Coverage of Preventive Services without Cost-Sharing

Impact on Lung Cancer Screening & Opportunities for States

American Lung Association.

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Over a decade has passed since the Affordable Care Act (ACA) became law, requiring certain preventive services to be covered without patient cost-sharing, including lung cancer screening for those at high risk. Lung cancer is the leading cause of cancer deaths in the United States, and the benefits of screening for lung cancer are well known; like many cancers, the earlier that lung cancer is detected, the better the treatment options and survival rate. Cost-free coverage of preventive services like lung cancer screening benefits both individual and public health and has generated cost-savings for the medical system as a whole. However, gaps in coverage remain and the *Braidwood v. Becerra* case threatens the coverage gains that have been made in the past decade.

This issue brief summarizes the current status of coverage of lung cancer screening and other preventive services without cost-sharing, the health benefits of this coverage, and potential state policy approaches to protect and expand cost-free coverage of screening and diagnostic services that could ultimately improve survival and quality of life for those living with lung cancer.

Current State of Coverage of Preventive Services with No Cost-Sharing

The ACA, the landmark healthcare legislation passed in March 2010, included a number of policies that have changed the health insurance landscape over the past decade. One such policy requires private health plans to provide coverage for a range of recommended preventive services with no cost-sharing. The requirement applies broadly to nearly all private health plans offered by individual, small and large insurers, as well as self-funded group health plans. Only grandfathered private plans, meaning an individual health insurance policy purchased on or before March 23, 2010 that has not changed significantly, are excluded. In 2020, a decade after the ACA passed, approximately 151.6 million people were enrolled in non-grandfathered private health insurance plans that cover preventive services with no cost-sharing.[1]

The law named four expert medical and scientific bodies from which the required preventive services are defined: the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), the Health Resources and Services Administration's (HRSA) Bright Futures Project, and the HRSA-sponsored Women's Preventive Services Initiative (WPSI).[2]

The USPSTF is an independent, volunteer panel of national experts in prevention and evidence-based medicine appointed by the head of the Agency for Healthcare Research and Quality (AHRQ), a component of the Department of Health and Human Services (HHS). USPSTF recommendations are based on reviews of existing peer-reviewed evidence and the Task Force members assign one of five letter grades (A, B, C, D, or I) to its recommendations. Only preventive services that receive an "A" or "B" rating from USPSTF must be covered by private insurers with no cost-sharing.[3] ACIP, made up of medical and public health experts appointed by the head of the Centers for Disease Control and Prevention (CDC), develops recommendations on the use of vaccines for adults and children in the U.S.[4] HRSA, an agency within HHS, operates the Bright Futures Program, which maintains and shares clinical guidelines aimed at improving the health of infants, children, and adolescents.[5] HRSA also

maintains WPSI, which develops guidelines for preventive care and screenings for women's health.[6]

The ACA also included requirements to cover preventive services with no cost-sharing under public insurance, Medicare and Medicaid. Similar to the requirements for private insurance, Medicare must cover free of cost-sharing USPSTF recommendations with Grade "A" or "B" ratings, but only if a Centers for Medicare and Medicaid Services' (CMS) National Coverage Determination (NCD) has been issued determining that the service is reasonable and necessary for the prevention or early detection of an illness or disability. There are approximately 61.5 million individuals enrolled in Medicare, all of whom potentially benefit from this provision of the ACA.[7]

For Medicaid, the ACA requirement for plans to cover preventive services without cost-sharing applies only to Medicaid expansion enrollees.[8] The Medicaid expansion population includes those who benefited from the ACA's provision providing states the option to expand Medicaid coverage to nearly all adults with incomes up to 138% of the Federal Poverty Level. As of April 2023, 40 states and the District of Columbia adopted Medicaid expansion.[9] For states that have and have not expanded Medicaid, coverage of preventive services for the traditional Medicaid population is a state option.

Lung Cancer Screening

When it comes to preventive services for lung cancer, low dose computed tomography (LDCT) is the standard of care and the only recommended screening test. LDCT is a unique computed tomography (CT) scan technique that combines special X-ray equipment with sophisticated computers to produce multiple, cross-sectional images of the inside of the body.[10] The National Lung Screening Trial compared the benefits of screening by LDCT or standard chest X-ray in individuals of a certain age with a significant history of smoking and found that when compared with chest X-ray, LDCT reduced the risk of death from lung cancer by 20%.[11]

The USPSTF first issued a recommendation for lung cancer screening in 2013 when the Task Force recommended annual screening for lung cancer with LDCT in adults aged 55 to 80 years who have a 30 pack-year smoking history (or an average of one pack a day for 30 years) and currently smoke or have quit within the past 15 years. It was further recommended that screening be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. The 2013 recommendation received a "B" rating qualifying it as a cost-free preventive service. The USPSTF updated these recommendations in 2021 lowering the screening age to 50 and changing the smoking history from 30 to 20 pack-years – the Task Force kept the "B" rating.[12] It is thought that these changes will reduce racial disparities in screening access. The 2013 recommendation was based on data from a trial for which 90% of the participants were white and while Black individuals typically have a lower smoking pack-year history, the risk for lung cancer is the same or higher when compared with white individuals.[13]

Medicare has issued two national coverage policies or NCDs related to lung cancer screening, in 2015 and again in 2022. The 2015 decision marked the first time that Medicare covered the costs of lung cancer screening for eligible beneficiaries. To be eligible under the 2015 NCD, beneficiaries had to be between the ages of 55 and 77, have a tobacco smoking history of at least 30 pack-years, and be either a current smoker or have quit smoking with the last 15 years. The NCD included other criteria, such as requiring the order for screening to come from a physician or qualified non-physician practitioner and prior to the first screening, the beneficiary must have received counseling and taken part in a shared decision-making visit with the clinician or practitioner who wrote the order.[14]

In early 2022, following the updated recommendations from the USPSTF, Medicare lowered the starting age for screening from 55 to 50 years and reduced the tobacco smoking history from at least 30 pack-year to at least 20 pack-years. The updated decision also simplifies the requirements for the counseling and shared decision-making visit.[15]

The Significance of Covering Preventive Services with No Cost-Sharing

The significance of the ACA provision to cover preventive services with no cost-sharing is evident not only for lung cancer but for many aspects of both individual and public health. And its importance has only been elevated by recent events, particularly the COVID-19 pandemic.

The public health benefits of covering preventive services with no cost-sharing are clear. Research shows that since the ACA's preventive services provision took effect in 2010, blood pressure screenings, cholesterol screenings, colorectal cancer screenings, HPV vaccines, and flu vaccines have all increased.[16]

Countless studies have also shown that cost is a deterrent when it comes to accessing medical services. A 2022 survey found that 43% of U.S. adults reported that they or a family member in their household put off or postponed needed healthcare due to cost.[17] Even small copays of $1–$5 have been shown to deter patients from accessing necessary care.[18]

This holds true for preventive services as well. One survey found that an estimated 40% of U.S. adults would be unable or unwilling to pay for the majority of USPSTF-recommended services.[19] And another recent survey found that 45% of American women skip preventive care services like check-ups, cancer screenings and vaccinations, often because the services are unaffordable.[20] These changes have a real health impact – for example, researchers found that when one health plan moved from covering statins at no cost to imposing copays and coinsurance, adherence to recommended statin therapy was significantly reduced, which in turn increase the risk of stroke and cardiac arrest.[21] Cost plays a key role in lung cancer screening as well, and research has shown that eligible individuals skip lung cancer screening due to confusion about what is covered with no cost-sharing.[22]

While typically the top priority when implementing healthcare-related policy change is improving overall health for the individual and the public, generating cost-savings is usually

not far behind. And covering preventive services with no cost-sharing generates savings for healthcare system overall. When individuals access preventive care, diseases are caught at an earlier stage when they are easier and typically, more affordable to treat or manage. This holds true for lung cancer – studies have shown that lung cancer screening is associated with cost savings due to the disease being identified at an earlier stage (i.e., stage 1 or 2) when compared with those who do not receive screening.[23]

The COVID-19 pandemic had a significant impact on cancer screening rates and reenforced the importance of removing barriers – including cost – that may impact access to these vital services. It is well documented that rates for cancer screening tests, including mammography, colonoscopy, and LDCT, decreased significantly in the early months of the COVID-19 pandemic.[24] A study examining national Medicare data found that the observed rate for LDCT during March 2020 to February 2021 was 24% lower than expected and during March 2021 to February 2022 was 14% lower than expected – showing that cancer screening rates also remained low later in the pandemic.[25] The downstream impacts are already apparent – as screening has resumed, an increased proportion of patients screened have had nodules suspected of malignancy.[26]

Gaps in Coverage and Policy Approaches to Protect and Expand Coverage

Policy change is rarely all encompassing and the ACA provision requiring coverage of preventive services without cost-sharing is no exception. Policy opportunities exist, however, to address these gaps. As the threats to the ACA continue, state policymakers are likely to continue to search for ways to protect and expand this coverage.

Legal Challenges

A current lawsuit, *Braidwood vs. Becerra*, directly threatens the ACA's preventive services requirements. In 2020, a class action lawsuit argued that all four preventive services requirements are unconstitutional and asked the court to declare that insurers and health plans are not required to provide cost-free coverage of all preventive services. The plaintiffs in the lawsuit argued that the law violates the Appointments and Vesting Clauses of the Constitution because members of the USPSTF, ACIP, and HRSA have not been nominated by the President or confirmed by the Senate but, according to the plaintiffs, can "unilaterally determine" the preventive care that must be covered by insurers and plans.[27]

The US District Court for the Northern District of Texas ruled that one part of the preventive services mandate (the requirement that most commercial plans cover services with an "A" or "B" recommendation from the USPSTF without cost-sharing) violates the Appointments Clause and is therefore unconstitutional. The Court then ruled that the U.S. Department of Health and Human Services can no longer enforce this requirement and that the remedy applies to all ACA-compliant plans. As a result, those with private health insurance coverage would no longer have the guarantee of cost-free coverage for preventive services recommended by USPSTF after the enactment of the ACA in March 2010, including lung cancer screening. In May 2023, the Fifth Circuit Court of Appeals issued an administrative stay pausing implementation of this rule.

Policy Opportunity

Given the threat to coverage of preventive services with no cost-sharing, many states have opted to pass state-level legislation protecting this coverage. As of November 2022, at least 15 states have passed laws requiring individual market insurers to cover the same categories of preventive services required by the ACA with no cost-sharing.[28] More states could opt to pass similar laws to protect this coverage, as well as update their state essential health benefits benchmark plan, certification standards for marketplace qualified health plans, and requirements for state employee health plans to preserve access to preventive services without cost-sharing.[29] However, states cannot regulate all types of plans currently covered by the ACA's preventive services coverage requirements, leaving gaps in coverage even if every state pursued these policies.

State Medicaid Programs

As is outlined above, the ACA provided states with the option to expand Medicaid to capture nearly all adults with incomes up to 138% of the Federal Poverty Level. Medicaid expansion, in the 40 states and the District of Columbia that have opted to enact the policy, has improved access to care among low-income individuals and is associated with increased access to preventive services, including cancer screenings.[30, 31] Medicaid expansion is credited with saving lives – there has been an estimated 39%–64% reduction in annual mortality rates for older adults who have gained coverage.[32]

However, Medicaid coverage of preventive services with no cost-sharing applies only to Medicaid expansion enrollees, and there are very few mandatory preventive services requirements for Medicaid. Tobacco cessation for pregnant women was the only preventive service listed under mandatory Medicaid benefits, until a law enacted in 2022 mandated Medicaid and CHIP programs to cover, with no cost-sharing, all approved adult vaccines recommended by ACIP beginning in 2023.[33, 34]

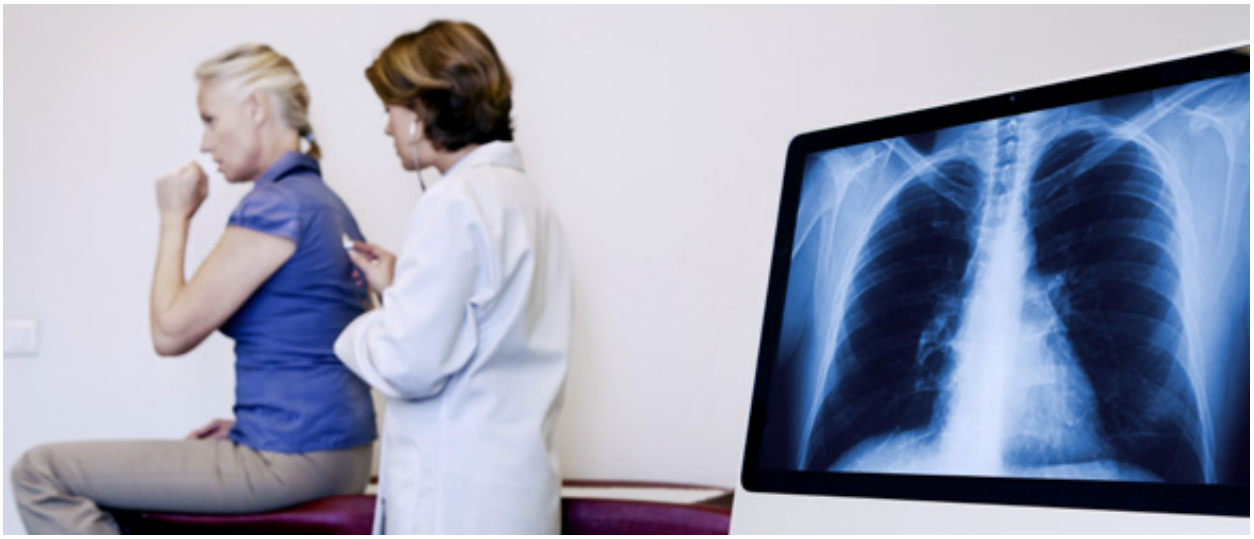
State Medicaid programs are one of the only healthcare payers not required to cover lung cancer screening for a significant portion of their enrollees: the traditional Medicaid population. If screening is covered, Medicaid programs may use different eligibility criteria, require prior authorization, or charge individuals for their scans.[35] As of April 2023, 47 states have confirmed Medicaid coverage of lung cancer screening, but less than half are using updated USPSTF guidelines to determine screening eligibility.[36]

Policy Opportunity

As of April 2023, 10 states have still not opted to expand Medicaid. These states can act now to do so, increasing access to insurance for low-income individuals, in turn increasing cancer screening rates, improving earlier detection and prevention of cancer, and ultimately saving lives. As for traditional Medicaid, states currently have the option to cover all USPSTF Grade "A" or "B" recommended preventive services and in return receive a one percentage point increase in the federal medical assistance percentage (FMAP) for those services. States could also require the Medicaid program to cover these services without cost-sharing.

Uninsured & Underinsured

In 2022, 43% of working-age adults were inadequately insured, meaning they were uninsured (9%), experienced a gap in coverage within the past year (11%), or were underinsured (23%).[37] Individuals who were underinsured, meaning that their coverage did not provide for affordable access to healthcare, included individuals with out-of-pocket healthcare costs over the prior 12 months equal to 10 percent or more of their household income (or 5 percent or more for individuals living under 200 percent of the federal poverty level), or who had a deductible that exceeded five percent or more of their household income. Data from the past decade show that nonelderly people of color have the highest uninsured rates in the U.S., particularly American Indian and Alaska Native and Hispanic people. Uninsured rates for nonelderly Native Hawaiian and Other Pacific Islander and Black people are also higher than the rate for their white counterparts.[38] Cost of insurance is the number one reason individuals cite as to why they are uninsured.[39]



As noted above, individuals often have insurance but are considered to be underinsured because the coverage they have does not allow for affordable access to healthcare. The underinsured often have coverage through what is colloquially known as a "junk plan." Junk plans can include short-term limited duration plans, excepted benefit plans, and health sharing ministries – the significant similarity being that these plans are all sold outside of the consumer protections put in place by the ACA. Because they do not have to abide by ACA rules, these junk plans can discriminate based on health status, exclude or cap major benefits, including preventive services, and impose very high cost-sharing.[40]

Finally, high deductible health plans (HDHPs) – insurance plans that offer lower premiums, but higher deductibles as compared to traditional plans – while subject to the ACA requirements to cover preventive services at no cost-sharing, have been linked to delayed cancer diagnosis and treatment.[41] A systemic review of the literature examining the relationship between HDHPs and healthcare use found that the plans appear to reduce healthcare costs by decreasing the use of both inappropriate but also appropriate health services, such as cancer screenings. Overall, the review found an adverse effect of HDHPs on the use of preventive services. Because enrollees in HDHPs are faced with large deductibles, many change their behavior and forgo needed care even if some services - like cancer screenings – are covered pre-deductible. Unfortunately, research has also shown that a majority of HDHP members are unaware of cost-sharing exemptions for preventive care.[42]

Policy Opportunity

In addition to expanding Medicaid in the 10 states that have not yet done so, which would help reduce the number of uninsured and underinsured individuals, states can also take action to regulate junk plans and dedicate resources to serve the uninsured/underinsured population. States are able to implement more restrictive rules than the federal government when it comes to junk plans, and many have. For example, at least 10 states have implemented mandates and regulations making it unfavorable for insurers to offer these plans and as a result, no short-term plans exist in these states.[43]

States can also increase their investments in cancer control and public health programs that expand cancer screenings and other preventive services to those who are uninsured or underinsured. For example, in 2022, Illinois included dedicated funding for lung cancer in its budget for the first time. As a result, the state funded a new program that aims to increase lung cancer screening rates in targeted communities – specifically white men and Black men and women – through a statewide network of lung screening centers, local clinics, health centers and community-based organizations. By building awareness and reducing barriers to care, the program will work to increase early-stage cancer diagnosis, early intervention, and reduce lung cancer morbidity and mortality rates.

Diagnostic Services

Cancer screenings, such as mammograms, colonoscopies, and LDCTs, are often only the first step in diagnosing cancer. Additional steps are required for proper diagnosis and treatment. Many times, follow-up diagnostic testing is needed to determine if something found on a suspicious screening is or is not cancer. While that initial screening may be free, the necessary follow up diagnostic testing or imaging typically is not, and often the cost is enough to deter patients from following through on appointments.

For example, in breast cancer, a routine screening mammography is considered a preventive service and is covered with no cost-sharing, but in order to determine if cancer is present, 16% of individuals must return for further diagnostic breast imaging which is not covered as a preventive service.[44] This additional imaging often leaves individuals with bills ranging from a couple hundred to more than one thousand dollars.[45] Similarly, follow-up testing is often needed to accurately diagnose lung cancer. A study looking at out-of-pocket (OOP) costs for lung cancer screening found that of the more than 6,000 individuals in the study, 7.4% required a follow-up procedure and over half were asked to pay something, ranging from hundreds to thousands of dollars. Follow-up after an abnormal result from a LDCT scan could include an additional LDCT scan, a different type of scan, such as a PET scan, or a biopsy to find out if a suspicious nodule is cancerous. Average OOP costs for follow-up tests after LDCT scans are $424.[46] When patients experience high OOP costs, they are less likely to return for a repeat annual lung cancer screening, even if the costs were unrelated to lung cancer screening.[47]

Policy Opportunity

This issue has been addressed in colorectal cancer and is an active issue for the breast cancer community at both the federal and state level.

For colorectal cancer, the ACA required colonoscopies to be covered with no cost-sharing as a preventive service if an individual meets the eligibility requirements. Even with this policy change, however, states were noticing disparities in who was participating in colorectal cancer screenings, and many believed that encouraging individuals to utilize easier at-home screening tests would help to address this. The catch was that if an at-home screening test turned up a positive result, the follow-up colonoscopy would come with a cost, potentially deterring individuals from completing their cancer screening. In 2014, Oregon passed legislation to require both Medicaid and some private insurance plans to make follow-up colonoscopies free for patients. Eight more states followed suit.[48] In 2021, USPSTF updated their recommendations for colorectal cancer screening to include that positive results on at-home screening tests require follow-up colonoscopies for the screening benefits to be achieved. And in 2022, CMS changed its policy to reflect the USPSTF and now recognizes the additional testing that is needed to determine a colorectal cancer diagnosis as a part of the continuum of a complete colorectal cancer screening and not a separate diagnostic procedure. As a result, if an additional colonoscopy after an at-home test is needed, it will be covered with no cost-sharing.[49]

Similar policy changes have been sought after for breast cancer as well. To date, 10 states have passed legislation requiring state-regulated health plans to cover additional diagnostic breast imaging – imaging needed after a routine screening mammogram to determine if cancer is present – with no cost-sharing.

Similar action could help improve access to the full spectrum of services needed to diagnosis lung cancer. State legislatures could introduce and pass legislation to require insurers cover with no cost-sharing medically necessary follow-up testing and procedures required to make a lung cancer diagnosis, such as additional LDCT scans, PET scans, and biopsies, making it more likely that individuals in need of additional screening are able to and will access it.

Conclusion

It is well-documented that cost is a deterrent when it comes to accessing medical services, including preventive services for lung cancer. The ACA's provision which led to the coverage of preventive services with no cost-sharing was significant and more than a decade later, the impact is apparent. Unfortunately, gaps remain. Lack of insurance or adequate insurance prevents individuals from accessing preventive services; associated costs for follow-up screenings when the initial screening is covered for free hinders access to the full continuum of services needed to diagnosis cancer; and ongoing legal challenges threaten the intent of the ACA to remove barriers, such as cost, to help improve access to cancer screening services.

States have options, however, that are currently available to them and have the potential to improve access to lung cancer screening. The ten states that have not yet expanded Medicaid can act now to do so, reducing the number of uninsured individuals and increasing access to preventive services with no cost-sharing. States can opt to cover all USPSTF Grade "A" or "B" recommended preventive services in traditional Medicaid in return for a one percentage point increase in the FMAP for those services. States can choose to regulate junk plans, such as short-term limited durations plans, to help reduce the number of underinsured individuals. States can also increase their investments in cancer control and public health programs that expand cancer screenings to those who are uninsured or underinsured. States can pass legislation to require insurers cover costs for follow-on tests which are often necessary to make a cancer diagnosis. And states can pass their own legislation to cover the same categories of preventive services required by the ACA with no cost-sharing.

Unfortunately, when it comes to accessing preventive services for lung cancer, cost is only one of many barriers. Even for those eligible, screening rates remain concerningly low.[50] There remains a lack of awareness among providers regarding screening criteria with studies suggesting that up to one-third of providers do not know the current lung cancer screening guidelines.[51] As a result, many physicians are not proactive when it comes to referring patients for screening. And, electronic health records– today's standard for documenting a patient's medical history – are often missing, or have outdated or inaccurate data related to a person's smoking history.[52] Stigma is also present – highlighting the causal link between smoking and lung cancer was critical for curbing tobacco use, but it unfortunately, also created an environment in which patients feel blamed.[53] Many of these barriers, in addition to cost, must be addressed to improve access to lung cancer screening and reduce mortality associated with lung cancer.

There is no question that lung cancer screening can save lives by detecting lung cancer sooner when better and typically cheaper treatment options exist. And while these barriers to accessing lung cancer screening remain, there are numerous policy opportunities to help address them and ultimately, lower mortality associated with lung cancer in the U.S.

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