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Increasing Receipt of Women's Preventive Services

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Abstract

The receipt of clinical preventive services is important for health promotion and prevention of illness, death, and disability for women in the United States. Today, the Affordable Care Act makes a variety of evidence-based preventive services available with no out-of-pocket cost to women with certain health insurance plans. Nevertheless, available service receipt data suggest receipt of the services for all American adults remains sub-optimal. This article seeks to raise awareness about the critical gaps in the delivery of preventive services to women and highlight opportunities for women, primary care providers and public health professionals to increase receipt of clinical preventive services among women.

Introduction

The receipt of clinical preventive services can significantly improve health outcomes for women, and save tens of thousands of lives per year.[1] For example, it is estimated that 3,700 lives would be saved and 30,000 cases of pelvic inflammatory disease would be prevented each year if 90% of women received appropriate screenings for breast cancer and chlamydia.[1] With approximately half of women in the United States not receiving the life-saving and evidence-based preventive care they need, increasing rates of preventive care receipt remains a long-standing public health goal.[2, 3] Clinical preventive services are an important part of protecting, promoting, and maintaining the health and well-being of women, while reducing the burden of disease, disability, and death.

One of the main hallmarks of the Affordable Care Act (ACA) is promoting and increasing access to receipt of clinical preventive services. In addition to creating the National Prevention Strategy and establishing the Prevention and Public Health Fund, the ACA has increased affordable access to health care—and preventive care in particular.

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The ACA has significantly reduced the number of uninsured. By allowing young adults up to 26 years of age to stay on their parents' health insurance plan (§1001), over 3 million young adults gained insurance between September 2010 and December 2011.[4] From the third quarter of 2013 to October 2014, enrollment in Medicaid increased by about 10 million Americans.[5] Additionally, over 11.7 million people enrolled in coverage for 2015 through the new Health Insurance Marketplace, with tax credits for those with incomes between 100% and 400% of the federal poverty level (FPL) and cost sharing subsidies for those with incomes between 100% and 250% of the FPL.[6] During the first operating year of the Health Insurance Marketplace, the percentage of women ages 18–64 who were uninsured declined from 18.9% in 2013 to 13.4% in 2014.[7] Subsequent enrollment for 2015 coverage is expected to further decrease the percentage of uninsured women.[6]

In addition to providing affordable insurance coverage to millions of women, the ACA (§1001, §4103–4107) has eliminated out-of-pocket costs for certain women's preventive care services in many health plans.[8] This provision applies to dozens of services for women of all ages (Table 1), includes well-woman visits, and is available to beneficiaries of the Medicaid expansion, non-grandfathered private health plans (grandfathered plans are exempt from the new regulations), and certain Medicaid and Children Health Insurance Programs. Medicare coverage with no out-of-pocket costs is provided for certain services. The complete list of services available with no out-of-pocket costs for non-grandfathered private health plans includes those recommended with an "A" or "B" grade by the United States Preventive Service Task Force (USPSTF), vaccinations recommended by the Advisory Committee on Immunization Practices (ACIP), and recommended services for women and children supported by the Health Resources and Services Administration (HRSA).[9] To date, HRSA has endorsed a set of preventive services for women recommended by the Institute of Medicine (IOM), the Bright Futures guidelines for children from the American Academy of Pediatricians (AAP), and newborn screenings from the Discretionary Advisory Committee on Heritable Disorders in Newborns and Children.[8]

The specifics of how the coverage requirement applies to individual plans and the details of what conditions must be met for the service to be covered without out-of-pocket costs are complex and available in a different publication for reference.[8] Despite these complexities, the preventive service coverage requirement is broad in its implementation. Approximately 30 million women are estimated to be newly covered for expanded preventive services under the ACA.[10, 11]

This preventive service coverage requirement, paired with the expansion of coverage, increases the opportunity for women to receive the preventive care they need to help prevent the onset of disease and reduce the severity and duration of adverse conditions when they are detected early.

Baseline Rates of Service Receipt

Although robust national data for preventive services are not currently available, data from the Centers for Disease Control and Prevention (CDC) and other sources may be leveraged to provide periodic insight into the progress being made in the delivery of clinical preventive

services to women. CDC published two Morbidity and Mortality Weekly Report (MMWR) supplements providing detailed baseline data for receipt of key clinical preventive services among adults and children.[2, 12] The findings from these reports confirm sub-optimal rates of receipt of recommended preventive care among children and adults prior to implementation of the ACA.

Baseline assessments suggest there is opportunity for increasing receipt of women's preventive services that address risk factors for cardiovascular disease, the leading cause of death for women.[13] The USPSTF recommends the use of aspirin, when appropriate, by women ages 55–79 for the prevention of ischemic stroke.[14] The prevalence of recommended aspirin use among this group of at-risk women was 21.7% in 2007–2008, the latest years for which these data are available.[15] Tobacco use screening and cessation is another service strongly recommended by the USPSTF.[16] Despite the strong evidence linking tobacco use to cardiovascular disease, cancer, and other ailments, 2009–2010 data showed that only 23.2% of women who used tobacco were provided cessation counseling or cessation medications.[17] Improvement in receipt of these high-value services is vital to reducing the burden of cardiovascular disease, and other chronic conditions, among women.

Lessons from Prior Health Reform Efforts

Findings from health reform efforts predating the ACA suggest that it may take several years for researchers using population-level surveys to measure and publish significant improvements in the receipt of preventive services, and that those changes will be most pronounced in the portion of people newly receiving health insurance coverage as a result of the reforms. For example, in 2007, a comprehensive health reform effort took effect in Massachusetts. Similar to the ACA, Massachusetts provided near-universal insurance coverage through shared individual, employer, and government responsibility. The uninsured rate among adults aged 19–64 years dropped from 13.4 percent (2006) to 5.8 percent (2010) following reform.[18] For that same age group, there were also increases in recent preventive care visits (69.9% to 75.8%) during the same timeframe.[18] Similarly, in 2008, Oregon used a lottery to expand enrollment in Medicaid to approximately 10,000 low-income adults. Getting Medicaid coverage increased the receipt of preventive care such as mammograms (by 100%), cervical cancer screening (by 30%), and cholesterol monitoring (by 50%) compared to those without Medicaid.[19] The results from these studies suggest the next few years may show significant increases in receipt of preventive services among those gaining health insurance through the ACA's coverage expansions that took effect in 2014.

Early Data Following Partial ACA Implementation

Preliminary findings from studies that have measured the receipt of preventive services following the implementation of the ACA in 2010, but before the full effect of the law can be measured, suggest the ACA has begun to improve the rate of preventive service receipt among women. A recent analyses by Lipton and Decker estimated that the ACA provisions that expanded coverage and provided no out-of-pocket cost coverage for preventive services increased likelihood of receiving and completing the human papillomavirus (HPV) vaccine by 7.7 and 5.8 percentage points, respectively, for women ages 19–25 relative to a control

group of women age 18 or 26.[20] This rise in receipt of the HPV vaccine ensures fewer women will develop infections and some cancers attributed to HPV infection.[21] Assessing the impact of Medicaid expansion - as per the ACA - on receipt of preventive services, Sabik et al. ascertained that Medicaid expansion was associated with a higher receipt of preventive services among women. Specifically, they discovered that women in non-expansion states had significantly lower odds of receiving recommended mammograms (OR=0.87, 95% CI=0.79, 0.95) or Pap tests (OR=0.87, 95% CI=0.79. 0.95).[22] The trend of preventive service receipt will be further assessed as the implementation of the ACA progresses and data on preventive service receipt becomes available.

Barriers and Opportunities to Receipt of Preventive Services

There are a number of individual and systematic factors that affect the receipt of recommended preventive care. Some of these factors include insufficient access to primary care providers, lack of patient education about services, limited time during patient appointments for the delivery of preventive services, and payment models that do not provide sufficient incentives to prioritize preventive care. Fortunately, there are opportunities to reduce or eliminate these barriers.

Access

Access to healthcare is critical for women to benefit from the preventive service coverage with no out-of-pocket cost provision in the ACA. Having sufficient access means consumers have the ability to afford health care services, access a health care location where needed services are provided in a timely manner, and find a health care provider with whom the patient can communicate and trust.[23] Gaining entry into the health care system in the United States generally begins with having health insurance. Accessing a health care location to receive preventive services requires consumers to find a primary care provider who will accept them as a patient. And, in order to benefit from coverage without out-of-pocket costs for preventive services, this provider must be within the patient's insurance network of providers. Successfully navigating all of these steps can be difficult given a shortage of primary care providers and family physicians who serve women.[24, 25] This may also be a challenge for women newly enrolled in a health insurance plan and not familiar with using health insurance to access primary care services. Assuming a consumer is able to secure a primary care provider and schedule a timely appointment, she must still make it to her appointment—a task that may be challenging for women who work, care for children, provide eldercare, or do both. Making scheduled appointments becomes more difficult if women encounter barriers to transportation, a factor that continues to adversely affect access to healthcare in the United States.[26] In the end, preventive service coverage alone is not sufficient for women to access preventive care.

Fortunately, there are a number of ACA provisions that aim to improve patient access to primary care. Patients' access to preventive care is primarily expanding as more Americans gain entry into the health system by obtaining health insurance coverage through the Health Insurance Marketplace. To date, an estimated 16.4 million previously uninsured people have gained health insurance coverage since the implementation of the ACA coverage provisions.[27] As the number of insured Americans continues to rise, the ACA expands the

capacity to provide primary care services by funding efforts to support the operation, expansion and construction of community health centers throughout the country over five years (§5313).[28] This funding is expected to increase the number of patients served by community health centers by 4.5 million – from 19.5 million in 2010 to a projected 24 million in 2014.[28] In turn, these clinics are supported by HRSA to receive recognition as patient centered medical homes (PCMHs), a designation reserved for clinics that achieve quality standards such as ensuring patient-centered access to care by expanding operating hours and offering alternative types of clinical encounters.[29, 30] In parallel, the ACA is expanding the primary care workforce by increasing investments in the National Health Service Corps, a program that funds 9,200 Corps clinicians to serve in medically underserved communities, and increasing investments in primary care residency positions and programs.[31, 32] Collectively, these ACA provisions are perceived to be improving consumers' access to preventive care.[7, 33]

Education

The ACA's preventive service coverage requirement has been in effect for certain plans for up to five years for the USPSTF and ACIP services and for up to two years for the HRSA-endorsed women's preventive services. A poll conducted in March of 2014 found that fewer than half of Americans were aware that the ACA eliminates out-of-pocket costs for select preventive care.[34] Addressing this knowledge gap is critical to optimizing preventive care receipt, especially among women given the tendency for women to forgo care due to cost or perceived cost. A recent survey found that 20% of women aged 18–64 report they postponed preventive services in the past year due to cost, including 13% of insured and 52% of uninsured women.[35] Knowing that some preventive care is available at no out-of-pocket cost may help mobilize consumers to seek out these services. Increased efforts by health care and public health professionals to make more women and their providers aware of this special coverage could help increase uptake of preventive services.

The U.S. Department of Health and Human Services is making strides to increase the public's knowledge about preventive service coverage and other health insurance benefits. There are a number of resources and tools available to help consumers learn about their preventive service coverage benefit. The Centers for Medicare and Medicaid Services (CMS) leads an initiative called "Coverage to Care," a campaign to help people use their health care coverage to access primary care.[36] Consumers can access the Coverage to Care Roadmap online at http://www.hhs.gov/healthcare/prevention/index.html. Healthcare professionals can also download or order free Coverage to Care materials online at http://marketplace.cms.gov/c2c. CMS also houses the Center for Consumer Information and Insurance Oversight (CCIIO), a government resource center that provides information and technical support through the Consumer Assistance Program to help consumers understand their health insurance coverage and, if appropriate, appeal coverage decisions.[37]

Consumer education about the value of clinical preventive services can be a contributing factor to the receipt of services.[38] If women are aware of the health benefits that preventive services may offer, they may be more inclined to receive recommended care.[39] For example, data suggest lack of knowledge is the main reason why parents of girls allow their child to

go without receiving the ACIP-recommended vaccine that protects against HPV infection.[21, 40] If more unvaccinated young women were informed about the benefits of the HPV vaccine – and its potential for being covered with no out-of-pocket costs – HPV vaccination coverage could rise.

Addressing knowledge deficits about recommended preventive care and the health benefits of these services is a key step to increase receipt of preventive care. Recently a wealth of consumer-facing information about recommended preventive services has been made publicly available online. One new consumer-facing tool is CDC's Prevention Checklist, an interactive tool, also available as a mobile application, that produces a list of recommended preventive services specific to the user based on sex, age and, if appropriate, pregnancy status.[41] Each service in the list also has a link to valid information about the preventive services for consumers. This tool is available online at http://www.cdc.gov/prevention/. Medicare also provides information about Part B preventive services coverage at http://www.medicare.gov/coverage/preventive-and-screening-services.html. Despite the public availability of this information, it remains critical for patients to speak with their providers about the preventive services that are recommended for them. This patient-provider dialogue is fundamental to the delivery of preventive services.[42–44] Given their knowledge of their patients' medical history and family health history and their extensive knowledge about the risks and benefits associated with preventive services, primary care providers are uniquely situated to champion the delivery of recommended preventive services.

Delivery

Receipt of clinical preventive services may also face barriers from the supply side. One key factor is the limited amount of time a provider has to provide preventive services. Yarnall et al. estimated that it would take a primary care provider in a standard-sized practice 7.4 hours of every working day to implement all of the USPSTF recommendations in every case that warranted a preventive service.[45] The authors also found that it would take two hours of every working day just providing the services recommended with an "A" grade by the USPSTF.[46] These time constraints may limit the degree to which primary care providers prioritize the delivery of preventive services during patient visits.

An emerging body of evidence suggests leveraging the workforce of other State-qualified non-licensed providers, like community health workers, can be an effective way to improve uptake of appropriate preventive services and help alleviate the limitations that come with health care provider time constraints.[47–51] With appropriate training and supervision, community health workers may be used to provide services like one-on-one counseling services.[52] These counseling services may address women's health issues such as breastfeeding, contraceptives, intimate partner violence, prevention of sexually transmitted infections and HIV, or diet and nutrition—all of which are services made available without out-of-pocket costs through the preventive services coverage requirement. Studies have also shown that community health worker interventions can increase preventive service receipt, particularly for immunizations, mammograms, cervical cancer screenings, and blood pressure management services.[47, 48, 53, 54] Overall, implementing a policy that authorizes non-physician team members, such as nurses, pharmacists, and community health workers,

to support primary care providers in the education or provision of preventive services can be an effective approach to address provider time constraints and increase the provision of preventive services.[55, 56] States are beginning to explore financing options to sustain the workforce of non-licensed providers, allowing for more clinics to adopt team-based models of care.[57]

The movement to improve the quality of care provided has also led to the development of new models of care that hold promise for increasing receipt of recommended services. For example, the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home Recognition program is the program that HRSA is using to certify HRSA-funded health centers as PCMHs across the nation. It has a “must-pass” standard that requires PCMH-recognized clinics to monitor receipt of preventive care services, chronic care measures, and/or immunization coverage for their patient population.[30] Studies suggest adoption of this PCMH model increases preventive service receipt.[58–60] Emerging payment models being explored by the CMS Center for Medicare and Medicaid Innovation are also expected to drive improvement in preventive service receipt.[61] Meaningful use of certified electronic health record (EHR) systems through the Medicare and Medicaid EHR Incentive Programs, for example, includes components that require providers to use clinical decision support tools to provide evidence-based care and develop registries to identify patients who are not up-to-date on their recommended preventive care. The 2019 launch of the Merit-based Incentive Payment System, a new quality reporting system that adjusts payments for services provided to Medicare beneficiaries based on providers’ performance measures, is expected to accelerate and sustain this movement towards value-based payment.[62] These types of systems are anticipated to improve receipt of appropriate clinical preventive services.

Conclusion

Baseline assessments indicate there is much room for improvement in the receipt of preventive services among women. The preventive services coverage requirement and other provisions in the ACA have increased access to preventive care, optimizing the opportunity for women to receive recommended clinical preventive services. These new opportunities, driven by the ACA and new models of care, have the potential to overcome barriers in the receipt of preventive care. If these opportunities are fully realized and leveraged, the increasing use of preventive services could allow more American women to enjoy longer, healthier lives from the timely detection and response to preventable adverse health conditions.

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Table 1

Clinical Preventive Services Recommended for Women and Girls by the USPSTF, ACIP, or Supported by HRSA: United States[*i]

Screenings/tests	**Vaccinations**
Anemia	Diphtheria, Tetanus, Pertussis
Autism	Haemophilus Influenzae type b
Bacteriura Infection	Hepatitis A
Blood Pressure	Hepatitis B
Breast Cancer	Herpes Zoster
Cervical Cancer	Human Papillomavirus
Chlamydia Infection	Inactivated Poliovirus
Cholesterol	Influenza (Flu)
Colorectal Cancer	Measles, Mumps, Rubella
Congenital Heart Defect	Meningococcal
Depression	Pneumococcal
Developmental	Rotavirus
Diabetes	Varicella
Gestational Diabetes	
Gonorrhea	**Screenings with Counseling or Intervention**
Hearing	Alcohol Misuse
Hematocrit or Hemoglobin	Intimate Partner Violence
Hemoglobinopathies or Sickle Cell	Obesity
Hepatitis B	Tobacco Use
Hepatitis C	
HIV	**Newborn Screenings**
Human Papillomavirus	
Hypothyroidism	Suite of 57 metabolic and hemoglobinopathy
Lead	screenings for newborns.
Lung Cancer	
Osteoporosis	**Other**
Phenylketonuria	Aspirin Use to Prevent Heart Attack or Stroke
Rh Incompatibility	Psychosocial/Behavioral Assessments
Syphilis	Breast Cancer: Medications for Risk Reduction
Tuberculin	Dental Caries Prevention
Vision	Developmental Surveillance
	Falls Prevention
	FDA-Approved Contraception
Counseling	Fluoride Chemoprevention
BRCA-Related Cancers	Folic Acid Supplementation
Breastfeeding	Gonorrhea Preventive Medication
Healthy Diet	Height, Weight, Head, and BMI measurements
Sexually Transmitted Infections	Iron Supplements to Prevent Anemia

Screenings/tests	**Vaccinations**
Skin Cancer	Oral Health Risk Assessment
	Well-Child Visits
	Well-Woman Visits

* These clinical preventive services apply according to age and other risk factors specified in the recommendations.

i ACIP = Advisory Committee on Immunization Practices

BMI = body mass index (defined as weight in kilograms divided by the square of height in meters)

FDA = Food and Drug Administration

HRSA = Health Resources and Services Administration

USPSTF = United States Preventive Services Task Force

Table 2

ACA Preventive Services Coverage Requirement by Payer (§1001, §4103–4107)[i,ii]

Payer	USPSTF Grade "A" and "B" Recommendations	ACIP Recommendations	Endorsed by HRSA (IOM Women's Preventive Service Guidelines, Bright Futures, Newborn Screenings)
Non-grandfathered private health insurance plans*	Required to cover with no out-of-pocket costs	Required to cover with no out-of-pocket costs	Required to cover with no out-of-pocket costs
Medicaid expansion plans	Required to cover with no out-of-pocket costs	Required to cover with no out-of-pocket costs	Required to cover with no out-of-pocket costs
Traditional Medicaid plans	No requirement. State option. Incentive of 1% increase in federal medical assistance percentage (FMAP) if all USPSTF and ACIP recommendations covered with no out-of-pocket costs.	No requirement. State option. Incentive of 1% FMAP increase if all USPSTF and ACIP recommendations covered with no out-of-pocket costs.	No requirement. State option.
Medicare	Required to cover with no out-of-pocket costs if preventive service is covered by Medicare	Required to cover with no out-of-pocket costs if preventive service is covered by Medicare	No requirement. Federal option.

*Grandfathered plans that were in existence on or before March 23, 2010, and have continually met certain requirements are not required to cover any preventive care.

[i]ACA = Affordable Care Act

USPSTF = U.S. Preventive Services Task Force

ACIP = Advisory Committee on Immunization Practices

IOM = Institute of Medicine

HRSA = Health Resources and Services Administration

[ii]Fox JB, Shaw FE: Clinical Preventive Services Coverage and the Affordable Care Act. *American journal of public health.* 2015;105:e7–e10.