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Chlamydia Screening for Sexually Active Young Women Under the Affordable Care Act: New Opportunities and Lingering Barriers

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Abstract

The Affordable Care Act of 2010 (ACA) contains a provision requiring private insurers issuing or renewing plans on or after September 23, 2010, to provide, without cost sharing, preventive services recommended by US Preventive Services Task Force (grades A and B), among other recommending bodies. As a grade A recommendation, chlamydia screening for sexually active young women 24 years and younger and older women at risk for chlamydia falls under this requirement. This article examines the potential effect on chlamydia screening among this population across private and public health plans and identifies lingering barriers not addressed by this legislation. Examination of the impact on women with private insurance touches upon the distinction between coverage under grandfathered plans, where the requirement does not apply, and nongrandfathered plans, where the requirement does apply. Acquisition of private health insurance through health insurance Marketplaces is also discussed. For public health plans, coverage of preventive services without cost sharing differs for individuals enrolled in standard Medicaid, covered under the Medicaid expansion included in the ACA, or those enrolled under the Children's Health Insurance Program or who fall under Early, Periodic, Screening, Diagnosis and Treatment criteria. The discussion of lingering barriers not addressed by the ACA includes the uninsured, physician reimbursement, cost sharing, confidentiality, low rates of appropriate sexual history taking by providers, and disclosures of sensitive information. In addition, the role of safety net programs that provide health care to individuals regardless of ability to pay is examined in light of the expectation that they also remain a payer of last resort.

Chlamydia is the most commonly reported sexually transmitted and notifiable disease (STD) in the United States.[1] Rates are highest for 15- to 19-year-old women, followed by 20- to 24-year-old women[2]; disparities exist among racial groups.[3–5] If left untreated, chlamydia can

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lead to complications that may influence current or future reproductive functioning.[6,7] To prevent this, recommendations developed by the Centers for Disease Control and Prevention[8] (CDC) and the US Preventive Services Task Force[9] (USPSTF) call for annual screening of sexually active young women younger than 25 years for chlamydia (and, though not the focus of this article, also for older women at increased risk). Despite recommendations, many women in this age group do not receive screening.[10] In 2010, the Healthcare Effectiveness Data and Information Set (HEDIS) indicated that among sexually active girls and women aged 16 to 24 years, only 44.9% enrolled in commercial health plans and 58.4% enrolled in Medicaid health plans were screened for chlamydia (unpublished data). These numbers are more striking given that HEDIS may overestimate coverage because it represents only women who seek reproductive health care services and not all women in need of screening.[10]

In recognizing prevention as a cornerstone of health,[11] the Patient Protection and Affordable Care Act of 2010 (ACA) requires new (non-grandfathered) group health plans and health insurers offering group or individual health insurance to provide coverage for certain preventive services without cost sharing to the patient.[12] The Congressional Budget Office estimates that the proportion of the population with health insurance will increase as the ACA is fully implemented, in part due to Medicaid expansion and the creation of health insurance Marketplaces designed as a portal for linking individuals with eligible health plans.[13] Increased enrollment represents a substantial increase in access to preventive health services without cost sharing, including chlamydia screening. However, enhanced access to chlamydia screening without cost sharing does not fully mitigate all barriers. This article explores the impact the ACA may have on the provision of chlamydia screening and the significant and lingering challenges that remain for preventing and treating chlamydia.

PREVENTIVE SERVICES AND PRIVATE INSURANCE

Only 3 states had enacted laws mandating health insurers to reimburse for chlamydia screening in at-risk populations before the passage of the ACA.[14] However, because the ACA requires private insurers issuing or renewing plans on or after September 23, 2010, to provide, without cost sharing, certain recommended preventive services (i.e., USPSTF [grades A and B], the Advisory Council on Immunization Practices [ACIP], and those supported by the Health Resources and Services Administration [HRSA][12]), the grade A USPSTF recommendation for chlamydia screening for women 24 years and younger[15] provides an explicit pathway to increased coverage of this service (see Table 1 for glossary.) The ACA also extends this requirement to most private and group health plans, including those offered to individuals and small businesses through either the state-run Marketplaces or the federally facilitated Marketplace (hereafter Marketplace[s]),[16–18] ensuring coverage of preventive services without cost sharing to people who will receive coverage through the Marketplace beginning as early as January 1, 2014 (2015 enrollment estimated at 13 million).[13]

The requirement to cover preventive services without cost sharing does not apply to “grandfathered” health plans (i.e., plans existing before passage of the ACA [03/23/2010] or those that have not substantially changed [i.e., reduced benefits and/or increased costs] since

passage of the ACA).[19–21] Likewise, grandfathered plans do not have to offer the "essential health benefits" (EHB) package of services, or the minimum categories of services to be offered by private plans sold in the Marketplaces that most individual and small group plans must offer beginning in 2014.[16,22] (Recent guidance from the President changed grandfathering in certain states.)[23] The number of plans meeting the definition of grandfathered is decreasing over time; in 2013, 36% of workers receiving coverage through their employer were enrolled in a grandfathered plan versus 56% in 2011.[24] High-end estimates indicate that up to 80% of small employer plans and 64% of large employer plans may relinquish grandfathered status by the end of 2013.[20] Many grandfathered plans cover chlamydia screening but may require young women to pay a portion of the cost. Once grandfathered status is relinquished, "new" plans will be required to cover preventive services without cost sharing.

PREVENTIVE SERVICES AND STANDARD MEDICAID

Under the standard Medicaid program (i.e., as it existed pre-ACA), which currently provides coverage for more than 62 million individuals, states are required to offer Medicaid enrollment to certain categorically eligible groups, including low-income children, pregnant women, and parents with dependent children with income below specified minimum thresholds. Although prevention is a major focus of health reform, the provisions under the ACA that seek to increase coverage of preventive services available under standard Medicaid and Children's Health Insurance Program (CHIP) programs (which are separate and distinct from "Medicaid expansion"),[25,26] are limited. Unlike coverage under private plans, Medicaid beneficiaries do not have universal coverage of preventive services, including chlamydia screening.[25] Nevertheless, the ACA attempts to move in the direction of universal coverage of preventive services in Medicaid by providing an incentive to encourage state Medicaid programs to cover preventive services with no cost sharing.

Preventive Services for Eligible Children Younger Than 21 Years

The Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program ensures Medicaid-enrolled individuals younger than 21 years receive a broad range of preventive and other services,[27] including all appropriate and medically necessary preventive services, with little or no cost sharing. Some states specifically include chlamydia screening as a required component of an EPSDT well-child visit (e.g., Alabama).[28] However, in practice, many states do not routinely monitor uptake of preventive services under EPSDT and may not undertake initiatives to promote their provision, effectively limiting access.[25,30] Furthermore, children enrolled in CHIP, which builds on Medicaid and covers close to 8 million children up to aged 19 years in low- and moderate-income families with income too high to qualify for Medicaid,[31] may have reduced access to preventive services because CHIP programs may not cover EPSDT. CHIP programs also have the flexibility to charge families for preventive services through cost sharing requirements.[32] These factors lead to low rates of chlamydia screening for sexually active youth enrolled in Medicaid.[33] The ACA does not change the EPSDT benefit or coverage available to children under the Medicaid/CHIP program.[25]

Preventive Services for Eligible Adults 21 Years and Older

As of 2010, 47 of the 48 state Medicaid programs providing data on their Medicaid benefits package reported covering chlamydia screening for sexually active women, although some did so only via the medical necessity standard. Of those, 13 states required beneficiaries to pay a copay to receive the screening.[34] Although chlamydia screening may be almost universally covered in some way under state Medicaid policies, Medicaid-enrolled adults have inconsistent access to preventive services without cost sharing. One cause of this inconsistent access may be a shortage of providers willing to accept Medicaid-enrolled patients.[35] In addition, compared with adults with private insurance, a lower percentage of adults covered by Medicaid receive preventive services, possibly due to provider confusion over whether a service is covered or as a result of low provider reimbursement.[29] However, among young women who do receive preventive services, provision of chlamydia screening is higher among the Medicaid population than among the commercially insured population.[10] This may be, in part, because providers are more likely to screen lower as compared with higher-income patients for STDs.[36] Coverage of preventive services, including chlamydia screening, is not required for Medicaid-enrolled adults 21 years and older under the ACA. Federal law defines these services as optional Medicaid benefits.[37] States have considerable flexibility to determine the scope of preventive services offered and the amount of out-of-pocket spending required of recipients.[38]

Although the ACA does not require coverage of preventive services or eliminate cost sharing in standard Medicaid, effective January 1, 2013, state Medicaid programs can receive a 1-percentage-point increase in their federal matching rate if they opt to cover all ACIP recommended vaccines, their administration, and the USPSTF grade A and B–recommended services without cost sharing. The HRSA-recommended services required to be covered by private insurers and the Medicaid expansion group are not included.[39] This financial incentive may provide the impetus for states to offer more robust coverage for preventive services. However, it is uncertain how many states will expand preventive service coverage and whether the 1-percentage-point increase will be enough to offset lost revenue from eliminating copays. Young women who are enrollees in standard Medicaid living in states choosing not to offer preventive services without cost sharing will still be responsible for copays for chlamydia screening.

PREVENTIVE SERVICES AND MEDICAID EXPANSION

Nonelderly, nonpregnant, nondisabled adults without dependent children have not previously been eligible for Medicaid. Some states have set more generous eligibility standards for childless adult populations, but most low-income adults are ineligible for Medicaid coverage and remain uninsured.[40] To increase coverage for low-income uninsured populations, one goal of the ACA was to expand Medicaid eligibility to all adults aged 65 years and younger at 133% or less (138% with income disregard)[41] of the federal poverty level (FPL; i.e., Medicaid expansion).[42] Original estimates projected that full implementation of Medicaid expansion would enroll 16 million uninsured individuals by 2019.[43] However, a June 2012 Supreme Court decision on the constitutionality of the ACA effectively altered Medicaid expansion from a mandatory provision to a state option.[44] As of January 2014, 26 states and

the District of Columbia have determined that they will participate in Medicaid expansion, with several states undecided.[45] Accordingly, fewer people will be covered by the Medicaid program moving forward than originally planned.[46] Some will obtain coverage through the Marketplaces, but many are expected to remain uninsured.[46–48]

Individuals eligible under Medicaid expansion are entitled to coverage, without cost sharing, of the preventive services included in the EHB package available to those enrolled in private plans through the Marketplaces (note that these benefits differ significantly from preventive benefits under standard Medicaid, as described above).[49] This extends this benefit to sexually active young women who are part of the Medicaid-expansion population, including young women who are not pregnant or parenting. Had Medicaid expansion moved forward as outlined in the ACA, it is likely that chlamydia screening without copay would have been extended to a number of eligible young women who may now remain uncovered. The impact would have been most noticeable in those states where income eligibility requirements for Medicaid are set at a low percentage of the FPL.[50]

THE SAFETY NET AND CHLAMYDIA SCREENING

Safety net providers provide health care to individuals at reduced or no cost and so often serve uninsured and Medicaid populations.[51] In addition, barriers to accessing chlamydia screening might lead some young women with insurance coverage to seek screening through safety net agencies which provide care underwritten by public dollars, including state or local health departments, federally qualified health centers (FQHCs), or Title X clinics, as these entities often provide confidential services for no cost or on a private pay, sliding-fee scale. Anticipating increased uptake of health care services as a result of coverage expansions, the ACA authorized US$11B for community health center expansion to meet new demand.[52] Likewise, the ACA requires all qualified health plans offered through state exchanges to include essential community providers (ECPs) within their network.[53] Proposed guidance offered by the Centers for Medicare & Medicaid Services indicates that eligible ECPs include FQHCs, Title X clinics, and STD clinics within health departments, although health plans are not required to contract with all of these entities within their covered area.[54]

The ACA was intended to reduce health care costs, in part, by shrinking the pool of individuals in need of uncompensated care. As such, the use of state or federally supported services by insured individuals who choose not to use their insurance and instead receive uncompensated care from one of these entities could constitute a diversion of funds away from care of the uninsured. Although ACA provisions strengthen the capacity of these providers, public funding should remain a payer of last resort for women with other reimbursement options.

LINGERING BARRIERS

Increased public and private access to preventive screening under the ACA is a positive step in preventing, identifying, and treating chlamydia among sexually active young women; however, substantial challenges remain.

The Uninsured

According to Congressional Budget Office estimates, 30 million individuals will remain uninsured even after full implementation of the ACA.[13] Undocumented immigrants, those with deferred action status, and lawfully residing noncitizens in the country less than 5 years (roughly 6% of the US population)[55] are ineligible for Medicaid expansion and do not qualify for standard Medicaid benefits.[56] (Lawfully residing immigrant children who have been in the country <5 years will be eligible for Medicaid coverage at state-option.)[57] Although qualified non-citizens may participate and receive premium subsidies in the Marketplaces, undocumented adults and children are barred from purchasing coverage through the Marketplace.[58] These restrictions may leave most immigrant populations out of ACA coverage expansions.[59]

US citizens living between 100% and 400% FPL will qualify for federal subsidies to purchase coverage from the Marketplaces.[60] In states not participating in Medicaid expansion, these subsidies will assist some of the would-be expansion population in securing a private plan through the Marketplace. However, premium subsidies will not reach the poorest of the poor (i.e., <100% FPL), most of whom will not be able to afford coverage on their own, causing them to remain uninsured.[61] Low enrollment in available coverage options could compound this because recent figures indicate that more than 70% of uninsured children are potentially eligible for Medicaid or CHIP but are not enrolled,[62] and only 63% of Medicaid-eligible adults are enrolled.[63] As young women without insurance will not benefit from ACA provisions, identifying the eligible but unenrolled and linking them to available resources may be an initial strategy for increasing screening.

Physician Reimbursement

The ACA expands access to preventive services but does not set minimum reimbursement rates for physicians who provide these services or require providers to offer these services to patients. If reimbursement rates fall short of actual costs, providers may not have the incentive to widely offer these services.[64] If providers cannot collect a copay from patients to offset costs or if they are paid one lump sum for a visit where multiple preventive services are offered (e.g., a well-woman visit), providers may have a decreased financial incentive to offer the service.[64,65] Lack of uniformity in coverage may complicate reimbursement efforts for providers, especially those with a patient population cutting across private insurance, standard Medicaid, and Medicaid expansion.

Cost sharing

Even when a patient has access to chlamydia screening without cost sharing, the diagnosis and treatment may not be provided for free. Patients may be billed separately for the cost of the associated office visit independent of the preventive services rendered or for any follow-up treatment. For some young women, these additional charges may be cost prohibitive and could prevent them from seeking chlamydia screening.[66]

Confidentiality

Research suggests that confidentiality is a primary concern of patients when seeking STD services, most often for stigma-related reasons.[67–70] Some patients may forego needed STD

services,[71] or go to a provider other than their primary care provider, if they are concerned or embarrassed about revealing sexual behaviors or disease status to their primary care provider.[72] New health plans are not required to cover preventive services provided out of network, as is standard. This may constrain the ability of some young women to seek chlamydia screening in a venue or with a provider who they feel will maintain their confidentiality.

Sexual History Taking

Sexual history taking may reveal that a young woman is sexually active and at risk for chlamydia, prompting the provider to offer screening. No system routinely monitors the percentage of providers who include sexual history taking as part of a medical visit, but it is unlikely done routinely.[72,73] Young women with asymptomatic chlamydia may be especially unlikely to receive screening.[10] Expanded coverage of chlamydia screening without cost sharing will not benefit young women, especially those with asymptomatic infections, if providers remain unaware of the need for screening due to failure to take a sexual history.

Disclosures of Sensitive Information

Provision of an explanation of benefits (EOB), which offers an accounting of all services health care providers bill, to health plan policyholders is generally required by state law as a safeguard against fraud and abuse.[74] Through them, policyholders may become aware that a spouse or child, who may otherwise not disclose this information, has received chlamydia screening. In this way, EOB policies may discourage young women from seeking chlamydia screening and follow-up treatment.[75,76] In addition, because EOBs are generally sent to the policyholder parent instead of the adult child patient, the ACA provision allowing adult children to remain on their parents' health insurance plan until age 26 years will increase the window during which EOBs may disclose sensitive screening information.[74] Similarly, access to confidential care for minors is further complicated by state minor consent and confidentiality laws, which vary in the extent to which they allow for minors to access sexual and reproductive health care services without parental consent or notification.[77] No provisions in the ACA mitigate this concern.[74]

DISCUSSION

Chlamydia screening of sexually active young women is a core component of STD prevention and control, and the ACA provides a number of opportunities for extending the reach of this critical service: requiring coverage without cost sharing for certain public and non-grandfathered private group and individual plans, introducing health insurance Marketplaces to make more accessible and simplify coverage options, providing premium subsidies to purchase insurance to individuals between 100% and 400% FPL, expanding Medicaid in participating states, and offering increased financial incentives to states with Medicaid plans which include coverage of preventive services without cost sharing. However, many challenges remain. Coverage requirements are not uniformly mandated across all private and public insurance plans. Women in non-grandfathered private plans enjoy chlamydia screening without cost sharing, whereas women accessing care via standard Medicaid may have inconsistent coverage of this service. Meanwhile, because many states

have not indicated that they will expand Medicaid, a number of young women might not be able to acquire coverage if they fall outside Medicaid eligibility categories and premium subsidy income requirements. Thus, local context may affect the potential impact of ACA requirements which facilitate chlamydia screening. For example, a young woman living in a state with a low threshold for Medicaid eligibility (e.g., ≤99% FPL) that does not adopt Medicaid expansion will likely see less benefit than a young woman who lives either in a state adopting Medicaid expansion or who qualifies for premium insurance subsidies.

Sufficient data are not yet available to estimate the effect of ACA-driven changes described here on chlamydia screening rates in the post-ACA era. Many of the law's provisions did not go into effect until 2014, and others have not been in place long enough to achieve mature implementation. Moving forward, however, the HEDIS measure of chlamydia screening among sexually active young women will provide insight into the impact of these changes at both the national and state levels and for women with private or public insurance.

Although many existing barriers to screening (e.g., confidentiality concerns and inadvertent disclosure of sensitive information) may need to be ameliorated through legal remedies at the state or federal level and thus may be beyond the reach of an individual public health professional,[74] an understanding of these issues can allow for local innovation to counteract their effects. Beyond this, public health professionals can play an important role in community-level prevention and control of chlamydia in the post-ACA health care landscape. Foci might involve working with health plans or state and local health departments to identify a network of safety net providers, providers accepting new Medicaid patients, or providers offering walk-in clinic hours or who see individuals on a walk-in basis for STD services. Likewise, provider education efforts may help improve performance on the HEDIS measure of chlamydia screening among sexually active young women by improving sexual history taking, focusing screening efforts on the appropriate target population, or suggesting small, often structural, changes within a practice, which have been shown to increase screening rates.[78] Overall, successful efforts by public health professionals to close the gap between the potential for increasing coverage and access to chlamydia screening offered by the ACA and complications and misunderstandings present in on-the-ground implementation could amplify the impact of the legislation.

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References

1. Satterwhite C, Torrone E, Meites E, et al. Sexually transmitted infections among US women and men: prevalence and incidence estimates, 2008. Sex Transm Dis. 2013; 40:187–196. [PubMed: 23403598]
2. Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2011. Atlanta, USA: Department of Health and Human Services; 2012.
3. Forhan SE, Gottlieb SL, Sternberg MR, et al. Prevalence of sexually transmitted infections among female adolescents aged 14 to 19 in the United States. Pediatrics. 2009; 124:1505–1512. [PubMed: 19933728]

4. Steele CB, Richmond-Reese V, Lomax S. Racial and ethnic disparities in HIV/AIDS, sexually transmitted diseases, and tuberculosis among women. J Womens Health. 2006; 15:116–122.
5. Datta SD, Sternberg M, Johnson RE, et al. Gonorrhea and chlamydia in the United States among persons 14 to 39 years of age, 1999 to 2002. Ann Intern Med. 2007; 147:89–96. [PubMed: 17638719]
6. Frye J, Wallace L, Chavez R, et al. Screening and treatment guidelines for Chlamydia trachomatis in incarcerated adolescents: A review. J Correctional Health Care. 2008; 14:89–98.
7. Gottlieb SL, Martin DH, Xu F, et al. Summary: The natural history and immunobiology of *Chlamydia trachomatis* genital infection and implications for chlamydia control. J Infect Dis. 2010; 201(suppl 2):S190–S204. [PubMed: 20524236]
8. Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines, 2010. MMWR. 2010; 59:1–116.
9. [Accessed April 17, 2013] USPSTF A and B Recommendations. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm
10. Hoover K, Leichliter J, Torrone E, et al. Monitoring chlamydia testing of adolescent females in the United States, 1999–2010. MMWR.
11. [Accessed April 17, 2013] HHS Secretary Kathleen Sebelius statement on national public health week. Available at: http://www.hhs.gov/news/press/2013pres/04/20130401a.html
12. Patient Protection and Affordable Care Act, Public Law No. 111–148, § 1001, 124 Stat. 131, (March 2010), amending Part A of title XXVII of the Public Health Service Act, 42 U.S.C. 300gg et seq.
13. [Accessed October 31, 2013] CBO's May 2013 estimate of the effects of the Affordable Care Act on health insurance coverage. Available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf
14. Owusu-Edusei K Jr, Gift TL. Assessing the impact of state insurance policies on chlamydia screening: A panel data analysis. Health Policy. 2010; 96:231–238. [PubMed: 20207440]
15. Screening for chlamydial infection, topic page. U.S. Preventive Services Task Force; Available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspschlm.htm [Accessed April 17, 2013]
16. Patient Protection and Affordable Care Act. Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. 77 Federal Register 70644. Nov 26.2012
17. Patient Protection and Affordable Care Act § 1301 et seq. (March 2010).
18. Patient Protection and Affordable Care Act, Public Law No. 111–148, § 1302(b), 124 Stat. 163, (March 2010).
19. Patient Protection and Affordable Care Act, Public Law No. 111–148, § 1251, 124 Stat. 855, (March 2010).
20. Interim final rules for group health plans and health insurance coverage relating to status as a grandfathered health plan under the Patient Protection and Affordable Care Act. 75 Fed. Reg. 34538. June 17, 2010.
21. [Accessed April 17, 2013] Questions and answers: Keeping the health plan you have: The Affordable Care Act and "grandfathered" health plans. Available at: http://www.healthreform.gov/about/grandfathering.html
22. Public Laws 111–148 & 111–152. Patient Protection and Affordable Care Act. Section 2001. March 2010.
23. Cohen, G. Standard notices for transition to ACA compliant policies. Department of Health and Human Services. Centers for Medicare & Medicaid Services. Center for Consumer Information and Insurance Oversight; 2013. Available at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/standard-notice-bulletin-11-21-2013.pdf [Accessed January 5, 2014]
24. Claxton G, Rae M, Panchal N, et al. Health benefits in 2013: Moderate premium increases in employer-sponsored plans. Health Affairs. 2013:32.
25. Baumrucker EP, Fernandez B. Comparing Medicaid and exchanges: Benefits and costs for individuals and families. Congressional Res Serv. 2013:R42978.

26. Stone J, Baumrucker EP, Binder C, et al. Medicaid and the state Children's Health Insurance Program (CHIP) provisions in PPACA: Summary and timeline. Congressional Res Serv. 2010:R41210.
27. 42 U.S.C. §1396d(a)(4)(B) and §1396d(r)(5).
28. Well Child Check-Up (EPSDT). Alabama Medicaid Agency; Available at: http://medicaid.alabama.gov/documents/6.0_Providers/6.7_Manuals/6.7.7_Provider_Manuals_2013/6.7.7.1_January_2013/6.7.7.1_Jan13_A.pdf [Accessed August 27, 2013]
29. United States Government Accountability Office. Report to the Chairman, Committee on Finance, U.S. Senate. GAO-09-578. Aug, 2009 Medicaid preventive services: concerted efforts needed to ensure beneficiaries receive services.
30. Rosenbaum, S, Wilensky, S, Allen, K. EPSDT at forty: modernizing a pediatric health policy to reflect a changing health care system. Center for Health Care Strategies, Inc; 2008.
31. [Accessed August 27, 2013] Children's Health Insurance Program (CHIP). Available online: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/Childrens-Health-Insurance-Program-CHIP.html
32. [Accessed August 27, 2013] CHIP cost sharing. Available online: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-Cost-Sharing.html
33. 2012 annual report on the quality of care for children in Medicaid and CHIP. Health and Human Services Secretary Kathleen Sebelius; 2012.
34. Kaiser Commission on Medicaid and the Uninsured. Coverage of preventive services for adults in Medicaid. Kaiser Family Foundation; 2012. Available at: http://www.kff.org/medicaid/upload/8359.pdf [Accessed April 17, 2013]
35. Colwill JM, Cultice JM, Kruse RL. Will generalist physician supply meet eemands of an increasing and aging population? Health Affairs. 2008; 27:w232–w241. [PubMed: 18445642]
36. Adams SH, Husting S, Zahnd E, et al. Adolescent preventive services: rates and disparities in preventive health topics covered during routine medical care in a California sample. Journal of Adolescent Health. 2009; 44:536–545. [PubMed: 19465317]
37. 42 C.F.R. § 440.225.
38. [Accessed August 27, 2013] Cost sharing out of pocket costs. Medicaid.gov. Available online: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Cost-Sharing/Cost-Sharing-Out-of-Pocket-Costs.html
39. Patient Protection and Affordable Care Act, Public Law No. 111–148, § 4106, 124 Stat. 855, (March 2010).
40. The uninsured: a primer. The Kaiser Commission on Medicaid and the Uninsured. 2011.
41. Medicaid program; eligiblity changes under the Affordable Care Act of 2010. Department of Health and Human Services. 77Federal Register. 2012;
42. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).
43. Holahan, J, Headen, I. Medicaid coverage and spending in health reform: national and state-by-state results for adults at or below 133% FPL. Kaiser Commission on Medicaid and the Uninsured; 2010.
44. National Federation of Independent Business v. Sebelius. No. 11–393, slip opinion 2012.
45. The Advisory Board Company. [Accessed August 20, 2013] Beyond the pledges: Where the states stand on Medicaid 28 states moving toward expansion. Available at: http://www.advisory.com/Daily-Briefing/Resources/Primers/MedicaidMap#lightbox/2/
46. Estimates for the insurance coverage provisions of the Affordable Care Act updated for the recent Supreme Court decision. Congressional Budget Office; Jul, 2012. Available online: http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf [Accessed April 17, 2013]
47. Updated budget projections: fiscal years 2013 to 2023. Congressional Budget Office; May, 2013. Available online: http://www.cbo.gov/sites/default/files/cbofiles/attachments/44172-Baseline2.pdf [Accessed on January 5, 2014]

48. Congressional Budget Office. Health insurance exchanges: CBO's February 2013 baseline. Feb, 2013
49. Federal Register. Vol. 78. Department of Health and Human Services; 2013. Medicaid and Children's Health Insurance Programs: essential health benefits in alternative benefit plans, eligibility notices, fair hearing and appeal processes, and premiums and cost sharing; Exchanges: eligibility and enrollment; Final Rule.
50. [Accessed May 27, 2014] The coverage gap: uninsured poor adults in states that do not expand. Medicaid Issue Brief. 2014. Available online: http://kaiserfamilyfoundation.files.wordpress.com/2014/04/8505-the-coverage-gap_uninsured-poor-adults-in-states-that-do-not-expand-medicaid.pdf
51. America's Health Care Safety Net: Intact but Endangered. Washington, D.C: National Academy Press; 2000.
52. Public Laws 111–148 & 111–152. Patient Protection and Affordable Care Act Section 10503 2010.
53. Public Laws 111–148 & 111–152. Patient Protection and Affordable Care Act Section 1311 2010.
54. Affordable Exchanges guidance. Center for Consumer Information and Insurance Oversight. Centers for Medicare & Medicaid Services; 2013.
55. State estimates of the low-income uninsured not eligible for the ACA Medicaid expansion. The Robert Wood Johnson Foundation: State Health Access Data Assistance Center; Mar, 2013. Available online: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf404825 [Accessed May 15, 2013]
56. Patient Protection and Affordable Care Act, Public Law No. 111–148, §2001(a)(1), 124 Stat. 855, (March 2010), amending the Social Security Act §1902(a)(10)(A)(i), 42 U.S.C. 1396a.
57. Patient Protection and Affordable Care Act, Public Law No. 111–148, §2001(a)(4), 124 Stat. 855, (March 2010), amending the Social Security Act §1902(a)(10)(A)(ii), 42 U.S.C. 1396a.
58. Patient Protection and Affordable Care Act, Public Law No. 111–148, §1312, 124 Stat. 855, (March 2010).
59. The Affordable Care Act: coverage implications and issues for immigrant families. Office of the Assistant Secretary for Planning and Evaluation (ASPE); Apr, 2012. Available online: http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Coverage/ib.shtml [Accessed April 17, 2013]
60. Patient Protection and Affordable Care Act § 1401. (March 2010).
61. [Accessed August 27, 2013] Quick take: key considerations in evaluating the ACA Medicaid expansion for states. 2013. Available online: http://kff.org/medicaid/fact-sheet/key-considerations-in-evaluating-the-aca-medicaid-expansion-for-states-2/#footnote-note11
62. Statehealthfacts.org. Kaiser Family Foundation; Available online: http://www.statehealthfacts.org/comparemaptable.jsp?ind=868&cat=4 [Accessed May 15, 2013]
63. Sommers BD, Tomasi MR, Swartz K, et al. Reasons for the wide variation in Medicaid participation rates among states hold lessons for coverage expansion in 2014. Health Affairs. 2012; 31:909–919. [PubMed: 22566429]
64. Melichar L. The effect of reimbursement on medical decision making: do physicians alter treatment in response to a managed care incentive? Journal of Health Economics. 2009; 28:902–907. [PubMed: 19395103]
65. Shen J, Andersen R, Brook R, et al. The effects of payment method on clinical decision-making: physician responses to clinical scenarios. Medical Care. 2004; 42:297–302. [PubMed: 15076830]
66. Guy GP Jr. The effects of cost sharing on access to care among childless adults. Health Services Research. 2010; 45:1720–1739. [PubMed: 20819108]
67. Parrish DD, Kent CK. Access to care issues for African American communities: implications for STD disparities. Sexually Transmitted Diseases. 2008; 35:S19–22.
68. Cunningham SD, Tschann J, Gurvey JE, et al. Attitudes about sexual disclosure and perceptions of stigma and shame. Sexually Transmitted Infections. 2002; 78:334–338. [PubMed: 12407233]
69. Cunningham SD, Kerrigan DL, Jennings JM, et al. Relationships between perceived STD-related stigma, STD-related shame and STD screening among a household sample of adolescents. Perspectives on Sexual & Reproductive Health. 2009; 41:225–230. [PubMed: 20444177]
70. Fortenberry JD, McFarlane M, Bleakley A, et al. Relationships of stigma and shame to gonorrhea and HIV screening. American Journal of Public Health. 2002; 92:378–381. [PubMed: 11867314]

71. Lehrer J, Pantell R, Tebb K, et al. Forgone health care among U.S. adolescents: associations between risk characteristics and confidentiality concern. Journal of Adolescent Health. 2007; 40:218–226. [PubMed: 17321421]

72. Nurutdinova D, Rao S, Shacham E, et al. STD/HIV risk among adults in the primary care setting: are we adequately addressing our patients' needs? Sexually Transmitted Diseases. 2011; 38:30–32. [PubMed: 20661176]

73. Irwin CE Jr, Adams SH, Park MJ, et al. Preventive care for adolescents: few get visits and fewer get services. Pediatrics. 2009; 123:e565–572. [PubMed: 19336348]

74. Slive L, Cramer R. Health reform and the preservation of confidential health care for young adults. Journal of Law, Medicine & Ethics. 2012; 40:383–390.

75. Fox, HB; Limb, SJ. [Accessed April 17, 2013] Fact Sheet #5State policies affecting the assurance of confidential care for adolescents. The National Alliance to Advance Adolescent Health. 2008. Available online: http://www.thenationalalliance.org/jan07/factsheet5.pdf

76. Gold RB. Unintended consequences: how insurance processes inadvertently abrogate patient confidentiality. Guttmacher Policy Review. 2010; 12Accessed May 15, 2013

77. English, A, Bass, L, Boyle, AD. , et al. State Minor Consent Laws: A Summary. 3. Chapel Hill: Center for Adolescent Health & the Law; 2010.

78. Why screen for Chlamydia? an implementation guide for healthcare providers. 2. Washington, DC: Partnership for Prevention: Partnership for Prevention; 2012.

TABLE 1

Glossary of Terms, Acronyms, and Initialisms Used Frequently in Discussions of the Impact of the Patient Protection and ACA of 2010 on Chlamydia Screening Among Sexually Active Young Women Aged 25 Years

Term	Definition
ACIP	A group of medical and public health experts that develops recommendations on the use of vaccines to control diseases in the U.S. Identified in the ACA as 1 of 3 bodies whose recommendations must be covered without cost sharing by non-grandfathered group and individual health plans (both inside and outside state and federal health insurance Marketplaces) and within Medicaid expansion.
CHIP	Provides health coverage to children up to age 19 years in families with incomes too high to qualify for Medicaid but who cannot afford private coverage. Like Medicaid, CHIP is administered by the states, but is jointly funded by the federal government and states. Every state administers its own CHIP program with broad guidance from the Centers for Medicaid and Medicare Services.
EPSDT	All children and adolescents enrolled in Medicaid are entitled to EPSDT benefits. The goal of this benefit is to ensure that Medicaid beneficiaries aged 21 years and younger receive age-appropriate screening, preventive services, and treatment services that are medically necessary to correct or ameliorate any identified conditions. This array of services is generally available without cost sharing. In states that run their CHIP programs as an extension of Medicaid, CHIP must include EPSDT, generally without cost sharing. However, in most states, CHIP is run as a separate program that is not required to cover EPSDT and has greater flexibility to impose cost sharing.
ECPs	Per ACA requirements, all health plans participating in state and federal health insurance Marketplaces must include in their networks, as available, “essential community providers” that serve predominately low-income, medically underserved individuals. All entities that currently participate in the 340b drug pricing program and certain other eligible providers qualify as ECPs. Health plans must include a sufficient number and geographic distribution of ECPs in their provider networks.
EHB package	All health plans participating in state and federal health insurance Marketplaces must offer a package of benefits that includes the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. States expanding their Medicaid programs must provide EHBs to people newly eligible for Medicaid.
EOBs	A communication between a health insurance plan and a policyholder listing services provided to any individual covered under a policyholder’s contract.
FPL	Calculation, varying by family size, of the minimum amount of gross income a family needs for food, clothing, transportation, shelter, and other necessities. The FPL is released by the Department of Health and Human Services (DHHS) yearly and used to determine eligibility for certain federal programs, including Medicaid and subsidies provided to families to purchase insurance on the state and federal health insurance Marketplaces.
FQHCs	Health care organizations that receive grants under Section 330 of the Public Health Service Act and qualify for enhanced reimbursement from Medicaid and Medicare. FQHCs must meet certain qualifications, including serving a medically underserved area or population.
Grandfathered health plans	Plans existing before passage of the ACA or those that have not substantially changed (i.e., reduced benefits and/or increased costs to consumers) since passage of the ACA.
HRSA	Agency within the DHHS dedicated to improving access to health care services for the uninsured, isolated, and/or medically vulnerable. Preventive care and screening guidelines supported by HRSA for women, infants, children, and adolescents must be covered without cost sharing by non-grandfathered group and individual health plans (both inside and outside of state and federal health insurance Marketplaces) and within the Medicaid expansion.
HEDIS	A tool used by the majority of US health plans that measures plan performance across a variety of indicators, including chlamydia screening among sexually active young women aged 24 years and younger.
Health Insurance Marketplace	A tool that helps consumers enroll in health insurance. Development of a health insurance Marketplace is a requirement of the ACA and can be done individually by states or by referral to the federal health insurance Marketplace for states without an individual Marketplace.
Medicaid	*Standard*: The nation’s main public health insurance program for low-income people, covering more than 62 million Americans and 1 in 3 children. Medicaid is administered by the states but is jointly funded by the federal government and states. Federal law specifies core requirements that all state Medicaid programs must meet as a condition of receiving federal Medicaid funding. However, beyond the core requirements, states have broad flexibility regarding eligibility, benefits, provider payment, delivery systems, and other aspects of their programs. States are required to offer Medicaid enrollment to certain categorically eligible groups, including low-income children, pregnant women, and parents with dependent children who meet state welfare eligibility (or FPL) levels. Historically, the program has excluded most nonelderly, childless adults. *Expansion*: Expands Medicaid beginning in 2014 to all individuals aged 65 years at or below 138% FPL as part of the ACA. The law eliminates categorical eligibility requirements and standardizes benefits offered to enrollees. Although Medicaid expansion was intended under the law to be mandatory, the Supreme Court ruling in *NFIB v. Sebelius* effectively converted the expansion to a state option. Thus, each state may decide whether to adopt the Medicaid expansion. For states that elect to expand Medicaid, persons newly eligible for Medicaid under the expansion are entitled to a range of “essential

Term	Definition
	health benefits" (term described above). Persons who were eligible for Medicaid before ACA remain entitled to the standard Medicaid benefit provided in the state, which, depending on the state, may be quite different from the EHB package.
Patient Protection and ACA of 2010	A federal statue signed into law on March 23, 2010 which contained multiple provisions designed to reform and improve the delivery of health care
Title X Clinics	A federal grant program created by Public Law 91-572 that provides funding to community-based health care providers offering comprehensive family planning and related preventive health services.
USPSTF	An independent panel of non-Federal experts—mainly primary care providers and national experts in prevention and evidence-based medicine—that works to improve health outcomes by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications. Identified in the ACA as 1 of 3 bodies whose recommendations must be covered without cost sharing by non-grandfathered group and individual health plans (both inside and outside state health insurance marketplaces) and within the Medicaid expansion