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Holding on to health reform and what we have gained for reproductive health

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Amid all the debate and hysteria around abortion in health reform, one of the crucial truths obscured is that the passage of the Patient Protection and Affordable Care Act in March 2010 [1] brought with it the promise of substantial improvements in insurance coverage of other reproductive health services in the United States. Expanded insurance coverage generally and new protections for the scope of services covered and patients' access to care have the potential to make family planning, maternity and sexually transmitted infection services more affordable and accessible. Yet, implementation of the overhaul faces several major, intertwined challenges, including a historic budget crisis affecting Medicaid and other health programs and an equally historic shift in political power with the November 2010 elections. As a result, we stand to lose these major gains even before they are fully realized.

1. Expanded insurance coverage

One of the primary impetuses for health-care reform was to address the large numbers of US residents who lacked health insurance—about 51 million people in 2009, amounting to 19% of the US population younger than 65 years [2]. That number includes nearly 14 million women of reproductive age (15–44 years), 22% of women in that age group [3]. Projections from the nonpartisan Congressional Budget Office indicate that the Affordable Care Act will, if implemented as written, make substantial inroads on this problem: 32 million fewer US residents would be uninsured than would otherwise be the case by 2019 [4].

About half that increase in coverage, 16 million, will be through the largest expansion to Medicaid since the program was established in 1965: All Americans with family income below 133% of the federal poverty level ($24,352 for a family of three for 2010) will become eligible for the program, starting in 2014. The greatest impact of this eligibility expansion will be for childless adults, who are almost entirely excluded from most states' programs today. In terms of reproductive health, this will allow Medicaid to help millions of women and couples time their first birth and will allow for a real conversation about preconception care.

The rest of the increase in coverage will come through private insurance purchased through the new health exchanges to be established by the states, also starting in 2014. American citizens and legal residents with incomes between 133% and 400% of poverty—most of those expected to make use of the exchanges—will be eligible for federal subsidies to help them afford the premiums and cost-sharing. Small employers, and perhaps larger ones eventually, also will be allowed to purchase plans through the exchanges.

Because these major expansions require years of preparation, the law also included a number of provisions to expand coverage in the short term. Under one of the most publicized of these provisions, private plans that cover dependent children must now extend that coverage to adult children younger than age 26, following the lead of laws passed in recent years in about half the states. This provision has the potential to help address the historically high levels of uninsurance among young adults and, in the process, that age group's comparatively high levels of unintended pregnancy and sexually transmitted infections (STIs) [2,5,6]. This expansion of dependent coverage makes it all the more critical to address long-standing confidentiality concerns: private insurers' claims-processing procedures can inadvertently undermine

confidentiality for sensitive services, notably by sending explanation-of-benefits forms to the policyholder, who may be a parent or spouse [7].

Another immediate provision of the law, and one that is particularly salient for reproductive health, allows states to expand Medicaid coverage specifically for family planning services to women and men up to the same income eligibility levels they use for pregnancy-related care, typically around 200% of poverty. This provision builds on the experiences of the 21 states that have already implemented such an expansion via a burdensome process to receive a federal "waiver" from Medicaid law [8]—a process states can now avoid because of the legislation.

2. New coverage protections

Other provisions in the Affordable Care Act are designed to ensure that newly insured Americans have coverage of and access to the services they need, including those related to reproductive health. For individuals who will be joining Medicaid, those standards will not change significantly: all Medicaid recipients were already guaranteed coverage of family planning services and supplies and of prenatal care, labor and delivery, and 60 days of postpartum care. Both of those packages of services come without cost-sharing for recipients, and states have almost universally been expansive in the list of specific methods and services they cover under each package [9,10].

Coverage in the private insurance market is more variable, but the law will help standardize plans in several ways. Starting in 2014, all plans offered through the new exchanges or in the individual or small group markets outside of the exchanges will be required to cover an "essential health benefits package" for all enrollees. The legislation specifies 10 broad categories of services in that package; that includes maternity care, closing a current, major coverage gap in the individual and small group market. Only 12% of individual insurance plans included comprehensive maternity coverage in 2008, according to a nationwide study of more than 3500 such plans [11].

The final package will be filled out in more detail by federal regulation but is supposed to reflect current insurance practices and the needs of different populations, including women; assuming the process is protected from political influence, it can be expected to include coverage of a broad range of reproductive health services, including those related to family planning, STIs and reproductive cancers. For example, about 95% of typical employer-based insurance plans cover major contraceptive methods such as the pill, the injectable and the IUD [12], and 27 states require insurers that cover prescription drugs in general to provide coverage of the full range of contraceptive drugs and devices approved by the Food and Drug Administration [13].

Many reproductive health services have already been required in all new private plans, under a provision that requires them to cover a range of preventive health services without any out-of-pocket costs to consumers, such as copayments or deductibles. An initial list of protected services, based on three sets of existing government-supported guidelines, began affecting plans in September 2010. That initial list includes breast and cervical cancer screening, screening and counseling for HIV and several other STIs, vaccination for human papillomavirus, numerous

components of prenatal care and pediatric care that for adolescents includes counseling for reproductive health issues [14].

The list of protected preventive services will be expanded in 2011 when the Department of Health and Human Services, assisted by a panel convened by the Institute of Medicine, settles on more comprehensive recommendations for women's preventive health care, although the new requirements may not be phased in for most women's coverage until January 2013. This fourth set of guidelines was required under a provision authored by Sen. Barbara Mikulski (D-MD) that was intended by its author and supporters to include contraceptive counseling, services and supplies, as well as other key services, such as an annual well-woman examination. The Institute of Medicine has been brought in to ensure that the recommendations reflect current, reputable scientific evidence, as well as the legislative history of the amendment and precedents in federal law and policy.

Finally, the Affordable Care Act includes a wide range of other provisions to prevent abusive practices seen commonly in the current private insurance market. Most notably for reproductive health, all new private plans must now allow women to visit a specialist for obstetric or gynecologic care without referral or prior authorization. Starting in 2014, private plans will be barred from denying or limiting coverage because of preexisting medical conditions, such as a prior cesarean section (a protection that became active for minors in September 2010) and from charging higher premiums to women than to men, a common practice known as gender rating.

3. The dangers ahead

All of this progress—much of it not yet crystallized—is beset by serious threats. First, the law continues to face numerous legal challenges that will almost certainly end up decided by the US Supreme Court. These challenges, the most significant of which focus on the law's requirement that all individuals have coverage and its unprecedented expansion of Medicaid, could affect key pieces of the law or unravel it completely.

Second, state Medicaid efforts are facing potentially draconian cutbacks, with some states going so far as to float the idea of withdrawing from the program entirely [15]. This sets up a collision with health reform's dramatic Medicaid expansion. For women of reproductive age, the timing is horrendous: just from 2008 to 2009, 2.3 million of these women lost private insurance coverage. Even though Medicaid took up some of that slack, 1.3 million more women of reproductive age ended up uninsured [3]. As a result, many more of them are turning to safety-net family planning centers, more than half of which have reported layoffs, hiring freezes, longer waiting times or cutbacks in services [16,17].

The third looming threat for health reform comes from the conservative landslide in the recent election. The new Republican leadership in the US House of Representatives has made opposition to the Affordable Care Act a centerpiece of its agenda. President Obama and the diminished Democratic majority in the Senate should be able to block the law's outright repeal. Yet, the law's opponents in Congress will also attempt to undermine it with piecemeal changes to unpopular provisions (such as the individual mandate), disrupt the funding needed for the

administration to issue regulations and set up new programs, and harass the administration at every turn in the guise of oversight. Meanwhile, a newly more conservative roster of state legislators, governors and other officials will have numerous opportunities to undermine the law's implementation, both generally and in terms of its potential benefits for reproductive health, and they will have the states' horrific budget situations behind which to hide. After all, it will fall to the states to set up and run the new exchanges and the expansion of Medicaid.

4. Next steps for reproductive health advocates

Those who care about coverage of reproductive health services have ample work ahead of them. As we see it, they have three main tasks.

First, they will be called on repeatedly to fend off the attacks on the Affordable Care Act that opponents of the law can be expected to make incessantly over the next several years, as the 2012 elections loom. That includes both broadside attacks on the legislation at large, as well as shots targeted at the gains for reproductive health services specifically. Notably, family planning opponents are loudly objecting to the potential inclusion of contraceptive services and supplies as a category of preventive services to be covered by all plans, and many have called for a broad-based exemption to coverage mandates for insurers or employers who object to care on religious grounds.

Second, reproductive health advocates will need to work with federal and state policymakers to promote the optimal implementation of key provisions of health reform. Broadly, they will need to keep a watchful eye as the federal and state governments set up the major infrastructures of health reform, including the scope of the essential benefits package, the structure and authority of the exchanges, and all that needs to be done to make the massive expansion to Medicaid work for individuals needing care and the safety-net providers seeking to meet the expected surge in demand. More specifically, advocates should help make the case to state officials that it is in the best interest of their residents and their own budgets to take up their new authority to expand Medicaid eligibility for family planning services; new Guttmacher Institute projections indicate that this would help prevent thousands of unintended pregnancies, while saving millions of public dollars [18]. By assisting women to avoid unintended pregnancies and plan when and how many children to have, publicly funded family planning saves taxpayers $3.74 for every $1 spent providing contraceptive care [19]. Advocates may also need to collaborate with policymakers and insurance officials to address issues of confidentiality for sensitive services.

Finally, even as we work to preserve and fully realize the promise of health reform, we face the herculean task of convincing Congress to fix what they have gotten wrong, including the outright exclusion of undocumented immigrants not only from Medicaid and federal subsidies for private insurance, but also from even purchasing coverage on the exchanges with their own money. Moreover, the promise of Medicaid coverage for millions under health reform brings with it an unprecedented expansion of the reach of the decades-old Hyde amendment, which prevents federal dollars from going toward abortion coverage under the program, except in the most extreme circumstances. More than two thirds of the new Medicaid enrollees are projected to be residents of states that have not chosen to counter this ban by using state revenues [20].

Although by contrast, exchange plans may include abortion coverage, the law sets up complicated systems for insurers and consumers designed to ensure that federal dollars do not go toward abortion coverage or services. These administrative hurdles, combined with attacks on abortion coverage by state policymakers, may end up dissuading insurers from offering the coverage at all. In the face of these dangerous restrictions, supporters of reproductive health will have the dual challenge of fighting off attempts at making them even more egregious while trying to make the case to the American public that abortion is basic health care that must be covered in both public and private insurance.

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