



Access to Preventive Services without Cost-Sharing: Evidence from the Affordable Care Act

Research examining the impact of the Affordable Care Act suggests that millions of individuals have benefitted from increased access to care and coverage of clinical preventive services without cost-sharing.

KEY POINTS

- The Affordable Care Act (ACA) substantially increased access to care and coverage of preventive services without cost-sharing for millions of Americans.
- Many preventive services including vaccinations, well-child visits, screening for HIV and sexually transmitted infections, HIV pre-exposure prophylaxis, contraception, and cancer screening are required to be covered by most group and individual health plans and for many Medicaid beneficiaries without cost-sharing.
- Expanded access to recommended preventive services resulted from increases in the number of people covered through private health insurance and Medicaid expansion under the ACA.
- Analysis of recent data indicates that more than 150 million people with private insurance – including 58 million women and 37 million children – currently can receive preventive services without cost-sharing under the ACA, along with approximately 20 million Medicaid adult expansion enrollees and 61 million Medicare beneficiaries that can benefit from the ACA’s preventive services provisions.
- Evidence from studies examining the impact of the ACA indicate increased colon cancer screening, vaccinations, use of contraception, and chronic disease screening.

BACKGROUND

Preventive services can help people avoid acute illness, identify and treat chronic conditions, prevent cancer or lead to earlier detection, and improve health. The Affordable Care Act (ACA) reduced financial barriers to accessing preventive services by requiring that most private health plans cover certain recommended preventive services without cost-sharing. This requirement became effective for new health coverage beginning on or after September 23, 2010, except for a requirement concerning women’s preventive services, which became effective for plan years beginning on or after August 1, 2012.

Under the ACA, in most instances group health plans and individual health coverage plans cannot charge a patient a copayment, co-insurance, or deductible for these services when they are delivered by an in-network provider.* One exception are so-called “grandfathered” plans, which are plans that were in existence prior to 2010 and are allowed to continue offering benefit designs other than those generally required by the ACA. By eliminating cost-sharing for these services, the ACA was designed to increase access and use of preventive care, especially among individuals for whom affordability was a key barrier.

This issue brief summarizes the ACA’s preventive services provisions for private health coverage, Medicare, and Medicaid; provides updated estimates of the number of people benefiting from these provisions nationally; and examines evidence on trends in utilization of preventive services and outcomes since the ACA’s preventive services coverage requirements went into effect.

POLICY OVERVIEW

Private Health Coverage

Under the ACA, most private insurance plans are required to cover four categories of preventive services in-network without cost-sharing, including:

1. evidence-based preventive services that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force (USPSTF), which indicates moderate to high certainty that the net benefits of those services are moderate to substantial;¹
2. routine vaccines for adults and children that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) and which has been adopted by the Director of the Centers for Disease Control and Prevention (CDC);²
3. evidence-informed preventive services for infants, children, and adolescents provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);^{†,3} and
4. preventive care and screenings for women, other than those that have in effect a rating of A or B in the current recommendations of the USPSTF, that are provided for in comprehensive guidelines supported by HRSA.⁴

These requirements do not apply to grandfathered plans, which are plans that existed on March 23, 2010, before the law was enacted, that meet certain requirements, and that are exempt from certain provisions of the ACA.[‡]

The range of preventive services covered without cost-sharing includes services such as alcohol misuse screening and counseling, blood pressure screening, depression screening, immunizations, and obesity screening and counseling. Certain covered preventive services recommended by the USPSTF are specific to people in certain age groups or individuals at increased risk; for example, screening for latent tuberculosis in populations at increased risk of infection, and colorectal cancer screening for adults aged 45 to 75.^{5,6,7} The USPSTF defers to the ACIP on recommendations concerning the use of vaccines.⁵

[†] The guidelines implemented by HRSA are commonly referred to as Bright Futures and the Women’s Preventive Services Guidelines.

[‡] These requirements also do not apply to coverage of certain services when a religious exemption applies.

[§] The Centers for Disease Control and Prevention (CDC) sets the U.S. adult and childhood immunization schedules based on recommendations from the ACIP.

Most health plans also generally must cover a set of preventive services for children without cost-sharing (i.e., those plans that are not grandfathered as discussed above) including those providing coverage in the group, individual, and Medicaid markets.⁸ Preventive services benefits for children include, but are not limited to, alcohol, tobacco, and drug use assessments for adolescents; universal newborn hearing screening; developmental and autism screening for children at 18 and 24 months; bilirubin concentration screening for newborns; blood pressure screening for children ages 0 to 17 years; developmental screening for children under age 3; and routine immunization for children from birth to age 18 (doses, recommended ages, and recommended populations vary).

In most instances, non-grandfathered group and individual health coverage plans are required to cover certain preventive benefits for women, including well-woman visits, screening and counseling for domestic violence, U.S. Food and Drug Administration (FDA)-approved contraceptive methods, and other services specified in the Women's Preventive Services Guidelines, which initially went into effect August 2012.⁹ These guidelines are updated periodically to reflect the latest evidence-based recommendations including, for example, a recommendation that adolescent and adult women have access to the full range of FDA-approved contraceptive products, effective family planning practices, and sterilization procedures for women to prevent unintended pregnancy and improve health outcomes.

Estimated Population Size with Private Health Coverage Benefitting from ACA Provisions

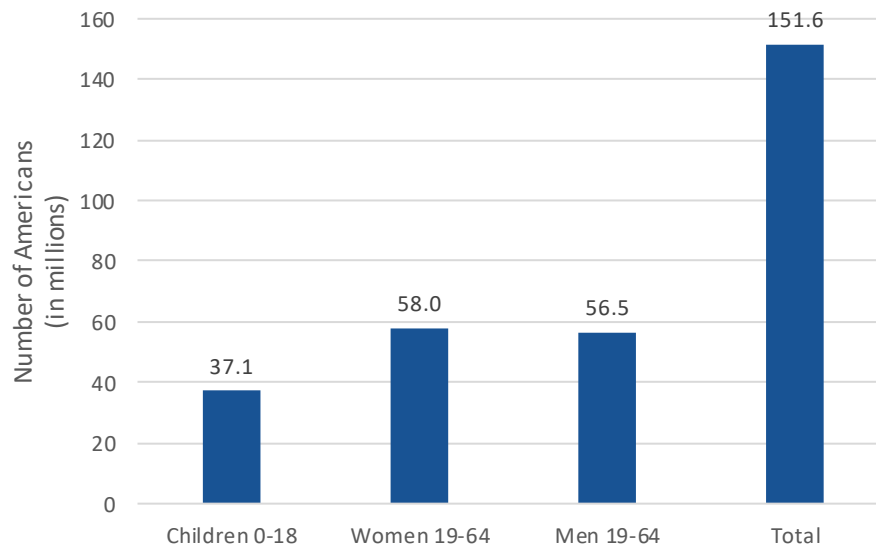
Previous analyses by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) estimated that approximately 137 million Americans with private insurance had access to preventive services without cost sharing in 2015.¹⁰ ** Using the same method, ASPE estimates that about 151.6 million had such coverage in 2020. The increase is due in part to growth in the number of people enrolled in private health coverage and a decrease in the share of such people enrolled in grandfathered plans.

In 2020, the most recent year of data available, 175.9 million people under age 65 had private health coverage, mainly through an employer, but also including coverage purchased through a state or federal Marketplace.¹¹ The 2020 Kaiser Family Foundation Employer Health Benefits survey found that 14 percent of individuals with employer-based health plans were enrolled in grandfathered plans, which are not required to provide preventive service coverage with zero cost-sharing (we assume that these individuals are subject to some level of cost sharing for preventive services). Data from the 2020 Final Rule on Grandfathered Health Plans and from the 2020 National Health Expenditures Accounts suggest that at most 12 percent of people with individual market coverage are enrolled in grandfathered health plans.^{††} Using these statistics, we estimate that a total of approximately 151.6 million individuals¹² currently have private health coverage that covers preventive services with zero cost-sharing (Figure 1).¹³ This includes approximately 58 million women, 57 million men, and 37 million children. Table 1 presents state-level estimates.

** ASPE released a different estimate in 2012 focused on the number of people *newly* gaining coverage for free preventive services, based on how many people with private coverage already had access to preventive care vs. how many were gaining it for the first time, with an estimate of 54 million. The more recent reports, including this report, provide estimates of how many *total* people have private coverage without cost-sharing for these services, whether or not some may have had similar coverage prior to the ACA.

†† See Figure 1 sources for more information on this estimate.

Figure 1. Estimated Number of Individuals with Private Health Coverage, by Age and Gender, with Preventive Services Coverage without Cost-Sharing, 2020 (in millions)



Note: ASPE subtracted estimated 14% and 12% of grandfathered plan enrollees from the total number of individuals with employee sponsored health insurance and the total number of individuals with nongroup insurance, respectively, to estimate the number of privately covered individuals with preventive services coverage without cost-sharing.

Sources: Privately insured individuals, by age and gender: 2020 Kaiser Family Foundation State Health Facts on Health Coverage and the Uninsured, developed from the 2017-2021 Current Population Survey (CPS) Annual Social and Economic Supplements: <https://www.kff.org/state-category/health-coverage-uninsured/>

Grandfathered plan estimates: 2020 Kaiser Family Foundation Employer Health Benefits Survey: <https://www.kff.org/health-costs/report/2020-employer-health-benefits-survey/>

Non group estimate calculated from 2020 Final Rule on Grandfathered Health Plans and 2020 National Health Expenditures Table 22 on coverage:

<https://www.govinfo.gov/content/pkg/FR-2020-12-15/pdf/2020-27498.pdf>

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical>

Table 1. State-level Estimates of Individuals with Private Health Coverage with Preventive Services Coverage without Cost-Sharing, 2020 (in thousands)

	Children (<19)	Women (ages 19-64)	Men (ages 19-64)	Total
United States	37,077	58,019	56,483	151,579
Alabama	513	813	757	2,084
Alaska	60	95	91	246
Arizona	758	1,121	1,163	3,042
Arkansas	274	480	460	1,214
California	4,411	6,718	6,860	17,988
Colorado	625	1,032	1,055	2,712
Connecticut	341	615	587	1,543
Delaware	92	174	153	420
District of Columbia	53	157	156	367
Florida	1,872	3,606	3,566	9,045
Georgia	1,081	1,871	1,706	4,658
Hawaii	134	229	236	599
Idaho	227	315	320	862
Illinois	1,656	2,429	2,433	6,518
Indiana	946	1,241	1,220	3,407
Iowa	406	588	593	1,587
Kansas	402	523	517	1,441
Kentucky	414	712	713	1,840
Louisiana	417	663	644	1,724
Maine	105	248	220	573
Maryland	800	1,195	1,118	3,113
Massachusetts	767	1,326	1,249	3,343
Michigan	1,203	1,759	1,697	4,659
Minnesota	817	1,145	1,135	3,097
Mississippi	294	513	445	1,252
Missouri	741	1,152	1,070	2,964
Montana	116	171	166	453
Nebraska	278	364	388	1,030
Nevada	316	524	529	1,369
New Hampshire	162	261	279	702
New Jersey	1,143	1,673	1,693	4,509
New Mexico	131	257	251	640
New York	2,073	3,452	3,067	8,592
North Carolina	959	1,908	1,783	4,650
North Dakota	114	141	156	411
Ohio	1,302	1,983	1,950	5,235
Oklahoma	379	578	579	1,537
Oregon	510	803	740	2,053
Pennsylvania	1,432	2,441	2,348	6,220
Rhode Island	127	206	191	524
South Carolina	483	887	905	2,275
South Dakota	113	163	174	450
Tennessee	685	1,118	1,093	2,895
Texas	3,472	4,884	4,583	12,939
Utah	617	620	591	1,829
Vermont	64	114	115	292
Virginia	1,115	1,680	1,596	4,392
Washington	896	1,502	1,477	3,875
West Virginia	172	277	294	743
Wisconsin	704	1,191	1,276	3,171
Wyoming	62	101	93	256

Note: ASPE subtracted the estimated 14% and 12% of grandfathered plan enrollees from the total number of individuals with employee sponsored health insurance and the total number of individuals with nongroup insurance, respectively, to estimate the number of privately covered individuals with preventive services coverage without cost-sharing. Numbers of individual children, women, and men may not sum to total due to rounding.

Sources: Privately insured individuals, by age and gender: 2020 Kaiser Family Foundation State Health Facts on Health Coverage and the Uninsured, developed from the 2017-2021 Current Population Survey (CPS) Annual Social and Economic Supplements: <https://www.kff.org/state-category/health-coverage-uninsured/>
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<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical>

Medicaid and Children's Health Insurance Program

In addition to the 151.6 million individuals with non-grandfathered group health plans and non-grandfathered group and individual health coverage who benefit from preventive services coverage under the ACA, the ACA provisions also address coverage of preventive services in both Medicare and Medicaid. Medicaid coverage offered by states (and the District of Columbia) that have expanded Medicaid eligibility to non-elderly adults with family incomes at or below 133 percent of the federal poverty level must cover the full range of preventive services required by the essential health benefits (EHB) regulations, which includes recommended preventive services coverage without cost-sharing.

In Medicaid, the ACA requirement for coverage of preventive services without cost-sharing applies only to Medicaid expansion enrollees and other Medicaid enrollees in Alternative Benefit Plans. As of October 2021, 38 states and the District of Columbia have expanded Medicaid.¹⁴ Under Medicaid expansion, approximately 20 million adults had coverage for preventive services without cost-sharing as of September 2021.¹⁵

Unrelated to the ACA, all children in Medicaid (31 million in December 2020)¹⁶ are covered without cost-sharing for Early and Periodic Screening, Diagnostics and Treatment (EPSDT), created in 1967, which includes well-child visits and ACIP-recommended vaccines,¹⁷ and other essential preventive health benefits for children.

Medicaid coverage of preventive services for adults in states that have not expanded Medicaid is a state option, but most states provided some level of coverage of these services before the ACA.¹⁸ Tobacco cessation for pregnant women is the only preventive service listed under mandatory Medicaid benefits.¹⁹ Optional benefits include "other diagnostic, screening, preventive and rehabilitative services." In traditional Medicaid, states that opt to cover all USPSTF Grade "A" or "B" recommended preventive services and ACIP-recommended vaccines and their administration without cost-sharing receive a one percentage point increase in the federal medical assistance percentage (FMAP) for those services.²⁰ State Medicaid Agencies are encouraged to consider this option to ensure access to preventive services without cost-sharing to additional Medicaid beneficiaries without mandatory coverage.

A total of 33 states covered well-adult exams in FFS and in managed care, and five states covered well-adult exams in managed care in 2012.²¹ Half the states charged co-pays in 2012. Three states did not cover screening mammograms at all, and two states did not cover Pap testing while some states covered Pap testing only as part of family planning visits. A 2018-19 study showed that only 24 out of 49 Medicaid state programs responding to a survey covered all 13 ACIP-recommended adult vaccines.²² A total of 48 Medicaid state FFS programs covered hepatitis B and meningococcal ACWY^{‡‡} vaccines and 47 Medicaid state FFS programs covered influenza; tetanus, diphtheria, and pertussis (Tdap); measles, mumps, and rubella (MMR); varicella; and pneumococcal vaccines. A total of 29 states out of 34 states responding to the survey required their Medicaid managed care plans to cover Tdap, hepatitis B, and meningococcal ACWY vaccines, and 28 states required their Medicaid Managed plans to cover influenza, MMR, varicella, pneumococcal conjugate, and meningococcal B vaccines.

The Children's Health Insurance Program (CHIP) is a program funded by the Federal government and states to cover children up to age 19 in households with income too high to qualify for Medicaid. Ten states and the District of Columbia cover all of their CHIP beneficiaries under Medicaid and provide them with the same Medicaid benefits, including EPSDT.²³ Thirty-eight states cover some CHIP beneficiaries under Medicaid and some under a separate CHIP program. Two states only have separate CHIP programs. All CHIP programs are required to cover well-child visits without cost-sharing.²⁴ CHIP programs are also required to cover vaccines

^{‡‡} Meningococcal ACWY vaccine can help protect against meningococcal disease caused by serogroups A, C, W, and Y.

and vaccine administration for children without cost-sharing. Fifteen states cover pregnant women under CHIP.²⁵ The American Rescue Plan Act (ARP) requires CHIP programs to cover COVID-19 vaccines for children and pregnant women without cost-sharing through the last day of the quarter of the end of the public health emergency.²⁶ Other preventive services may be covered with or without cost-sharing by separate state CHIP programs, but there are no studies on this. All children enrolled in CHIP (6.7 million in December 2020)²⁷ are covered for vaccines and well-child visits without cost-sharing and may be covered for other preventive services with or without cost-sharing.

Medicare

Under the ACA, services recommended by the USPSTF with a Grade “A” or “B” must be covered by Medicare without cost-sharing if the Secretary of the U.S. Department of Health and Human Services (HHS) determines through the national coverage determination process that they are reasonable and necessary for the prevention or early detection of an illness or disability, and appropriate for individuals entitled to the program’s Part A benefits or who are enrolled in Part B.²⁸ There are approximately 61.5 million individuals enrolled in Medicare, all of whom potentially benefit from this provision of the ACA.²⁹

After the ACA was enacted, HHS issued new rules on November 29, 2010, to eliminate Medicare cost-sharing for USPSTF recommended preventive services and to provide Medicare coverage for an annual wellness visit that includes a comprehensive health risk assessment and a 5- to 10-year personalized prevention plan. Medicare Part B provides coverage without cost-sharing for certain USPSTF-recommended services and four vaccinations: COVID-19, influenza, hepatitis B, and pneumococcus. Medicare Part B does not currently cover preventive shingles and tetanus, diphtheria, and pertussis (Tdap) vaccinations.³⁰ Optional Medicare Part D plans generally cover these other vaccinations, though they may include cost-sharing.^{55,31} The Build Back Better Act (BBB), being considered in the Congress, proposes covering these vaccinations without cost-sharing in Medicare Part D.

EVIDENCE ON CHANGES IN UTILIZATION AND OUTCOMES

Research shows that the ACA reduced health coverage disparities across racial groups and expanded access to a range of clinical services including preventive services.^{32,33} Gains in access to services were due in large part to uninsured individuals obtaining health coverage. For example, people who became newly covered under Medicaid and the Marketplace through the ACA in 2014 were much less likely than uninsured people to report being unable to get care or delaying needed care because of cost.³⁴ There have been fewer studies specifically examining the effects of eliminating cost-sharing for preventive services among individuals who already had health coverage. In this section, we describe the effects of the ACA on utilization of several types of preventive services; these effects are likely a combined result of the provisions expanding coverage to the uninsured and the provisions increasing access to preventive services without cost-sharing.

Cancer Screening

Overall, Americans utilize recommended clinical preventive services at low rates, and utilization of preventive services such as cancer screening differs across racial and ethnic populations.^{35,36,37} ACA provisions to eliminate cost-sharing for recommended clinical preventive services, such as cancer screenings, presented an opportunity to increase early diagnosis of cancer. Studies examining changes in cancer screening among privately insured individuals after the ACA eliminated cost-sharing show an overall increase in colorectal cancer screening tests, while breast cancer screening rates were stable; rates of Pap testing decreased, though

⁵⁵ Generally, Medicare prescription drug plans (Part D) cover all commercially available vaccines (e.g., shingles) needed to prevent illness.

this time period coincided with revised cervical cancer screening recommendations that include less frequent testing for many patients.^{38,39} An analysis of 2013-2016 national survey data indicated utilization rates among newly insured immigrants increased for colon cancer screenings but did not change for Pap testing or mammography.⁴⁰ Some research also shows that patient navigation interventions have helped increase cervical cancer screening rates among Latinas and Chinese-American women.⁴¹ While the studies reviewed show some evidence of improved use of cancer screening since enactment of the ACA, disparities remain.^{42,43}

The USPSTF announced a new recommendation in May 2021 that colon cancer screening start at age 45 instead of 50.⁴⁴ We estimate that this means an additional 15.0 million to 17.5 million individuals will be able to benefit from the ACA's provisions for preventive services without cost-sharing for colon cancer screening.⁴⁵ An analysis of data from 2009 and 2014 suggest that the elimination of cost-sharing under the ACA positively affected colorectal cancer screening among men and women with private health coverage, and among men and Hispanic beneficiaries with Medicare coverage.⁴⁶ While data show that colon cancer mortality among men and women was decreasing prior to the ACA, colon cancer remains one of the leading causes of cancer deaths, and increased screening – which can result in identification and removal of precancerous growths – has resulted in a decrease in colorectal cancer incidence.⁴⁷

Health coverage is important for individuals with cancer because access to care can affect health outcomes. Annual out-of-pocket costs among recently diagnosed survivors of cancers like breast, prostate, colorectal, and lung cancers average more than \$1,000 for medical care costs, depending on age.⁴⁸ Some research suggests that increased access to preventive services and increased affordability of care since the ACA has helped cancer survivors obtain the care they needed.^{49,50} However, decreases in cancer screenings during 2020 as a result of the COVID-19 pandemic indicate the need to monitor post-pandemic changes in cancer incidence, later-stage cancer diagnosis, and cancer mortality.^{51,52}

Vaccinations

One ACA provision with particular relevance for young adults is the dependent coverage provision, which generally allows young adults to stay on their parents' health care plans until age 26. With the ACA dependent coverage provision and the provision for preventive services without cost-sharing, an estimated 854,000 young women completed the human papillomavirus (HPV) vaccine series from 2010 to 2012, an increase of 5.8 percentage points compared to a control group of women who were not eligible for dependent coverage.⁵³ Coverage without cost-sharing was associated with a 4.3 percentage point increase in HPV vaccine completion for females aged 9 to 26 who were privately insured and a 5.7 percentage point increase for Medicaid enrollees in three states (Massachusetts, New Hampshire, and Maine) in a study of 2009-2015 claims.⁵⁴

Influenza vaccinations showed a small but significant increase from 2009 to 2011/2012 after the elimination of cost-sharing among adults with private health coverage.⁵⁵ National survey data from 2016 showed that among adults 65 and older, 70.4 percent received an influenza vaccine and 66.9 percent had been vaccinated against pneumococcal disease; Tdap vaccination of adults 19 years and older was just 26.6 percent.⁵⁶ Thus, many adults do not receive all of the recommended vaccinations, sometimes for reasons other than cost, and there is still potential for greater uptake and utilization of routine vaccination among adults who have private health coverage, Medicare, and Medicaid.⁵⁷

Medicare Wellness Visits

The percentage of Medicare beneficiaries utilizing annual wellness visits increased 14.9 percentage points between 2011 (the first year when such visits were covered) and 2016, rising from 8.1 percent to 23.0 percent.⁵⁸ This trend suggests that it may take time for beneficiaries and providers to use a new service when it becomes available. However, the utilization of this new service was characterized by disparities, with

utilization 10.2 percentage points lower for non-Hispanic Black Medicare beneficiaries and 11.6 percentage points lower for Hispanic beneficiaries than non-Hispanic White beneficiaries in 2016.

Women's Health and Contraception

Provisions in the ACA addressed a range of women's health needs by increasing health coverage – which increased access to medical and mental health care – and by establishing HRSA-supported Women's Preventive Services Guidelines specifying certain services that must be covered without cost-sharing by non-grandfathered group and individual health coverage. Services included in the Women's Preventive Services Guidelines are: screening for anxiety, breast cancer screening for average-risk women, breastfeeding services and supplies, screening for cervical cancer, contraception (including contraceptive counseling), screening for gestational diabetes mellitus, screening for diabetes after pregnancy, screening for human immunodeficiency virus infection, screening for interpersonal and domestic violence, counseling for sexually transmitted infections, well-woman preventive visits, and screening for urinary incontinence.

Most recently in January 2022, the Guidelines incorporated new, updated evidence-based recommendations for breastfeeding services and supplies, contraception, screening for human immunodeficiency virus (HIV) infection, counseling for sexually transmitted infections, and well-woman preventive visits, and added a new recommendation for preventing obesity in midlife women.

Access to contraceptives has been shown to improve a variety of women's health and economic outcomes, including reduced rates of entry into poverty, increased rates of entry into professional school, or the labor force, and increases in wages.^{59,60} Access has also had intergenerational effects. Children of women who have access to contraceptives have been shown to achieve higher rates of college graduation and higher incomes than children of women who did not have access to contraceptives.⁶¹ Contraceptives include a wide array of products. Long-acting reversible contraceptives (LARCs) – which include intrauterine devices (IUDs), intrauterine systems (IUSs), and subdermal implants – are among the most effective methods of contraception, while the birth control pill is among the most popular. Other types of contraception include the hormone patch, the vaginal ring, and emergency contraceptive medication. The ACA provision requiring coverage of contraceptives without cost-sharing mitigated a major barrier to contraceptive use: cost. High cost-sharing has been shown to be associated with contraceptive nonadherence and discontinuation, as well as lower use of LARCs, which often have high one-time costs even though they can be less expensive over time than methods that must be purchased periodically such as the birth control pill.^{62,63,64,65}

A comparison of out-of-pocket costs for contraception before and after the implementation of the ACA found that average costs for every category of contraception decreased. The mean out-of-pocket cost for an IUD fell from \$262.38 in the first half of 2012 to \$84.30 in the first half of 2013. The ACA provision saved an average of \$255 annually per user of birth control pills between 2012 and 2013.⁶⁶ After the implementation of the ACA's preventive service zero-cost sharing requirements, the median out-of-pocket spending for all categories except the vaginal ring and the subdermal patch was \$0. The estimated out-of-pocket savings to women totaled approximately \$1.4 billion in 2013.

Research also demonstrates that the reduction in cost-sharing led to increased use of LARCs. One study found that the reduction in cost-sharing was associated with increases in prescription contraceptive usage, with a shift toward longer-term methods (including non-reversible options such as sterilization).⁶⁷ A later study found that women enrolled in high deductible health plans (HDHPs) initiated LARC use at rates more than twice as high than women in non-high deductible health plans (non-HDHPs) beginning after the implementation of the ACA. This study is consistent with the idea that women in HDHPs were hesitant to access IUDs/LARCs because they would have had higher cost-sharing due to their high deductibles, until the ACA provision removed that barrier.⁶⁸

An analysis of data through 2018 showed that ACA Medicaid expansion was associated with greater preconception health counseling and postpartum use of effective birth control methods among low-income women, and another study found that expanded Medicaid coverage under the ACA was associated with decreases in the proportion of pregnancies that were unintended among individuals with a high-school degree or less, but was not associated with any significant change in the overall birth rate.^{69,70} The overall national rate of intended pregnancy decreased from 67 percent of births to 62 percent of births between 2011 and 2019.^{***,71}

Chronic Conditions

Gaining access to health coverage and preventive services can allow earlier detection and treatment of chronic health conditions such as hypertension and diabetes. Several studies have found that the ACA resulted in improvements in affordability of care, regular care for chronic conditions, medication adherence, and self-reported health.^{72,73} During 2012-2015, the percentage of adults aged 18 to 64 with two or more chronic health conditions who delayed or did not obtain needed medical care due to cost decreased.⁷⁴

More adults with private insurance received blood pressure and cholesterol screening in 2011-12, compared to pre-ACA screening rates in 2009.⁷⁵ An analysis of 2012-2018 data showed that ACA Medicaid expansion was associated with sustained increases in improvements in blood pressure and glucose control over a five-year period among individuals receiving care at Federally Qualified Health Centers, especially Black and Hispanic patients.⁷⁶ Preventive services and chronic disease management contribute to improvements in cardiovascular health, blood pressure control,⁷⁷ and both the incidence and care for diabetes; increasing access to such services is an important factor in improving health outcomes over time and addressing health disparities. ACA implementation has also contributed to improved health outcomes among people living with HIV in terms of viral suppression and retention in care.⁷⁸

CONCLUSIONS

The implementation of the ACA increased health coverage, especially among Black Americans, Latinos, Asian Americans and Pacific Islanders, American Indians/Alaska Natives, and individuals living in states that expanded Medicaid.^{79,80,81,82} We estimate that more than 150 million people with private health coverage are now benefitting from the ACA's coverage of preventive services without cost-sharing, across a range of services and conditions. In addition, tens of millions of Medicare and Medicaid beneficiaries are also benefitting from the ACA provisions regarding preventive services without cost-sharing. Studies demonstrate increases in access to preventive services, including colon cancer screening, HPV vaccination, Medicare annual wellness visits, and contraceptive use. Investments in prevention in the early and middle decades of life, when people are more likely to be covered by private health coverage including Marketplace insurance and Medicaid, may also help people enter the Medicare program at age 65 in better health. Ongoing research can help monitor the impact of the ACA on access to care, use of preventive services, health disparities, and long-term health outcomes.

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