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A State of Uncertainty: An Analysis of Recent State Legislative Proposals to Regulate Preventive Services in the United States

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Abstract

This policy brief examines preventive services state legislation trends in the United States during uncertainty regarding the Affordable Care Act (ACA), which requires certain coverage of 4 evidence-based preventive services categories without additional patient costs under §2713. We used a legal mapping approach to search for and analyze state legislation related to preventive services proposed or enacted over a 25-month period of ACA uncertainty. We screened 1231 bills and coded the 76 screened-in bills. Next, we determined their characteristics and examined trends. Bills originated in 28 states, and 69.7% were not enacted. Only 3.9% contained requirements contingent on ACA modifications. About 56.6% referenced services covered by §2713, but usually not entire §2713 categories. Bills also mentioned preventive services in general (53.9%) and services outside §2713's scope (21.1%). About 55.3% applied to private insurance, and 75.0% only to one patient group. Bills generally promoted access, and 51.3% specifically prohibited cost-sharing. But 26.3% of the bills limited access to preventive services. State-level legislation targets preventive services, usually expanding, but sometimes limiting, access. Most bills single out specific services without fully incorporating evidence-based recommendations. State legislation may therefore promote access to preventive services but can favor certain services, deviate from experts' recommendations, and increase nationwide variability. State legislation can function as an important lever for access to preventive services across patient groups. This may be especially important during uncertainty about federal policy. However, the design of state-level proposals is critical for maximizing access to preventive services.

Keywords

health reform, Affordable Care Act, preventive services, health care access

What do we already know about this topic?
Policy shapes access to preventive services.
How does your research contribute to this field?
States in the United States are legislating around preventive services during a time of uncertainty about federal policy.
What are your research's implications toward theory, practice, or policy?
State legislation may be crafted to promote access to preventive services for certain groups of patients.

Introduction

Preventive services can extend life, promote health, and save money.[1] But the costs of preventive services may affect patients' abilities to access them.[2,3] In the United States, §2713 of the Patient Protection and Affordable Care Act (ACA) prohibits cost-sharing for 4 categories of evidence-supported preventive services for many insurance plans: (1)

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preventive services rated A or B by the US Preventive Services Task Force; (2) immunizations recommended by the Advisory Committee on Immunization Practices; and Health Resources and Services Administration-recommended services for (3) children, and (4) women.[4] These services are recommended by experts based on scientific findings and analysis.[3,4,5] Prohibited cost-sharing for preventive services can be linked to increased utilization.[3,5] We analyzed recent state-level legislation addressing preventive services to anticipate the future of prevention-services access given the ACA uncertainty that has resulted from repeated federal efforts to curtail the ACA through legislative and executive efforts[6,7] and states' roles as emergent health systems regulators that function within the federalist system.[8]

Methods

In 2017 and 2018, we used a legal mapping approach to collect legislative data and analyze its content[9] to examine state-level bills addressing prevention services proposed or enacted between November 1, 2016, and December 27, 2018. This was a time of heightened ACA uncertainty given a combination of long-standing polarization around the ACA and its proximity to a regime shift resulting from a change in the US Presidential administration and potential, as well as ultimately actual, one-party control of the federal legislative and executive branches. After scoping searches using legislatures' websites, we searched Westlaw's NetScan state legislation database across 50 states and Washington, DC. Search terms were based on scoping and §2713. The final structured search was: ("health reform" or "affordable care act") /255 (prevent! or "cost sharing" or contracepti! or screen! or counsel! or immuniz! or vaccin! or test! or visit or check-up). It generated 1231 bills.

We "screened-in" bills mentioning the ACA and referring in legislative language to preventive services, including testing, screening, counseling, or immunization for physical or mental health conditions. We "screened-out" bills outside the period and that were nonsubstantive (eg, nonbinding resolutions) because of our interest in state actions with potential real-world consequences for patients. We excluded bills regarding abortion, which we deemed not preventive; "essential health services" absent express mentions of prevention because of the treatment focus; and containing appropriations, which are often temporary. We retained the latest versions of screened-in bills and removed companion legislation (ie, same session and identical language but originating another chamber) before further analyses. Of the 1231 bills, we screened out 1037 for not meeting inclusion criteria and 92 as duplicates or companions; we further analyzed the remaining 102.

After reading bills, we created, then piloted and refined, a coding instrument and coded each bill. We excluded 26 more bills during coding because they did not clearly address preventive services, often because we determined that the bills were about treatment and not diagnosis or prevention or because references to prevention were in existing law rather than proposed language. We extracted bill pass statuses from legislative websites and all other variables from bill language. Finally, we reanalyzed the 76 bills, examined bill characteristics, and generated summary statistics.

Results

Our findings are summarized in Table 1. Twenty-eight states (54.9%) introduced bills meeting inclusion criteria, with variability in bill distribution. One state had 10 bills while most (n = 12) had only one. Among included bills, all referenced the ACA, but only 3 (3.9%) contained prevention-related requirements applicable upon ACA modification. Fifty-three bills (69.7%) were not adopted as of December 27, 2018.

Forty-three bills (56.6%) concerned services covered by §2713. They referenced services individually (eg, mammograms, obesity screening, or tobacco cessation) (n = 33, 43.4%), as entire §2713 categories (n = 5, 6.6%), or both (n = 5, 6.6%). For example, a Connecticut bill referenced folic acid supplementation and §2713 category 1.[10] All bills referencing §2713 categories referred to category 4. Four (40.0%) referenced all 4, 2 (20.0%) referenced 3, and 4 (40.0%) referenced 2 §2713 categories.

Most bills (n = 41, 53.9%) contained general references to "preventive services" or groups of preventive services (eg, prenatal care, dental preventive services)—terms usually undefined within legislation. Thirteen of these 41 bills (31.7%) also referenced at least one category or service covered by §2713. Of the 16 (21.1%) bills referring to preventive services not covered by §2713 (eg, kidney disease and prostate cancer screenings), 12 (75.0%) simultaneously referenced §2713 services or categories or preventive services in general.

Interestingly, all but 5 bills (93.4%) promoted access to preventive services. This included requiring coverage, restricting patient costs, sharing coverage information, or expanding provider pools. Most bills (n = 39, 51.3%), including each bill referencing a §2713 category, built on the ACA structure by prohibiting cost-sharing or additional consumer payments. Twenty bills (26.3%) limited access to preventive services through higher copayments, reduced coverage, or exempted entities—usually religious exemptions for contraception coverage. But 15 of them (75.0%) simultaneously expanded access to some preventive service.

Fifty-seven bills (75.0%) applied to only one type of patient. Nineteen (n = 19, 25.0%) applied to multiple patient groups. Most bills (n = 42, 55.3%) affected private insurance beneficiaries and fewest (n = 12, 15.8%) government employees.

Table 1. Characteristics of Proposed or Enacted Preventive Services Legislation.

	No. of bills (% of bills)
Legislative status (c. December 27, 2018)	
Introduced in at least one legislative chamber but did not pass in any chamber	45 (59.2)
Passed one legislative chamber only	6 (7.9)
Passed both legislative chambers but not enacted into law	2 (2.6)
Adopted into law either when signed by the executive or through veto override	23 (30.3)
Legislative frequency	
Introduced in a state with 1 bill (AR, FL, KS, MA, OK, OR, PA, TN, TX, VA, WV, WY)	12 (15.8)
Introduced in a state with 2 bills (AL, ME, IA, MI)	8 (10.5)
Introduced in a state with 3 bills (DC, NJ, NY, NV, RI)	15 (19.7)
Introduced in a state with 4 bills (CA, HI, MD)	12 (15.8)
Introduced in a state with 5 bills (CT, WA)	10 (13.2)
Introduced in a state with 9 bills (IL)	9 (11.8)
Introduced in a state with 10 bills (MS)	10 (13.2)
References to the ACA	
Express reference to the ACA in proposed or existing language	76 (100)
Prevention-related requirements apply only upon an ACA change or repeal	3 (3.9)
References to preventive services covered by ACA §2713	
All preventive services rated A or B by the US. Preventive Services Task Force (category 1)	7 (9.2)
All immunizations recommended by the Advisory Committee on Immunization Practices (category 2)	7 (9.2)
All preventive care & screening services for infants, children, and adolescents per the comprehensive guidelines supported by the Health Resources and Services Administration (category 3)	6 (7.9)
All preventive care & screening services for women per the comprehensive guidelines supported by the Health Resources and Services Administration (category 4)	10 (13.2)
At least one specific preventive service covered by §2713	38 (50.0)
References to other preventive services	
General "preventive services" or group of preventive services	41 (53.9)
At least one specific preventive service not covered by §2713	16 (21.1)
Access to preventive services	
Promotes access	71 (93.4)
Limits access	20 (26.3)
Prohibits cost-sharing or additional patient payment	39 (51.3)
Types of patients covered	
Medicaid or another program in which the state pays for health services	31 (40.8)
Private insurance, including group, individual, and employer-sponsored plans or health maintenance organizations	42 (55.3)
Government employees	12 (15.8)
Everyone or anyone lacking acceptable coverage	16 (21.1)

Note. November 1, 2016, to December 27, 2018 (50 states & Washington, DC). Percentages do not add up to 100 because bills often exhibited multiple characteristics at the same time. ACA = Affordable Care Act.

Discussion

Our finding that most states are legislating around preventive services during ACA-related uncertainty[6,8]—despite §2713 mandates—illustrate the prominence of states in regulating health services.[8] The bill adoption rate is consistent with broader state legislative patterns.[11]

The 86.8% of bills referencing specific services or "preventive services" in general, instead of §2713 categories, create potential ambiguity, deviate from evidence-informed recommendations, and potentially forgo automatic state law updates. This may result from deliberate policy choices or political processes.

Most bills expand access to preventive services. But as almost half lack cost-sharing prohibitions similar to those in §2713, even though cost can affect utilization.[2,3,5] Espousing additional cost-sharing restrictions may promote utilization. Some of the legislation deviates from the ACA by limiting access to seemingly disfavored services (eg, contraception). Curtailing §2713 in this way could widen preventive service coverage gaps nationwide.

Although bill applicability to 4 distinct patient groups highlights the breadth of state-level authority, the federal Employee Retirement Income Security Act may limit the applicability of state legislation to self-funded, employer-based plans.[12] Furthermore, when state fund patient services (eg, Medicaid, government employees, or single-payer systems), legislation could be motivated both by health insurance market dynamics *and* by cost containment.

This study has limitations. We did not account for changes across bill versions, coded some bills with similar but distinct language, and may have missed relevant bills in searches or through exclusion criteria. State legislative activity may have varied at this time, and we did not examine existing legal requirements or covered patient groups.

Conclusion

Our findings are important for prevention. State legislation can promote or hinder preventive services access for some patient groups. Diverse state legislative approaches to preventive services suggest that deviating from ACA's §2713 could increase nationwide coverage variability, favor certain services, and increase out-of-pocket, consumer costs. Although §2713 integrates evidence-based preventive services into law, alternative approaches could distance requirements from scientific findings. Researchers should study what shapes adoption and implementation of state-level preventive services requirements and track them over time to enable testing their impacts on utilization.

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