NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

03-06

STATEMENT OF POLICY

Coverage of Preventive Services

Policy

The National Association of County and City Health Officials (NACCHO) supports the provision of comprehensive coverage by all public and private health insurers and healthcare plans of preventive health services, including those provided by local health departments. These benefits include routine health and disease screening, immunizations, health and dental check-ups, preventive medicines, and patient counseling.[1] NACCHO urges the Centers for Medicare and Medicaid Services, state and local governments, and private insurance health plans to retain or increase funding for preventive services consistent with the recommendations of the U.S. Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP), Health Resources and Services Administration's (HRSA) Bright Futures Project, and the HRSA/National Academies Committee on Women's Preventive Services. In addition, NACCHO advocates for improved integration between preventive and clinical services that ensure continuity of care and address persistent inequities in access to care, utilization of services, and health outcomes for underserved and marginalized populations. This includes coordination with, and possible reimbursement for, local health departments who provide covered services. Lastly, NACCHO supports efforts to expand insurance provider networks and service delivery settings covered to better meet the needs of all community members.

Justification

Preventive services are intended for the early diagnosis of health problems and for promoting healthy behaviors that can reduce the risk of developing chronic conditions.[2] The Affordable Care Act (ACA) offers expanded coverage for preventive services. Plans purchased through the healthcare marketplaces are required to cover all preventive services receiving an A or B recommendation from the USPSTF at no cost to the patient. In addition, ACA requires coverage, at no-cost, for recommended services from the ACIP, HRSA's Bright Futures Project, and the HRSA/National Academies Committee on Women's Preventive Services. The requirement to cover these services also applies to Medicaid plans for individuals qualifying under the ACA expansion. Medicaid plans for individuals traditionally qualifying for Medicaid are not required to cover these preventive services, but the ACA offers an expanded match of 1% for states that do not pass on the cost of services to their patients. The ACA also expanded Medicare's coverage of preventive services, again at no cost to participants.[3] These provisions reflect extensive research showing that out-of-pocket payment by consumers contributes to the underuse of services and exacerbates long-standing utilization disparities by race, ethnicity, and socioeconomic status.[4]

In 2016, total direct costs for treatment of chronic health conditions topped $1.1 trillion, equaling 5.8 percent of U.S. gross domestic product. The chronic health conditions contributing most to this figure included cardiovascular conditions, diabetes, Alzheimer's disease, arthritis and back pain, and cancers.[5] Many of these conditions are preventable, and with early intervention, identification and treatment, it is estimated that preventive services could potentially save up to an estimated $7 billion and prevent 100,000 deaths annually.[6,7]Yet only 8 percent of U.S. adults (ages 35 and older) receive all the high-priority, appropriate preventive services recommended for them and nearly 5 percent received no preventive services.[8]

The ACA includes many requirements that have demonstrated advances in health equity in the commercial coverage market and shown progress in narrowing racial and ethnic health disparities. There are strategies health insurers could adopt to improve access to culturally competent, diverse providers, while ensuring equitable and inclusive access. The ACA requires marketplace plans to have an adequate provider network and to contract with Essential Community Providers. To ensure inclusiveness and health equity, and to meet the needs of enrollees of color, as well as other underserved communities (e.g., LGBTQ people and people with disabilities), insurers could widen their networks to include a broader range of providers. Evidence shows that the services from non-clinical providers such as community health workers and perinatal workers, including midwives and doulas, are linked to better outcomes.[9,10]

References

1. Information for consumers. United States Preventive Services Taskforce. Accessed March 3, 2022. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/information-for-consumers.
2. Ranji U, Gates A, Snyder L. Coverage of preventive services for adults in Medicaid. Kaiser Family Foundation. Published November 13, 2014. Accessed March 3, 2022. http://kff.org/medicaid/issue-brief/coverage-of-preventive-services-for-adults-in-medicaid.
3. Seiler N, Malcarney MB, Horton K, Dafflitto S. Coverage of clinical preventive services under the Affordable Care Act: from law to access. *Public Health Rep*. 2014;129(6):526-532. doi:10.1177/003335491412900611
4. Lantz PM, Rosenbaum S. The potential and realized impact of the Affordable Care Act on health equity. *J Health Polit Policy Law*. 2020;45(5):831-845. doi:10.1215/03616878-8543298
5. Waters H, Graf M. *The costs of chronic disease in the U.S.* Milken Institute; 2018. Available at: https://milkeninstitute.org/sites/default/files/reports-pdf/ChronicDiseases-HighRes-FINAL_2.pdf
6. Institute of Medicine (US) Roundtable on Evidence-Based Medicine. The healthcare imperative: Lowering costs and improving outcomes: Workshop series summary. Yong PL, Saunders RS, Olsen LA, editors. Washington (DC): National Academies Press (US); 2010. 6, Missed Prevention Opportunities. Available from: https://www.ncbi.nlm.nih.gov/books/NBK53914/
7. Levine S, Malone E, Lekiachvili A, Briss P. Health care industry insights: Why the use of preventive services Is still low. *Prev Chronic Dis* 2019;16:180625. doi: http://dx.doi.org/10.5888/pcd16.180625
8. Borsky A, Zhan C, Miller T, Ngo-Metzger Q, Bierman A, Meyers D. Few Americans receive all high-priority, appropriate clinical preventive services. *Health Affairs.* 2018; 37(6): 925-928.
9. Keith K. How insurers can advance health equity under the Affordable Care Act. *Commonwealth Fund Blog.* 2021. Available at: https://bit.ly/CommonwealthBlogHEACA
10. Ahmed S, Chase LE, Wagnild J. *et al.* Community health workers and health equity in low- and middle-income countries: Systematic review and recommendations for policy and practice. *Int J Equity Health.* 2022;21(49). Available at: https://doi.org/10.1186/s12939-021-01615-y

Record of Action

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