The Affordable Care Act and Reproductive Health: Potential Gains and Serious Challenges

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Abstract

After nearly a century of failed or incomplete legislative efforts, the Patient Protection and Affordable Care Act (PPACA), enacted by Congress in March 2010, establishes the principle that every American is entitled to affordable and effective health insurance coverage regardless of income or health status. Although many aspects of the act have received broad attention, its impact on reproductive health has received considerably less scrutiny, except when debated through the specific lens of particularly polarized ideological concerns. If fully implemented as planned, the PPACA has the potential to improve reproductive health in the United States in at least three ways: increasing the number of women and men with insurance coverage; increasing the value of insurance coverage for addressing reproductive health needs; and improving access to reproductive health services and information more generally. Several PPACA provisions stand out as having particular importance for reproductive health, including Medicaid family planning expansions, standards for an essential health benefits package, expanded coverage for contraception and other clinical preventive services, and teen pregnancy prevention programs. All these potential gains, however, are threatened by political, economic, and logistical challenges to the PPACA and by flaws in the legislation itself.
illness or injury must be protected against the financial burdens associated with high out-of-pocket payments or lifetime benefit caps.

If fully implemented as planned in 2014, the PPACA would eventually extend coverage to approximately 30 million people who would otherwise go uninsured. It would spend an estimated $1.5 trillion over ten years on coverage for low-and moderate-income Americans (CBO 2012). Some of these individuals will receive assistance through Medicaid. Others will get affordability credits to help them purchase coverage through the new health insurance exchanges. In short, the act represents a milestone in the history of US social policy.

The PPACA has the potential to have a positive impact on reproductive health in at least three ways: (1) increasing the number of women and men with insurance coverage; (2) increasing the value of insurance coverage for addressing reproductive health; and (3) improving access to reproductive health services and information more generally. All these potential gains, however, are threatened by political, economic, and logistic challenges to the PPACA and by flaws in the legislation itself.

Expanding Coverage

The most frequently articulated rationale for the PPACA was to address the large and growing number of Americans who lack health insurance coverage. Today about 50 million Americans are uninsured (DeNavas-Walt, Proctor, and Smith 2011), including 13 million women of reproductive age (15–44), fully 22 percent of women in that age group (Jones 2011).

Although the uninsurance problem was worsened by the Great Recession, it reflects a long-term trend. Between 2000 and 2010, the number of uninsured Americans increased by 36 percent. As the costs of health coverage increase, fewer Americans are offered or accept health insurance through their employers. Medicaid and the Children’s Health Insurance Program (CHIP) have served as a safety net for millions of Americans, with enrollment in those public insurance programs growing by nearly 75 percent over the decade. Yet that safety net has wide gaps: eligibility for those programs under current law varies greatly across the states, with the eligibility ceiling for parents with dependent children lower than 25 percent of the federal poverty level in several states; most states now exclude childless adults regardless of their income (Heberlein et al. 2011).

To address this problem, the PPACA includes two major coverage expansions, both scheduled to be implemented starting in 2014. First, the law’s authors intended to require every state to extend Medicaid eligibility to all citizens (as well as to immigrants after five years of legal residence) in families with incomes at or below 138 percent of the federal poverty level — an attempt to close the current gaps in the safety net insurance system. The Congressional Budget Office projects that if all states participated in this expansion, an additional 17 million Americans would be covered under Medicaid in 2016 than would otherwise be the case (CBO 2012). However, a July 2012 Supreme Court ruling essentially turned the Medicaid expansion into an option for states, a decision that could lead to substantially fewer Americans receiving coverage, at least initially (see Continuing Challenges, below).
Second, individuals and small employers will be able to purchase private insurance through new marketplaces called exchanges. US citizens and legal residents with incomes too high for Medicaid but below 400 percent of the federal poverty level — the large majority of individuals expected to make use of the exchanges — will be eligible for federal subsidies to help them afford the premiums and to limit patient cost sharing. The combination of the exchanges and the subsidies is projected to account for the rest of the long-term improvement in US insurance coverage under the PPACA.

The act also includes several provisions to help ameliorate coverage problems in the short term, before these major expansions can be implemented. Most notably for reproductive-age women and men, the law requires private health plans that cover dependent children to now extend that coverage to adult children younger than age twenty-six. About half the states had passed similar laws in recent years. But the PPACA’s reach is considerably broader, and this provision appears to have produced markedly greater take-up among eligible individuals. The Obama administration estimates that 3.1 million young adults have gained coverage under the provision (US DHHS 2012). Young adults exhibit historically high levels of uninsurance (DeNavas-Walt, Proctor, and Smith 2011) and of such reproductive health problems as unintended pregnancy (Finer and Henshaw 2006) and sexually transmitted infections (CDC 2010).

**Medicaid Family Planning Expansions**

The PPACA includes one small but crucial provision for expanding coverage under Medicaid specifically for family planning services. Since the 1980s, the Medicaid program has provided special coverage during pregnancy and the postpartum period to millions of women not otherwise eligible for Medicaid. Most states today set their income eligibility levels for pregnant women at or near 200 percent of poverty (Heberlein et al. 2011); nearly half of all US births are covered by Medicaid or CHIP (Sonfield et al. 2011).

In the mid-1990s, several states sought and received permission from the federal government to also expand eligibility for family planning services, usually up to the same income eligibility level they set for pregnant women. In doing so, states were helping women and men plan their families and improving use of prenatal care by ensuring that pregnancies are planned. As a by-product of the policy, expanded access to family planning services reduces Medicaid expenditures, because such services are far less expensive than maternity and infant care.

By the time Congress was writing the PPACA, about half the states had implemented Medicaid family planning expansions, and program evaluations — required by the federal government of all such research and demonstration “waiver” programs — had demonstrated them to be effective and cost effective, each year serving several million individuals and saving each state tens of millions of dollars or more (Sonfield and Gold 2011).

Based on this experience, the PPACA includes a provision that greatly simplifies the process for a state seeking to expand eligibility for family planning under Medicaid. Rather than having to apply and periodically reapply for waivers to bypass Medicaid’s rules, states now have the
authority to expand eligibility by amending their state Medicaid plans, a quicker and more streamlined process and one that does not require them to seek periodic renewals. Under this process, states may cover a larger population of individuals than is covered under any existing waiver program and are required to cover adolescents and men — two populations that are often excluded from waiver programs (Sonfield, Frost, and Gold 2011).

**Improving Coverage**

The PPACA was designed to do more than reduce the number of uninsured. It was also designed to address underinsurance — gaps and limitations in health coverage that can impair affordability and use of needed care. The law curbs or eliminates many practices that have been common in the private insurance market, including annual and lifetime limits on coverage, retroactive policy cancellation, coverage denial or limitation because of preexisting medical conditions, and gender rating (charging higher premiums to women than to men).

Some of these policies took effect for new plans starting in September 2010. Others are being phased in or take effect in 2014. Notably for reproductive health, all new private plans are now required to let women visit a specialist for obstetric or gynecologic care without referral or prior authorization.

Several provisions in the PPACA also look to improve the package of services included in health coverage. Coverage of reproductive health services under Medicaid was already strong prior to the PPACA. This package will remain similarly comprehensive for individuals made newly eligible for the program. Medicaid enrollees have for decades been guaranteed coverage of family planning services and supplies and of prenatal care, labor and delivery, and sixty days of postpartum care. For both sets of services, patients may not be charged any co-payments. States have latitude in the specific family planning and maternity care services that they cover, but almost all states have traditionally been expansive (Ranji et al. 2009a, 2009b).

Coverage of abortion is the primary exception. Under the long-standing policy known as the Hyde Amendment, the federal government may not pay for abortions except in the most extreme circumstances. The PPACA effectively extended the Hyde Amendment to millions more women (see Continuing Challenges, below). Despite this restriction, seventeen states use their own funds to pay for abortions for women with Medicaid coverage (Guttmacher Institute 2012c).

In the private market, coverage of reproductive health services has been more variable. Women with employer-sponsored health coverage typically have relatively expansive coverage for contraceptive services and supplies, maternity care, and other reproductive health services (Sonfield et al. 2004). In fact, the Pregnancy Discrimination Act (PDA) of 1978 requires health plans sponsored by employers with fifteen or more employees to cover pregnancy, childbirth, and related medical conditions for employees and their spouses in the same way they cover other medical conditions.

The US Equal Employment Opportunity Commission (EEOC) ruled in 2000 that the PDA also applies to prescription contraception (EEOC 2000), and twenty-eight states have laws or policies
requiring insurers that cover prescription drugs in general to provide coverage for the full range of contraceptive methods (Guttmacher Institute 2012a). Yet plans offered by smaller employers or in the individual market are exempt from the PDA and many other insurance requirements. As a result, only 12 percent of plans in the individual market included comprehensive maternity coverage in 2008, and additional riders for maternity coverage, when available, can cost thousands of dollars annually and have waiting periods and coverage limits (Codispoti, Courtot, and Swedish 2008). Similarly, the EEOC ruling and the state contraceptive coverage requirements leave substantial gaps in contraception coverage, and high and rising co-payments and other out-of-pocket costs for patients can interfere with the ability of women and couples to choose the contraceptive method that is best for them.

**Essential Benefits and Preventive Services**

Two major PPACA provisions will help fill in some of the gaps in private health insurance coverage. Starting in 2014, all plans offered through the exchanges, as well as other individual or small group plans, will be required to cover an essential health benefits package. The legislation specifies ten broad categories of services that must be included in that package, including maternity and newborn care. Under proposed guidance issued by the federal government in December 2011, states will have considerable flexibility to determine the details of this package by selecting a “benchmark plan” as a model, such as one of the largest small-group markets in the state or one of the largest plans for federal employees (US DHHS 2012).

A second coverage provision, which took effect in September 2010, provides a stronger federal requirement for covering preventive services: it requires all new private health plans, including those sponsored by large employers, to cover a range of preventive services without any out-of-pocket costs for the patient, such as co-payments or deductibles. Most prominently, that list includes all clinical preventive services granted an A or B rating by the US Preventive Services Task Force. USPSTF, a heretofore somewhat marginalized expert body, now has a direct role in the design and reimbursement of clinical preventive services. This immediately fosters improved reimbursement and use of specific services such as chlamydia screening that are unlikely to be the subject of focused political advocacy or that may have been excluded from coverage because they were viewed as public health services rather than clinically indicated diagnostic tests for particular patients (Pollack 2011).

Pertinent reproductive health services include screening for cervical cancer (USPSTF 2012), screening for a variety of sexually transmitted infections (Meyers et al. 2008), interventions to facilitate breast feeding, evidence-based smoking cessation interventions for pregnant women, and more (USPSTF 2010). The preventive services provision also encompasses federally recommended vaccinations, including the one for human papillomavirus, and the full range of preventive care for minors recommended by the American Academy of Pediatrics, including counseling for reproductive health issues.

For new plans written as of August 2012 or later, the list of protected preventive services has been expanded to include another set of women’s preventive services recommended by a panel of the National Academies’ Institute of Medicine (2011). Those recommendations include
contraceptive counseling and the full range of contraceptive methods, as well as at least one well-woman preventive care visit annually, expanded services for pregnant women (e.g., screening for gestational diabetes, and lactation counseling and equipment to help women who choose to breast-feed do so successfully), and screening and counseling for interpersonal and domestic violence.

**Contraceptive Coverage**

Inclusion of contraception on the list of preventive services is the culmination of nearly two decades of work to improve insurance coverage in that realm and an extension of the EEOC’s 2000 ruling and the laws passed in more than half the states. These provisions are especially important for low-income women, given evidence of important financial barriers to effective contraception, particularly in encouraging greater use of long-acting contraceptive methods (Kavanaugh, Jones, and Finer 2011; Blumenthal, Voedisch, and Gemzell-Danielsson 2011; Trussell and Wynn 2008; Trussell and Kost 1987).

Nearly all American women end up using a method of contraception at some point in their lives. Many encounter difficulties using contraceptives consistently and most effectively. Among women at risk of an unintended pregnancy, the one-third who do not use a method or who use one inconsistently account for 95 percent of unintended pregnancies each year (Gold et al. 2009).

Although many things hinder women’s efforts to practice contraception effectively, cost is one important factor — particularly for low-income women, who have the highest rates of unintended pregnancy. A 2004 survey found that one-third of US women using reversible contraception would switch methods if they did not have to worry about cost; these women were especially likely to be relying on condoms and other lower-cost methods (Frost and Darroch 2008). Similarly, a recent study of ten thousand women in the St. Louis area found that when offered the choice of any method at no cost, two-thirds chose long-acting methods, a level far higher than in the general population (Secura et al. 2010).

Covering preventive services such as contraception, and excluding them from cost sharing, is designed to help people overcome these financial barriers. One-quarter of uninsured Americans went without needed care in 2009 because of cost, compared with 4 percent of privately insured adults (Kaiser Commission on Medicaid and the Uninsured 2010), and numerous studies have found that even small amounts of cost sharing reduce the use of preventive health care, especially among low-income Americans (Swartz 2010).

Removing these barriers can also help improve contraceptive use. Three recent studies found that having insurance is significantly associated with increased use of prescription contraceptives (Culwell and Feinglass 2007a, 2007b; Nearns 2009). Another recent study found that when a California health insurer eliminated cost sharing for long-acting methods, enrollees’ use of these highly effective methods increased substantially — by 137 percent for IUDs and 32 percent for injectables — and their risk of contraceptive failure decreased as a result (Postlethwaite et al. 2007).
These patterns matter, because proper provision and use of appropriate contraception are likely to reduce the incidence of unplanned pregnancies and to improve birth outcomes by promoting planned pregnancies. They also improve other health, social, and economic outcomes, from frequency of breast feeding to relationship stability to women’s participation in the workforce (IOM 2011; Guttmacher Institute 2011). Several analyses underscore the cost-effectiveness of contraceptive services (Trussell 2007).

Despite the considerable evidence of the benefits of contraception as preventive care, contraception’s inclusion under the preventive services provision has been singled out for criticism. In adopting the IOM’s recommendations for women’s preventive care, the Department of Health and Human Services (DHHS) also adopted an exemption from providing contraception coverage to certain religious organizations that provide health benefits. The exemption is relatively narrowly crafted to encompass churches, associations of churches, and integrated church auxiliaries (HRSA 2011).

The US Conference of Catholic Bishops and other groups opposing the contraceptive use requested that DHHS expand the exemption’s scope to a wider range of employers and insurance plans — including, for example, plans offered by Catholic hospitals, schools, and charities, which employ and serve large numbers of non-Catholics (USCCB 2011). DHHS initially declined to do so (Sebelius 2012), though it subsequently provided a one-year grace period to other religiously affiliated employers and proposed an accommodation that would involve having an insurance company or another third party pay for, arrange, and communicate to employees about contraceptive coverage (Kliff 2012). The details of that accommodation are still being worked out through the regulatory process. In the meantime, a collection of religiously affiliated organizations has filed several dozen legal challenges to the requirement, and several bills have been proposed in Congress to eliminate the mandate or provide sweeping exemptions.

Improving Access

The PPACA also includes numerous provisions that extend beyond expanding and improving health insurance coverage to address other problems in the health care system and public health. Many of these provisions could have substantial benefits for reproductive health.

Much effort was devoted to alleviating the nation’s shortage of medical providers, a problem that could be heightened by increasing the number of insured Americans. The PPACA includes provisions to expand provider training and encourage providers to work in underserved communities. The provision of new funding — $11 billion over five years — to support and expand the network of community health centers is especially important to improve access to reproductive health services for low-income patients. Those community health centers are required by law to provide patients with access to family planning services, and they provide pregnancy-related care to nearly half a million women each year (HRSA 2009). They are particularly crucial for providing care to noncitizens, many of whom are not eligible to participate in Medicaid or the new exchanges. The PPACA requires insurance plans in the upcoming exchanges to contract with community health centers and many other safety net
providers. The law also creates a new grant program for school-based health centers, many of which provide contraception and other reproductive health care to students.

The PPACA established a Prevention and Public Health Fund to support preventive services and public health infrastructure. The fund is slated to provide billions of dollars over the next decade. So far DHHS has used the fund for a range of activities, including several in the reproductive health field (e.g., HIV prevention and case finding for sexually transmitted infections and related support for the infrastructure of epidemiological surveillance systems).

Congress also included a wide array of other, more focused public health funds as part of the PPACA, several of which are related specifically to reproductive health issues. One of the largest is a $1.5 billion investment over five years in home visiting programs, which send experts (often nurses) to the homes of new and expecting parents to provide information about pregnancy and parenting. Several home visiting models have been established and evaluated across the country; however, the programs have never had a dedicated source of public funding of this magnitude, which may eventually enable nationwide access to these services for any at-risk families that want them. Evaluations of the most successful home visiting models have found that they help parents improve pregnancy-related outcomes as well as other outcomes, including parenting skills and financial self-sufficiency (Boonstra 2009; Olds et al. 1997, 2007; Maynard 1997).

Similarly, the PPACA invests $25 million annually for ten years to support pregnant and parenting teens and women. With these grants states can provide or establish connections to health and support services such as prenatal care, housing, and baby food and clothes to college and high school students; they can also direct aid to pregnant women experiencing intimate partner violence (Boonstra 2010b).

**Teen Pregnancy Prevention**

One of the most important PPACA public health investments in reproductive health is in the area of sex education and teen pregnancy prevention. In his initial budget request in 2009, President Barack Obama proposed eliminating two long-standing federal programs dedicated to promoting abstinence outside marriage that had proved ineffective: the Community-Based Abstinence Education (CBAE) program and the Title V abstinence education grants to the states. He proposed shifting that funding to evidence-based, medically accurate, and age-appropriate teen pregnancy prevention programs. In December 2009, in the middle of the health reform debate, Congress responded by replacing the CBAE with a new teen pregnancy prevention effort that has been funded at more than $100 million for each of the past three fiscal years. Most of the money is designated to replicate programs proven to reduce teen pregnancy or its underlying or associated risk factors; smaller amounts are reserved for testing other promising strategies and for training, technical assistance, evaluation, outreach, and other support activities.

When it passed the PPACA, Congress included a second similar program of grants to states, designed as a replacement for the Title V abstinence-only program, whose funding had expired in June 2009. This new five-year Personal Responsibility Education Program (PREP) provides funding to teach adolescents about both abstinence and contraception as well as healthy
relationships, parent-child communication, and decision-making skills. The PPACA included $75 million annually for PREP, with most of the funds devoted to implementing proven programs to prevent teen pregnancy and sexually transmitted infections. A smaller piece of that funding is for grants to public and private entities to test other innovative prevention strategies.

Advocates for comprehensive sex education have praised the new programs for their focus on scientific evidence and medical accuracy. In contrast, earlier abstinence-only programs were tied to a restrictive, eight-point definition of abstinence education that included such tenets as “a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity” and “sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects” (42 U.S.C. 710). Such prior approaches may have missed opportunities to prevent teen pregnancy and related negative outcomes. They may also have missed the chance to promote healthy behaviors and relationships more broadly among sexually active youth and young adults (Boonstra 2010a).

However, even as Congress devoted funding to a new evidence-based approach, another PPACA provision revived the old Title V abstinence-only program for five years. And for FY 2012, House leaders succeeded in resurrecting a version of the CBAE as well, albeit with only $5 million in funding. In sum, the move toward a more comprehensive approach to US policy on teen pregnancy prevention is incomplete and remains an ongoing political battleground.

**Continuing Challenges**

In addition to reviving federal funding for abstinence-only education, the PPACA leaves serious gaps in who will have access to affordable health insurance and what services will be covered.

**Immigrants and Noncitizens**

Some of the most important limitations concern noncitizens. Many documented and undocumented immigrants will be limited in their health coverage options even after health care reform takes full effect in 2014.

Unauthorized residents have long been barred from Medicaid and CHIP. The PPACA prohibits these individuals from receiving federal subsidies for private insurance. Unauthorized residents are also forbidden to purchase coverage with their own money via the upcoming exchanges. Federal law does require hospitals to provide labor and delivery care to all women, regardless of immigration status; this provision does not apply to prenatal and postpartum care.

Under a 1996 federal law, most legal immigrants are also excluded from Medicaid during their first five years of residency, although states can eliminate that waiting period for children and pregnant women under a 2009 law. During that five-year waiting period, legal immigrants will be eligible for subsidized coverage on the exchanges starting in 2014, but they will have to contribute more to premiums and cost sharing than they would under Medicaid.
Abortion

The most restrictive PPACA service provisions pertain to abortion. With Republicans voting as a bloc against the act, conservative Democratic representatives held political leverage on abortion rights and other matters. To secure the required votes, PPACA supporters accepted amendments and understandings that in some ways tightened long-standing restrictions on abortion coverage. Starting in 2014, millions of women newly covered under Medicaid will be subject to the Hyde Amendment. Across the country, more than two-thirds of potential new Medicaid enrollees live in states that have not chosen to fund abortion with state revenues (Gold 2010).

For individuals purchasing coverage through the new exchanges, the situation is more complicated. Under the final language of the PPACA — which was the subject of some of the most heated rhetoric of the entire health reform debate — exchange plans are allowed to include abortion coverage, but only if they and their customers adhere to complicated systems to ensure that federal dollars do not pay for abortion coverage or services. These administrative hurdles, combined with heightened attacks on abortion coverage by antiabortion policy makers and advocates, may entirely dissuade insurers from offering the coverage. Moreover, the PPACA explicitly permits states to ban coverage of abortion by plans in their exchanges. By the middle of 2012, twenty states had laws in place that will do so; eight of those states prohibit any state-regulated insurance plan — including those outside the exchanges — from covering abortion (Guttmacher Institute 2012b).

Medicaid Expansion

One unexpected set of obstacles arose as a result of the 2012 Supreme Court decision in National Federation of Independent Business v. Sebelius, 567 US ___ (2012). Although the Court upheld the PPACA, it created what could prove to be a large gap in access to affordable health coverage. Since 1965 federal Medicaid law has required states to follow all the program’s requirements or risk losing some or all of their federal Medicaid funding. Seven justices effectively narrowed the scope of federal power by ruling that the federal government could not use this enforcement mechanism to require states to join the new Medicaid expansion enacted under the PPACA. This decision effectively converted the act’s Medicaid expansion into a state option. The full implications of this decision remain unclear at this writing.

In states that decide not to take up the option, millions of low-income individuals could encounter a new Medicaid “donut hole,” becoming ineligible for both Medicaid and subsidized coverage under the exchanges. That discrepancy arises because Congress, in drafting the PPACA, assumed that all states would expand Medicaid and set the exchange subsidies on a sliding scale for people between 100 percent and 400 percent of the federal poverty level. Among those who will be newly eligible for Medicaid under the expansion, only two relatively small groups will be eligible for exchange subsidies under the current statute if their state opts out: those with incomes between 100 percent and 138 percent of poverty and legal immigrants.
during their first five years of residence. The Urban Institute projects that 11.5 million currently uninsured adults could end up without any options for affordable coverage (Kenney et al. 2012).

In the weeks following the Supreme Court decision, it became clear that the Medicaid expansion is a contentious political issue in many states. The controversy is accentuated by the fact that the decision was rendered four months before the 2012 presidential election — an election in which health reform occupied a central place.

Despite contrary statements proffered by many governors, states have strong economic and political reasons to eventually participate. The PPACA’s Medicaid expansion would greatly benefit millions of vulnerable state residents. It would also ease the financial pressures on hospitals and other health care providers from uncompensated care. It would therefore benefit powerful constituencies, including safety net providers, city and county governments, and private health insurance companies that would run Medicaid managed care plans. The expansion would also attract billions of dollars to state economies, including expanded health sector employment and expanded revenues for health care providers.

Moreover, those federal Medicaid dollars will be provided over time with roughly a 19:1 match to state expenditures. The federal government will cover all costs for newly eligible Medicaid recipients from 2014 to 2016 and will gradually decrease its share to 90 percent by 2020 — a share that will still be far higher than the share set for current Medicaid costs.

Ironically, the dynamics of Medicaid federalism bear some similarity to the late 1960s, when several states initially declined to participate. Over the life the program, every state has eventually availed itself of funds available for program expansion. Nonetheless, conservative policy makers in numerous states have said they will opt out or are leaning in that direction. Many of these policy makers have also indicated that they will use their newfound leverage to extract concessions from the federal government.

**Broader Fiscal and Social Politics**

The debate over Medicaid expansion is just one of many remaining legal, political, and technical hurdles to implementing health reform. At this writing no one can precisely predict the fate of the PPACA. The law still faces legal challenges over specific provisions, such as the contraceptive coverage requirement.

At the same time, federal and state budget pressures have led many policy makers to attempt to scale back pieces of the PPACA. Components of the new law most dependent on the appropriation decisions of future congresses are consequently the most vulnerable (Pollack 2011). This vulnerability was exposed after the 2010 elections when Republicans won major victories at both federal and state levels; many of the newly elected officials targeted PPACA repeal as a top legislative priority. These victories had significant implications for the general implementation of the law, particularly regarding reproductive health.
At this writing, the Prevention and Public Health Fund’s political future remains in doubt. Both Democrats and Republicans proposed cutting these expenditures in the “super-committee” deficit reduction process (Pollack 2012). Budget pressures have led almost every state to cut Medicaid costs by, among other things, reducing provider payment rates, restricting optional benefits, and increasing patient co-payments (Smith, Gifford, and Ellis 2011). Public health infrastructure investments have faced additional cuts, including substantial decreases to the Centers for Disease Control and Prevention (Pecquet 2011).

Outside the immediate domain of health reform, House Republicans propose to convert Medicaid into a block grant for the states — something that could undermine coverage for reproductive health services while shifting risks and costs onto individuals and state governments. In addition, critics of abortion and contraception have constrained reproductive health services in other ways — for example, through intensified attacks on the Title X family planning program and more generally on funding for providers such as Planned Parenthood (Gold and Sonfield 2011).

Despite the outcome of the 2012 elections, PPACA opponents have considerable opportunities to restrict appropriations, delay implementation, and otherwise undermine the law. The economist Henry Aaron (2010), writing before the 2010 midterm elections, described the political stakes, highlighting the possibility that Republican efforts to repeal the law will fail but that a variety of tactics to cripple or slow implementation will prove more effective. Aaron describes the likely consequences were this to transpire: “The nation would then be left with zombie legislation, a program that lives on but works badly, consisting of poorly funded and understaffed state health exchanges that cannot bring needed improvements to the individual and small-group insurance markets, clumsily administered subsidies that lead to needless resentment and confusion, and mandates that are capriciously enforced” (ibid.: 1687).

Much rides on these battles. The PPACA may be the most important measure ever passed to expand access to evidence-based reproductive health services in the United States. The structures and policies put in place through health reform — should they survive — will define the reproductive health battleground for many years to come.

References


Pecquet, J. 2011. “HHS Details $2.5 Billion in Cuts for Rest of the Year.” Healthwatch, May 16.


