Ensuring Young People’s Access to Preventive Services in the Affordable Care Act

Young people need access to a full range of sexual and reproductive health care services. By requiring most health plans to cover preventive services without cost sharing, the Affordable Care Act (ACA) holds the potential to make many critical healthcare services more accessible to young people, including screenings for sexually transmitted infections and HIV, contraceptive care, pregnancy-related care, and HPV immunizations, among other services. Additionally, the ACA has made it possible for many young people to stay on their parents’ plans up to age 26, and those with income under 133 percent of the Federal Poverty Level are eligible for Medicaid coverage. Since young people ages 15 to 24 are more likely to experience unintended pregnancy and STIs than most other age groups, increased access to these services has the potential to make a real difference in many young people’s lives. In fact, it already has: since the implementation of the ACA, young people are significantly more likely to receive a routine examination including preventive care services.

But at the policy level, a number of challenges exist to successful implementation of the preventive services provisions of the ACA, especially those pertaining to reproductive and sexual health. Several high-profile lawsuits have challenged the contraception provisions of the law. In addition, half of states opted out of the Medicaid expansion — meaning young people in those states may not be able to obtain health insurance. These challenges threaten to undermine the ability of patients to benefit from the reforms.

At the level of implementation, insurance plans can create barriers for young adults if they impose additional fees, do not consider confidentiality in billing and claims processes, and do not include coverage for treatment of the conditions screened for in-plan benefits. Young people may also encounter issues with implementation stemming from providers including additional costs, discrimination, or difficulty finding in-network providers who follow clinical recommendations for contraception and testing.

This paper examines the preventive services available to young people through the ACA and how advocates and policy makers can help ensure that young people have access to the health care they need. In the writing of this analysis, Advocates for Youth staff conducted a series of exploratory interviews with state-level experts to investigate the effect of ACA implementation on young people’s access to confidential sexual and reproductive health care services. Advocates reached out to teen pregnancy prevention organizations, health care providers, and public health professionals in Georgia, North Carolina, South Carolina, and Massachusetts.

BACKGROUND

The Patient Protection and Affordable Care Act (ACA) became federal law in 2010. As part of Congress’ vision for comprehensive health care reform, the ACA requires that most health plans provide coverage for certain preventive services without cost-sharing. The language of the ACA, however, does not specify the health care services insurers must offer. Instead, Congress left it up to the Department of Health and Human Resources (Department) to define what preventive services must be covered without a copay or coinsurance. In turn, the Department worked with the Institute of Medicine and the U.S. Preventive Services Task Force to develop a menu of services. Based on these recommendations, beginning in September 2010 most health plans were required to cover preventive services for adults and children without cost-sharing, while the preventive services guidelines specific to women’s health care needs went into effect on August 2012.

PREVENTIVE SERVICES AVAILABLE WITHOUT COST-SHARING

According to the new guidelines, most health plans must now cover a range of preventive services without cost-sharing. The preventive services benefits include sexual and reproductive health care services that are critical for young people, including STI/HIV screenings, access to contraceptives and related services, pregnancy-related care, and HPV immunizations. A comprehensive list...
of the preventive services currently provided without cost sharing is above.

**WHICH PLANS MUST COMPLY?**

While most individuals covered under private health plans have a right to access preventive services without copay or coinsurance, there are three exceptions. Grandfathered plans, self-funded student health plans, and church plans do not have to comply with the no cost-sharing requirement.

Grandfathered plans are plans to which no significant changes have been made since the ACA was signed into law in 2010. This is a shrinking minority of all plans – about 36 percent of workers in 2013 were on grandfathered plans and the figure was expected to decrease further in 2014. Self-funded student health plans, offered at some 30 institutions, are not regulated by the ACA either. These plans are maintained by educational institutions instead of through third-party insurers like many other insurance plans. Finally, individuals insured under a special class of employer-sponsored health plans called church plans do not have to provide no cost-sharing contraception under the preventive services mandate.

Although at publication, for-profit and nonprofit organizations have challenged the contraceptive coverage mandate on religious grounds with varying success, these suits have not yet affected employee and student coverage for individuals insured outside of church plans.

**WHEN ARE THESE SERVICES COVERED?**

Even when a health plan is governed by the no cost-sharing requirement, in some instances covered individuals may still have to pay out of pocket for preventive services.

Insurance plans are only required to cover services with no cost-sharing when patients see an in-network health care provider. Under the ACA, plans do not have to fully cover preventive services when they are furnished by out-of-network providers.

When it comes to prescription drugs, such as birth control, health plans are free to determine which brands to include in their formularies. Individuals may have to pay out of pocket if they are prescribed a brand that is not covered.

Even when the services accessed are fully covered themselves, there are some billing scenarios permissible under the ACA that allow a facility to charge for an office visit. This is
VOICES FROM THE FIELD

“We've heard about some issues in accessing care since implementation. For example: Providers may be refusing to write prescriptions for teens without parental consent, or they may be charging facility fees. State insurance commissioners may be refusing to enforce regulations. Plans may be failing to comply with the new cost-sharing restrictions. Colleges and universities may be refusing to implement required services as well, two biggest offenders being Catholic Universities who are choosing not to offer contraception care in their student health insurance plans AND insurance companies deciding which contraception (not all contraception) to offer with no copay. Only generic brands might be offered without cost-sharing, and people are reaching out to us to know what rights they have. “I can't take the generic option” or “that is not what my doctor prescribed”. – Health care advocate in Massachusetts

PREVENTIVE SERVICES & MEDICAID

Many individuals accessing care through Medicaid also have a right to obtain certain preventive services without copay, and state programs have the option of covering additional services.

Medicaid is a joint program between federal and state governments providing health care coverage for low income individuals. Under the ACA, states have the option of expanding Medicaid coverage to those with incomes up to 133 percent of the Federal Poverty Level. This newly eligible group (called the Medicaid expansion population) must receive the same coverage for preventive services as private health plans outlined above. Medicaid expansion holds the potential to greatly increase coverage among low-income young people for preventive health care services.

For those individuals who would otherwise be Medicaid eligible without expansion (the traditional Medicaid population), some but not all preventive services are offered without copay or coinsurance. For example, no state programs may impose cost sharing on preventive services for youth under 21 under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. The EPSDT benefit covers a range of sexual and reproductive health services for adolescents, including STI screenings and immunizations. Furthermore, programs cannot require cost-sharing for individuals accessing reproductive health services through the Medicaid family planning program. Both the EPSDT and family planning programs are mandatory.

Unlike the expansion group, state Medicaid programs are not required to provide adults in the traditional Medicaid population with coverage for additional preventive health care services without cost-sharing. However, the ACA gives states the option of fully covering additional preventive services for adults in exchange for an increase in federal matching funds. These optional services include STI/HIV screening and counseling, cervical cancer screenings, HPV immunizations, and pregnancy-related services. Many states have opted to cover one or more of these recommended preventive services for adults without cost-sharing.

ENFORCEMENT OF THE ACA

The responsibility to enforce the ACA’s preventive services benefit falls on both federal and state agencies that are charged with implementing the law.

At the highest level, federal agencies are responsible for administering the ACA’s provisions. Some provisions of the ACA, including the preventive services benefit, modify laws currently under federal agency jurisdiction including the Public Health Services Act (PHSA), the Employee Retirement Income Security Act (ERISA), and the Internal Revenue Code (IRC). The U.S. Departments of Health and Human Services, Labor, and the Treasury have authority to enforce these three laws, and will likely enforce the amended sections under existing frameworks. For example, ERISA governs employer-sponsored health plans and is therefore enforced by the Department of Labor. Thus, if an employer-sponsored plan was not covering contraception without cost-sharing, a claim could be brought through the Department of Labor. Similarly, governmental plans, such as state employee plans, are regulated by the Department of Health and Human Services. The Department of Treasury oversees all tax issues and has jurisdiction over employer-sponsored group health plans through the imposition of tax penalties. The Department of Treasury also oversees self-insured health plans offered by religious institutions to employees of houses of worship – plans that are exempt from many of the ACA’s requirements.

State agencies also share in the responsibility for enforcement. Most states are required to work with the federal government to enforce the market reforms and consumer protections guaranteed by the ACA. State Insurance Commissioners must approve all health plans sold in their states and have primary responsibility for oversight of the benefits offered. Commissioners are able
to use their plan approval procedures and audit powers to regulate the market and hold insurers accountable. Additionally, consumers can file complaints against plans through state commissioners.25

The National Association of Insurance Commissioners (NAIC) has proposed model language, best practices and technical assistance for state-level commissioners related to consumer appeals processes. Model standards may create the opportunity for national uniformity, but insurance regulation is generally highly variable state by state. For effective regulation of plans, states will also have to carefully monitor and report key data to illuminate compliance issues.26

**BARRIERS TO ACCESS FOR YOUNG PEOPLE**

The ACA's preventive services benefits hold the potential to improve youth access to critical sexual and reproductive health services. But some young people continue to face barriers to using their health coverage to obtain care. Although young people must be enrolled in ACA-regulated plans to receive preventive services without cost-sharing, enrollment alone does not guarantee access. Some important remaining obstacles include a lack of awareness of eligible benefits under the new law, lack of youth confidentiality, and discomfort and stigma.

**Awareness of Benefits under the ACA**

Many young people remain unaware of the ACA's preventive services benefit and the importance of timely preventive sexual and reproductive health care. In a 2014 survey by Advocates for Youth, only 26 percent of 18 to 29 year olds knew that insurance plans must cover preventive care with no copay or other costs.27 Latino young people were the least knowledgeable (15 percent) compared to African American (25 percent), Asian Pacific Islander (28 percent) and Caucasian (30 percent) young people. Even those who do seek out services from a provider may be mistaken about the services they've received. For example, although approximately 4 in 10 women reported being tested for HIV/STIs, about half mistakenly assumed the test was a part of a routine examination. Moreover, lack of knowledge about sexual and reproductive health care and fear keep youth from seeking care in the first place. Limited information about the importance of testing or where to go for care, a fear that peers will find out they are at risk for or have an STI, and fear of discrimination stop some young people from accessing services.

**CASE STUDY: LONG ACTING REVERSIBLE CONTRACEPTION AND THE ACA**

There are many barriers to services young people may seek out under the ACA. Long-acting reversible contraception, or LARCs, provide one such example. A lack of awareness of benefits, confidentiality concerns, and discomfort and stigma on the part of providers all play a role and contribute to low rates of use of LARCs in young people, even though LARCs are highly effective at preventing pregnancy and are cost effective over time.

Although LARCs are highly effective, recommended by major medical organizations for young women who wish to prevent pregnancy,22,23 and should be covered without copay under most health plans, few young women are using them. According to one study, less than 5 percent of young women ages 15-19 were currently using a long-acting method, such as an injectable or intrauterine device (IUD).23

A lack of training and knowledge on LARCs, as well as problems with reimbursement and coverage contribute to low rates of use. Surveys of clinicians show a shortage of providers who are trained and knowledgeable about LARC methods. This may be due in part to low rates of reimbursement. If providers feel they are adequately paid for time spent counseling and delivering LARCs, they are more likely to seek training.24 Moreover, patients may not be receiving full coverage of LARCs despite the ACA's coverage of preventive services without cost-sharing. A study of early implementation of the ACA provisions showed that most women were receiving contraception methods at lower cost than before reform, except for women using LARCs. This suggests that providers are charging facility fees for insertion, imposing additional costs for follow-up care and removal of devices, or that health plans are out of compliance with the law.25 Finally, as was previously discussed, young people may fear that LARC consultation and provision may be revealed to their parents in billing and paperwork.

“Health insurance plans seem to be choosing what they want to cover; most times LARCs are not covered. We are definitely seeing that problem with LARCs where people are told there is no generic LARC, so one cannot be provided. It differs from plan to plan, so it is hard to understand where the problem is. Is it the pharmacy? The insurer? Or the doctor?” – Health care advocate in South Carolina

**VOICES FROM THE FIELD**

“The biggest barrier may be adolescent awareness of where they can access services. Young people aren’t getting information about where to access services.” – Health care advocate, North Carolina

“There was a big enrollment campaign, but no public information campaign on the services that are available to young people.” – Health care advocate, Massachusetts
Confidentiality & Consent

State laws and insurance policies that fail to secure young people’s confidentiality deter youth from accessing sensitive health care services, including sexual and reproductive health preventive services. In a recent survey, 71 percent of young women ages 18-25 rated confidentiality as important when receiving health care, including sexual health services. Numerous studies confirm that confidentiality is critical to getting young people the care they need.

In general, states require parental consent before a health care provider treats a minor patient. However, most states specify some medical services to which minors may independently consent. These statutes are based on the fact that minors may be deterred from seeking sensitive health care services if they have to notify their parents. For example, in all jurisdictions minors may consent to STI screening and treatment without the consent of a parent. In most but not all jurisdictions, at least some minors can independently consent to contraceptive services as well.

Widespread insurance communications practices inadvertently risk compromising the confidentiality of youth insured as dependents. An insurer issues an explanation of benefits (EOB) to a policyholder when any benefits are rendered under a plan. When young people access care through their parents’ health plans, EOBS and other insurance communications disclose sensitive medical information to their parents. For example, a report from Colorado found that young people living with HIV/AIDS who are covered under their parents’ plans as dependents are faced with the choice of disclosing their HIV status to their parents or not accessing HIV care through insurance coverage, since parents receive copies of medical bills/payments. The issuance of EOBS is often mandated or presumed under state law, and is intended as an anti-fraud measure. In response to the threat to youth confidentiality, at least 8 states have passed statutes or promulgated regulations to secure greater privacy protections for individuals insured as dependents.

Discomfort & Stigma

Discomfort and stigma contribute to poor communication between health care providers and youth, creating an obstacle for young people to access sexual and reproductive health care.

First, young people may be uncomfortable discussing their sexual health with providers. Teens are unlikely to bring up concerns or risky behaviors with their provider, especially with a parent present. Teens may be especially sensitive to what they perceive as rude, dismissive or judgmental responses from providers. As a result, providers may miss the opportunity for discussions about preventive care with sexually active youth.

Additionally, providers may not feel adequately prepared or effective when providing counseling on sexual and reproductive health. In a study of physician attitudes on STI services and contraception, most providers reported low confidence and barriers such as a lack of training and time constraints. Furthermore, providers are not confident that their counseling efforts are effective, even when they feel comfortable engaging their patients; 70 percent believed their counseling was ineffective. Only half of providers report that their medical training on STI prevention, counseling, and treatment was adequate. As a consequence, many young people who do visit health care providers do not receive the counseling and care they need.

Other barriers for youth to clinical services include a lack of transportation, inconvenient clinic hours, and challenges making an appointment and navigating the health system. Patients who do not speak English as a first language may not have the same comfort, counseling, and education during care as a native English speaker. Finally, the clinic environment can further discourage youth from seeking care, particularly where it is not perceived as a private, accessible, and non-judgmental space.

VOICES FROM THE FIELD

“One issue that has come up for young people on their parents plan is confidentiality. In Massachusetts all health plans, except Medicaid, send out explanations of services rendered to the plan holder. Young people are concerned about accessing contraception and abortion services because they don’t want notices being sent to their parents. We are trying to craft legislation to change that. Medicaid does NOT send out explanations, which is why young people, prior to the ACA, utilized it. There is general confusion and misinformation about the preventative services, and what services are covered without copay. When does it go beyond an annual well woman’s visit? If a doctor orders a test that’s not offered in that category, who ends up paying for it?” – Health care advocate, Massachusetts
RECOMMENDATIONS FOR POLICYMAKERS, PROVIDERS & ADVOCATES

Young people need access to a full range of sexual and reproductive health care services. While the ACA holds the potential to expand coverage of many of these services, young people still face significant obstacles in accessing affordable, confidential care. Policymakers, health care providers, and advocates should take action to remove these barriers by ensuring young people have coverage, educating young people on their benefits under the law, and safeguarding youth-friendly care.

RECOMMENDATIONS FOR POLICYMAKERS

Policy makers should:

- Expand efforts to educate and enroll all eligible individuals in coverage. Youth who qualify may be encouraged to apply for their own individual coverage where possible, rather than as a dependent.
- Put clear enforcement and investigation mechanisms in place to guarantee health plans comply with coverage regulations.
- Create benchmarks and tools to track implementation, especially issues regarding plan design, care delivery, and youth access.
- Consider making state-level mandates for contraceptive coverage.
- Raise awareness among the general population and young people about new preventive services covered under the ACA through ad campaigns, educational materials, and targeted outreach.
- Institute professional development for providers for delivering preventive services to youth, especially LARC methods.
- Ensure that youth have the right and ability to access important services by overturning or guarding against parental consent laws and other threats to confidentiality.
- Ensure funding for Title X is maintained by Congress to strengthen the safety net, and promote funding for Federally Qualified Health Centers, family planning clinics and coordinated care models.

VOICES FROM THE FIELD

“Many providers don’t care or don’t want to learn how to counsel these young people about their choices. Time (and procedures done) is money, so counseling is virtually nonexistent. Providers function in their own vacuum and may or may not know what the law is, and if there is a fear of legal repercussion, they will not function the way the law says they must. “ – Health care advocate, Georgia

RECOMMENDATIONS FOR PROVIDERS

Providers should:

- Participate in efforts to enroll individuals through outreach and education to currently uninsured patients.
- Work with insurance companies to make sure they include preventive service coverage in offered health plans and only contract with plans that do so.
- Avoid additional charges to patients for services, specifically LARC methods. Work with insurance companies or policymakers to provide adequate reimbursement that does not require cost-sharing.
- Raise awareness among all patients about new preventive services.
- Educate youth about their risk of unplanned pregnancy and STIs, as well as the importance of contraception and testing.
- Understand the federal and state consent, confidentiality, and non-discrimination laws governing provider practice.
- Develop protocols in clinics that increase health literacy and understanding.
- Train providers to effectively serve adolescents in an inviting and confidential environment that includes conversations about sexual health and prevention.
- Meet the practical needs of youth, for instance, by keeping flexible hours and providing more than a month’s supply of contraception at a time, especially on site at the clinical location.

VOICES FROM THE FIELD

“In Massachusetts, all health plans, except Medicaid, send out explanations of benefits rendered to the plan holder. Young people are concerned about accessing contraception and abortion services because they don’t want notices being sent to their parents. We are trying to craft policy to change that.” – Health care advocate, Massachusetts
Understand importance of primary prevention (contraception and condoms, education) before the onset of sexual activity, with screening used as secondary prevention.

Encourage primary care providers that offer comprehensive services to offer sexual health services to youth as well. Research shows that young people, especially males, feel more comfortable accessing sexual health services where they can also access sports physicals and general care.

VOICES FROM THE FIELD

“At least some providers in [our state] have been unwilling to provide contraceptive services without parental notification. This wasn’t because they thought parents should know. It was because they wanted to know they’d get paid, and parents are the ones who usually have the insurance cards … they were concerned they wouldn’t be compensated for the services. [We] approached one such provider … Some providers probably continue to do this though.” – Health care advocate, Georgia

RECOMMENDATIONS FOR PROGRAM PLANNERS

Advocates and program planners should:

- Monitor implementation of Medicaid expansion where it exists to make sure it is done smoothly and comprehensively.
- Work to persuade all states to expand Medicaid. Call for special legislative sessions and ballot initiatives.
- Advocate for non-citizens and new citizens to access insurance coverage, Medicaid and other services.
- Assist youth navigating the medical system, including filing appeals when plans deny claims or are out of compliance with coverage requirements. Raise awareness among population about new preventive services.
- Educate young people about their care options and locations, how to navigate a medical system, and where to find care.
- Empower youth to know their rights and state laws about confidentiality. Educate providers on these policies as well.
- Undertake professional development efforts so that providers have the knowledge they need to deliver youth-friendly services in line with clinical guidelines, including proper counseling and testing is being provided.
- Advocate for confidentiality policies for adolescent and young adult patients.
- Educate and assist providers to develop confidential ways to bill for services.

VOICES FROM THE FIELD

“We are doing work in North Carolina to increase provider awareness of best practices around working with adolescents. These best practices include same day appointments with adolescents, weekend appointments, counseling for methods of birth control, promoting LARCs, educating providers around how safe LARCs are and the benefits of encouraging adolescents to use LARCs, having time alone with adolescents on a visit. Providers say that parents want to remain during visits and providers are having a hard time making that transition. We’re also making sure that providers are doing either self-reported history on sexual health, or that it is done with the professional at the visit. These are just a few of the best practices we are working on.” – Health care advocate, North Carolina
The ACA is a collection of reforms related to many areas of the health care delivery system and insurance market. The most well-known provisions are those that broaden access to affordable insurance coverage, from eliminating eligibility exclusions to requiring all Americans attain an insurance policy. In addition to reforms that will lead to more people being insured, the ACA mandates that certain screenings and contraception be available through insurance plans without cost-sharing (co-payments, co-insurance and deductibles).25

The sections of the law that expand insurance coverage to young people and the provisions that relate to covering preventive services, contraception and family planning are outlined below.

**ACA §1001: PREVENTIVE SERVICES, CONTRACEPTION & EXTENDED COVERAGE**

Section 1001 of the ACA modifies Section 2713 of the Public Health Service Act to require that “a group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost-sharing requirements for—

(1) evidence-based items or services that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force;

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.

(5) for the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.26

The law relies on expert guidance from the U.S. Preventive Services Task Force (USPSTF), which creates clinical guidelines for preventive services. Coverage is required for all services the Task Force deems most effective and advisable, as indicated with an A or B grade. The Health Resources and Services Administration (HRSA) also requested the Institute of Medicine (IOM) to make recommendations for women’s preventive health services to supplement the Task Force guidelines.26 The resulting guidelines, updated regularly based on scientific evidence and practice, include many standard medical screenings and immunizations, all FDA-approved contraceptive methods as prescribed, STIs risk assessment, screening and counseling (including chlamydia, HIV, gonorrhea, syphilis, HPV), immunizations for HPV, and other behavioral health screenings and counseling.27 (USPSTF, January 2014.)

Cost-sharing for services in not allowed when the services are “not billed separately from the office visit and [are] the main reason for the office visit.” There may be circumstances for which the insurance company can still impose a co-payment for an office visit, particularly if the screenings are not the reason for the visit.28 The ACA prohibits insurance companies from charging beneficiaries for the services when performed by in-network providers. However, according to the provisions of the law, if there is no in-network provider to deliver the service, the beneficiary can receive the service without cost-sharing from an out-of-network provider.29
Prescriptions from a provider are required for contraceptive methods (including the pill, patch, ring and LARCs). Cost-sharing may apply for non-prescription and over-the-counter contraceptive methods. Over the counter products can be obtained without cost-sharing with a prescription, such as emergency contraception. If a generic equivalent of a prescribed method is available, the plan may charge for the brand name drug. A waiver process is available for women whose provider determines that a brand name drug is the best method for her. Condoms and vasectomies for men are not covered without cost-sharing.7

Section 1001 also requires insurance companies to allow unmarried dependents of policyholders to remain on health plans up to 26 years old, extending an important coverage option for young adults on their parent’s plans. More than 3 million young people have gained access to coverage under this provision.

**ACA §1302: ESSENTIAL HEALTH BENEFITS**

The establishment of 10 categories of “Essential Health Benefits” creates a standard core of benefits for plans offered in individual and group markets, both inside and outside of the exchanges (or “marketplaces”) created by the ACA, and for those insured in the Medicaid expansion. Plan benefits must include: 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. While these benefits must be included in plans, they may be subject to cost-sharing, unless they are services covered by Section 1001 (see Figure 1).30

**ACA §1557: PROHIBITS DISCRIMINATION**

Section 1557 prohibits discrimination based on age, sex, gender identity, race, nationality and disability, in any health program or activity funded or administered by the federal government, including the preventive service provisions of the ACA, the health insurance exchanges, Medicaid and others. It is the first federal law to prohibit sex discrimination in the health care system.31 The non-discrimination provisions in the ACA prohibit insurers from using exclusions, spending maximums and premium rating of patients who may be more costly based on their health status, race, age, or gender. The “guaranteed issue” standard must apply to all new plans.32 The requirement extends from plan design to marketing and assistance provided in applying for coverage. The provision ensures that groups will not be subjected to arbitrary limits or exclusions in their insurance plans or provided lower quality care.

**ACA §2001: MEDICAID EXPANSION**

Medicaid is a health coverage program, managed by the states and governed by the federal government, which provides insurance to children and adults below certain income thresholds, disability, and other means tests. Before the ACA, Medicaid eligibility was only open to very poor children and their mothers in most states, so many low-income Americans were excluded from coverage. The ACA established more generous eligibility criteria in all states to a standard income threshold – up to 138 percent of the Federal Poverty Level (FPL) – for men and women.33

The ACA’s coverage requirements for contraception, preventive services and EHBs apply to the plans the “newly eligible” group receives, while states receive a subsidy to provide the “traditional” Medicaid beneficiaries with a similar level of coverage. However, the legality of this expansion was challenged and the Supreme Court overturned the mandate. As will be discussed in more detail below, it now is optional for states to expand the program, and while the federal government is paying the majority of the cost for the newly eligible populations, about half of states are “opting out.” If states did elect to expand Medicaid, they were required to amend their State Plan (the federally-approved structure and rules governing the program in each state). States were allowed to “phase-in” coverage for newly eligible as early as 2010.31

**ACA §2004: MEDICAID COVERAGE FOR FORMER FOSTER YOUTH**

The ACA grants Medicaid coverage up to age 26 to former foster children who did or otherwise would age out of state assistance at 18 years old. This measure insures approximately 180,000 youth who, as a group, have an increased risk for mental health problems and barriers to health care, and fewer social and financial resources.33

**ACA §2303: OPTION FOR FAMILY PLANNING UNDER TRADITIONAL MEDICAID**

Individuals enrolled in Medicaid before the ACA was enacted will still be treated under pre-ACA guidelines, even in states expanding
the program. This creates two groups under Medicaid – traditional and newly-eligible – which have different rules and benefits. States are not required to meet new preventive services requirements for the traditional group. As an alternative, Section 2303 creates a new option for states to extend family planning-specific plans to a broader group. Under Section 2303, family planning services will be reimbursed by the federal government at an elevated rate, up to 90 percent. Including counseling for contraception and STIs, screening and (in some cases) treatment. Many states actually already offered this broader family planning coverage through special demonstration projects or “waivers” prior to the ACA because they recognized the importance and cost-effectiveness of this category of services. This provision is one of many that raise the bar for coverage of preventive services across all insurance types.

**ACA §2953: PERSONAL RESPONSIBILITY EDUCATION FUNDING**

In order to prevent teen pregnancy and disease transmission, this provision funded Personal Responsibility Education grants to states and tribal organizations for education programs. The allocation was $75 million per year through 2014. Section 2953 specified that funding would be for education about both abstinence and contraception, and other “innovative teen pregnancy prevention strategies and services to high-risk, vulnerable, and culturally under-represented populations,” including “research and evaluation, training, and technical assistance.”

**ACA §4106: ADDITIONAL FUNDING FOR MEDICAID PREVENTIVE BENEFITS**

In addition to the other provisions boosting Medicaid’s capacity to provide family planning services, this section increased the federal payment to states by 1 percent in order for them to enhance coverage of preventive benefits for traditional Medicaid beneficiaries without cost-sharing.

**NOTE ON ABORTION COVERAGE**

For several statutory reasons, the ACA does not create access to abortion coverage in the way it does other reproductive health care. In addition to the federal Hyde Amendment, which has banned abortion coverage in Medicaid except in cases of rape, incest or threat to the life of the pregnant woman since 1976, the Nelson Amendment of the ACA mandates that all plans offered on the insurance exchanges segregate funds for abortion coverage from funds for other care. Further, the ACA allows states to take a step further and outlaw abortion coverage in insurance products sold in their state. Twenty-one states have enacted such laws for plans sold in the exchange, including eight states that ban insurance coverage of abortion altogether. The law explicitly prohibited The Department of Health and Human Services from including abortion services in the Essential Health Benefits. These restrictions add further barriers to women seeking abortions, on top of other state-based laws such as provider limitations, notification laws or mandatory wait-periods.
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MISSION
Established in 1980 as the Center for Population Options, Advocates for Youth champions efforts to help young people make informed and responsible decisions about their reproductive and sexual health. Advocates believes it can best serve the field by boldly advocating for a more positive and realistic approach to adolescent sexual health.

OUR VISION: THE 3RS
Advocates for Youth envisions a society that views sexuality as normal and healthy and treats young people as a valuable resource.

The core values of Rights. Respect. Responsibility.® (3Rs) animate this vision:

RIGHTS: Youth have the right to accurate and complete sexual health information, confidential reproductive and sexual health services, and a secure stake in the future.

RESPECT: Youth deserve respect. Valuing young people means involving them in the design, implementation and evaluation of programs and policies that affect their health and well-being.

RESPONSIBILITY: Society has the responsibility to provide young people with the tools they need to safeguard their sexual health, and young people have the responsibility to protect themselves from too-early childbearing and sexually transmitted infections (STIs), including HIV.

SOME RELATED PUBLICATIONS FROM ADVOCATES FOR YOUTH

The Affordable Care Act: Preventive Services and Barriers to Care for Teens and Young Adults

Policy Brief: Youth Confidentiality in the Affordable Care Act.

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