The New Health Care Reform Legislation: Pros and Cons for Reproductive Health

Fourteen months into his administration, President Obama secured his top public policy priority: a health care reform measure that has been aptly described as the most sweeping domestic policy enactment since Medicare and Medicaid in 1965. For the nation's consumers and providers of reproductive health care, and for advocates of reproductive health and rights, however, the final bill, signed into law in March, is a decidedly mixed bag. Its onerous abortion restrictions have been rightly denounced by reproductive rights supporters. And significant new funding for evidence-based sex education was paired at the last minute with the retention of a failed and discredited abstinence-only program (related article, page 27). But the comprehensive measure also contains numerous positive provisions that, taken together, should constitute a significant step forward for the reproductive health of America's women and men. How many of these provisions will play out is a question that hangs largely on how they are implemented, giving reproductive health advocates many years of work ahead of them.

Abortion

The bill's restrictive abortion provision—named after antiabortion Democratic Senator Ben Nelson (NE)—was putatively designed to uphold the status quo on the question of federal funding. Accordingly, federal funds—in this case, subsidy dollars for individuals purchasing insurance plans on the new health care "exchanges" that are slated to become operational in 2014—may not be used to pay for abortion coverage (except in extreme cases), but individuals, at least in theory, may purchase a plan that includes abortion coverage so long as the abortion coverage itself is paid for with their own money. (This mirrors the Hyde Amendment, under which federal Medicaid dollars may not be used to pay for most abortions, but states may cover the procedure for their Medicaid recipients using their own funds, as 17 states do currently.)

In practice, however, because of the complex, politicized arrangements it necessitates, the Nelson language militates heavily against the likelihood that many such plans will be purchased—or even offered. Consumers purchasing exchange plans that include abortion coverage (whether that is their specific goal or not) would have to make two separate premium payments—one to cover abortion services and one to cover everything else. For their part, insurance companies offering such plans would have to jump through numerous, unprecedented hoops to estimate the cost of abortion coverage and ensure that the abortion payments never mix with other funds. Insurers also are likely to face extensive public scrutiny and protest around whatever coverage decisions they make, as well as a patchwork of state laws governing abortion coverage; by mid-May, three states—Arizona, Mississippi and Tennessee—had already passed new laws restricting private insurance coverage of abortion within their borders, and legislation had made significant headway in several other states. All told, according to an analysis by George Washington University's Sara Rosenbaum, "the more logical response" for private insurers marketing plans within the exchanges—and eventually in the broader market as well—"would be not to sell products that cover abortion services."

As the end-game approached, major antiabortion constituencies, including the Catholic Health Association and organizations representing most U.S. nuns, agreed that the Nelson language—which was part of the Senate bill that was being presented to the House for an up-or-down vote—was sufficiently antiabortion for them to support the overall legislation. However, a small cohort of antiabortion House Democrats, led by Rep. Bart Stupak (D-MI) and backed by the U.S. Conference of Catholic Bishops and the National Right to Life Committee, held out until the last minute for their stricter version that would have not only prevented public funding of abortion itself but also prevented federal dollars from going to any insurance plans that use other dollars for abortion coverage. To secure their votes for final passage, President Obama ultimately agreed to sign an executive order that restates the abortion-related provisions of the legislation, directs the Department of Health and Human Services to issue regulations detailing how insurers would comply

and reaffirms that community health centers cannot use any federal money for abortion (in response to a specious, last-ditch argument that the legislation would somehow *require* those centers to provide federally funded abortions).

The executive order, signed on March 24, may have little or no practical impact, but abortion rights advocates protested it as one more slap in the face from a self-described pro-choice president and as a statement that is at least symbolically harmful for future efforts to overturn the Hyde amendment and restore federal funding for abortion under the nation's Medicaid program. They also expressed particular outrage over a late change to one of the bill's nondiscrimination provisions, which as finally written prohibits insurance plans participating in the exchanges from discriminating against providers and facilities who are unwilling "to provide, pay for, provide coverage of, or refer for abortions"—but not those *willing* to provide abortions or abortion referrals, which would have been an important protection against religiously affiliated plans using their influence to curtail access to abortion outside those plans.

Medicaid

A central component of the new health care reform law is a major expansion of the Medicaid program to cover all Americans with a family income below 133% of the federal poverty level; according to the Congressional Budget Office, this will allow 16 million more Americans to join Medicaid by 2019 than would otherwise be the case. All Medicaid recipients receive the program's guarantee of coverage for family planning services and supplies without cost-sharing, along with coverage for its comprehensive package of reproductive health services beyond family planning. (The major exception, of course, is abortion; however, this provision effectively will expand abortion coverage in states that fund abortions for their Medicaid recipients with state dollars.)

In fact, the legislation goes one step further: It allows states to expand Medicaid coverage for family planning services for women and men with incomes well above 133% of poverty, to the same income eligibility levels they use for pregnancy-related care, typically around 200% of poverty. This marks the culmination of a decade-long effort by lawmakers and family planning advocates to build on the experiences of the now-21 states that have already implemented such an expansion via a burdensome process to receive a federal "waiver" from Medicaid law—a process states can now avoid because of the legislation (related article, Spring 2008, page 7). That provision went into effect immediately, and the Centers for Medicare and Medicaid Services is expected soon to provide guidance to states on how and how best to make use of this new authority.

Private Insurance

All told (including the Medicaid expansion), the legislation would extend insurance coverage by 2019 to 32 million Americans who would otherwise be uninsured. Beginning in 2014, those uninsured individuals with incomes above 133% of poverty will purchase private insurance coverage through the new health care exchanges, almost all of them with the help of a federal subsidy. (Small employers, and eventually larger ones, also will be allowed to purchase plans through the exchanges.)

Exchange plans will be required to offer a similar package of core services. The deliberately sketchy package described in the legislation specifies maternity care, closing a current, major coverage gap in the individual and small group market. The final package, as filled out by regulators, is also expected to include coverage of a broad range of reproductive health services, including contraceptive services and supplies, as is typically the case in private-sector plans today. Insurance plans participating in the exchanges also will be required to contract with essential community providers, defined to include family planning centers, community health centers, public hospitals and HIV/AIDS clinics, among others. Safety-net providers, especially the smaller, specialized ones, often have trouble negotiating contracts with such plans today.

Meanwhile, all private insurance plans, both inside and outside the exchanges, will be required to cover, without cost-sharing, a package of preventive and screening services for women beginning this fall (related article, page 2). Similarly, all private plans that provide dependent coverage will be required to make it available for adult children younger than age 26. This provision, which also goes into effect in September, represents another important avenue in the short-term for young adults to receive reproductive health care coverage. Even after the exchanges are up and running, this option would provide them with coverage that will be far better (for reproductive health and otherwise) than the catastrophic coverage plans that will be allowed to be marketed to young adults, because those plans will require substantial out-of-pocket payments before coverage begins.

Public Health

Finally, although improving the public health and strengthening the health care provider network were rarely mentioned as core goals of health care reform, the new law includes a vast array of provisions and funding sources toward those ends. It includes, for example, $1.5 billion over five years to support maternal, infant and early childhood home visiting programs, with a focus on high-risk families (related article, Spring 2009, page 11). The programs would be designed to improve prenatal, maternal and newborn health, including pregnancy outcomes, and to otherwise improve childhood outcomes. Several widely adopted home visiting models, including the Nurse-Family Partnership, incorporate family planning counseling as one way to help achieve these goals.

The new law also provides a significant increase—roughly 50%—in the rebates pharmaceutical manufacturers must offer to state Medicaid programs for both brand-name and generic drugs and in the discounts offered to safety-net providers, including Title X–supported family planning centers, under the 340B Drug Pricing Program (related article, Winter 2010, page 13). It further will increase manufacturers' accountability in accurately calculating price ceilings under the 340B program and in offering the required discounts to providers.

The new health care law includes many billions of dollars in new funding for community health centers, which provide family planning services and other basic reproductive health care to their clients, and establishes a dedicated $50 million yearly funding stream for school-based health centers, many of which provide contraceptive care to students in need. It also includes several dozen programs designed to bolster the health care workforce through loan forgiveness and provider training programs, several of which are relevant for family planning providers. All of these efforts to bolster the provider network will be critical in the years to come, as the tens of millions of newly insured women and men seek out health care providers for perhaps the very first time.—*Adam Sonfield*