be relatively inexpensive to perform, but may result in few health benefits. Under a net cost criterion, this intervention might be covered, whereas an intervention that increased costs but conferred substantial health benefits might not be covered. This approach, therefore, implicitly returns to the question of cost-effectiveness (191).

Options Regarding Sources of Information on Effectiveness and Cost-Effectiveness

If Congress decides to make coverage decisions based on effectiveness and cost-effectiveness information, Congress could identify a source, or sources, for this information. The following options concern organizations which could provide information on effectiveness and cost-effectiveness either to Congress or to other entities and individuals making coverage and/or purchasing decisions. It is important to note that independent of the source of information, Congress could outline criteria, or methods, for evaluating evidence on effectiveness and costs, or designate some other entity to outline such criteria or methods.

OPTION 4. *Congress could identify one or more U.S. Executive Branch agencies that would determine whether specific clinical preventive services are effective and the cost-effectiveness of those clinical preventive services.*

Many agencies within the Department of Health and Human Services have been involved in efforts to evaluate the effectiveness of specific clinical preventive interventions and have issued recommendations regarding their appropriate utilization.[3] Congress could use the evaluations by one or more of these agencies to design and update a clinical preventive services benefit package. It would be useful, however to have more consistency among those agencies in the use of criteria and methods to evaluate effectiveness.

OPTION 5. *Congress could identify provider organization(s) that would determine whether specific clinical preventive interventions are effective and their* cost-effectiveness.

Many organizations representing health care providers (e.g., the American College of Physicians, the American Academy of Pediatrics) have issued recommendations regarding the use of specific clinical preventive services. Although input from providers seems an appropriate part of

3 For example, the National Institutes of Health have issued recommendations on many types of screening tests, including hypertension and cholesterol screening. The Centers for Disease Control and Prevention have developed expert panels which have issued recommendations for screening for sexually transmitted diseases and immunizations. The Agency for Health Care Policy and Research has been involved in synthesizing the information on the effectiveness of a variety of medical interventions (e.g., screening for sickle cell disease). Finally, the Office of Disease Prevention and Health Promotion (ODPHP) established, and provides staff support to, the U.S. Preventive Services Task Force (USPSTF), which evaluated the effectiveness of a number of clinical preventive services.

effectiveness assessments, there are problems with relying exclusively on provider groups. First, provider groups may have an incentive to encourage the use of services and thus there is a potential conflict of interest. Second, many provider groups have based their assessments of clinical preventive services on expert opinion rather than on comprehensive reviews of the literature and they have not clearly documented the basis for their decisions.

OPTION 6. *Congress could determine whether specific clinical preventive interventions are effective and evaluate their cost-effectiveness.*

Rather than identifying one or more U.S. Executive Branch agencies to determine whether specific clinical preventive interventions are effective, Congress could make this determination. In the past, Congressional agencies have evaluated the effectiveness of clinical preventive services,[4] However, Congressional agencies do not have the resources to design a comprehensive benefit package based on effectiveness and cost-effectiveness information.

Options Regarding Specific Benefit Design Features

Designing an insurance benefit package requires a number of decisions beyond the choice of which clinical preventive services to cover. These decisions include: whether to circumscribe coverage for particular services based on patient characteristics, frequency of use, and other parameters; whether to apply cost-sharing and, if so, to what extent; and whether to reimburse services as a package or individually. The following options relate to these decisions.

OPTION 7. Congress could identify a Federal agency to determine the specifics of the benefit package (e.g., periodicity schedules, covered populations).

Seemingly innocuous decisions about the frequency of clinical preventive services, and the populations who should receive clinical preventive services, can have a large impact on the overall costs and effectiveness of the service. Further, information about the costs and benefits of particular protocols for providing interventions is constantly changing as new research emerges. Decisions about the specifics of the benefit package could be delegated to a Federal agency.

OPTION 8. *Congress could require full insurance coverage for clinical preventive services for those individuals with incomes below a given level.*

If the primary purpose of insurance coverage for preventive services is to increase the use of these services, policymakers may want to link the degree of coverage to the degree to which use is actually increased, The effect of providing insurance may vary for different segments of the population; for example, people with lower income may increase their use of services in response to insurance to a greater extent than those at higher income levels. Moreover, the benefits of clinical preventive services may be greater for those at lower incomes due to their greater risk for particular conditions. Congress could require full insurance coverage (i.e., no cost-sharing) for prevention only for those with incomes below a given level.[5]

OPTION 9. *Congress could require full insurance coverage for clinical preventive services for the total insured population.*

Requiring full insurance for the total insured population reduces some of the administrative

[4]For example, as part of its effort to obtain information on the consequences of expanding Medicare benefits for preventive services, Congress asked OTA to study the effectiveness of selected preventive services for the elderly. OTA subsequently completed evaluations on pneumococcal vaccines, influenza vaccines, breast cancer screening, glaucoma screening, cholesterol screening, colorectal cancer screening, and cervical cancer screening in the elderly.

[5] patient cost. sharing for clinical preventive services is described more fully in the OTA Background Paper, *Benefit Design in Health Care Reform: Background Paper—Patient Cost-Sharing (203).*

OTA STAFF

Neighborhood health centers often provide clinical preventive health services.

burden associated with determining who would be eligible for insurance without cost-sharing. Moreover, it is consistent with the goal of providing insurance for clinical preventive services to increase utilization. However, because patient cost-sharing typically reduces the use of services, this option is likely to be more costly than imposing cost-sharing on some, or all, of the insured population (203).

Access Options

Insurance coverage increases the use of services by lowering the out-of-pocket price to consumers at the time of purchase. There are, however, other approaches Congress could take in order to encourage greater use of clinical preventive services, rather than, or in addition to, requiring insurance coverage for clinical preventive services. Two of these approaches are outlined below.

OPTION 10. Congress could encourage the provision of clinical preventive services by directly allocating funding to programs that provide clinical preventive services, such as public clinics, school-based clinics, and work-site programs.

The advantages and disadvantages of this approach rest on many assumptions concerning health care reform (e.g., whether the U.S. health care system continues to be primarily private, what sort of incentives providers will face, whether new delivery systems are developed).

Numerous agencies within Federal, State and local governments allocate funding to programs that provide clinical preventive services. One advantage of financing preventive services through such programs, rather than through insurance, is that prograMmatic approaches may allow greater flexibility in the delivery, and range, of interventions. For example, rather than being delivered in physicians' offices, preventive interventions could be provided at school and at work, thereby making them more accessible. In addition, programs may be more easily targeted to populations that are at ''high risk.' For example, low-income mothers may benefit more from programs to increase their use of prenatal care than other mothers.

There are several drawbacks with directly funding individual programs. First, funding may fluctuate across regions. In contrast, mandated insurance benefits, to the extent that they apply to everyone, might allow more equal access to services. On the other hand, if services were lacking in certain areas, such as rural or inner-city locations, insurance coverage might do less to encourage access than the provision of public programs.

A second potential problem is that funding school-based and work-site programs, and public clinics, might result in a more fragmented delivery system. For example, if people had their blood pressure and cholesterol measured at work, were screened for sexually transmitted diseases at public clinics, and received immunizations at a physician's office, documentation and coordination of care might suffer.

The relative costs, and costs to various parties, of directly funding programs versus providing

insurance coverage is hard to determine and will depend on the overall structure of the health care system, as well as the structure of the individual programs. Factors such as whether insurance premiums are capped, whether providers face global budgets, the presence of other provider incentives, and the structure of the programs will affect relative costs,

OPTION 11. Congress could encourage the provision of clinical preventive services by encouraging programs aimed at reducing nonfinancial barriers to access.

Nonfinancial barriers have been identified as important obstacles to receiving clinical preventive services (189). Congress could encourage the Centers for Disease Control and Prevention, or other government agencies, to develop programs aimed at reducing nonfinancial barriers to access to clinical preventive services. Efforts to reduce nonfinancial barriers include reminder systems, improved record-keeping systems, more convenient settings, the use of nonphysician medical professionals, the use of multilingual and culturally sensitive providers, physician education, and patient education.

Research Options

OPTION 12. *Congress could encourage the provision of effective clinical preventive services by promoting research on the efficacy, effectiveness, and cost-effectiveness of clinical preventive services.*

A key finding of this report is that many clinical preventive services have not been evaluated in terms of their efficacy, effectiveness, and cost-effectiveness. Congress could promote more research on the efficacy of clinical preventive services for example, by funding more randomized clinical trials or other types of studies.

OPTION *13. Congress could encourage the provision of effective clinical preventive services by promoting the dissemination of information on efficacy.*

OTA STAFF

Schools and workplaces are alternative sites for providing clinical preventive services.

This report focuses on using information on effectiveness, cost-effectiveness and net costs to define a benefit package for clinical preventive services. One of the justifications for this approach is that, in the absence of benefits that detail the services that will be covered, ineffective services will be provided and effective services will not be provided. There are, however, numerous ways in which the effectiveness of preventive medicine may be improved other than, or in addition to, using benefit design, Methods for improving effectiveness include improved methods of disseminating information resulting from technology assessments, such as through decision support tools (e.g., reminder systems, algorithms, practice guidelines), feedback systems to providers on outcomes (e.g., profiling, outcomes measurement), and continuing education. These methods were not explicitly evaluated in this report but are being evaluated, in part, in the ongoing OTA study, *Prospects for Technology Assessment.*

The advantage of improving effectiveness through the dissemination of information, in contrast to attempting to improve practice through benefit design, is that it allows greater

flexibility and tailoring of services to individual circumstances. Moreover, it places less burden on the developers of a benefit package to define what are effective clinical practices and to continually make timely adjustments to the benefit packages. A potential disadvantage of this approach is that most efforts to educate providers through guidelines and other means have not been extensively evaluated, and their ability to alter practice patterns is unclear.