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The Supreme Court rules, and it's both good and bad news for reproductive health

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The U.S. Supreme Court settled one of the nation's loudest political arguments on June 28 when it ruled that the "individual mandate" and almost all of the other provisions of the Affordable Care Act (ACA) are constitutional [1]. Policy-makers, pundits and the general public will continue to argue over whether the ACA is good or bad policy and whether it should be retained and tweaked over time or repealed. Despite all the heated rhetoric, everyone should keep their eyes on the central fact that if the law is fully implemented on schedule, tens of millions of Americans who otherwise would remain uninsured will instead be able to gain comprehensive health coverage, including strong coverage of reproductive health care.

The ACA relies on two major coverage expansions to address high US rates of uninsurance [2]. For US citizens and immigrants after five years of legal residence with a family income below 138% of the federal poverty level ($26,344 for a family of three in 2012), the law looks to Medicaid for their coverage [3].* If implemented in all states—now a big "if" in the wake of the court decision—this would be a major change from today's program. Currently, the eligibility ceiling for parents varies widely across states and dips as low as 17% of poverty ($3,245 for a family of three), and childless adults are typically excluded regardless of their income [4]. For higher-income Americans, the ACA relies on private insurance plans. Specifically, it sets up new marketplaces ("exchanges") for individuals, families and small businesses; it requires that most Americans have health insurance or else pay a penalty; and it provides federal subsidies for citizens and legal residents below 400% of poverty ($76,360 for a family of three), to make coverage affordable. Both of these expansions are slated to become effective in 2014. Several other coverage provisions have started up earlier, including a requirement that insurance plans allow individuals to remain on their parents' policy through age 26.

Medicaid and most private insurance plans already cover most reproductive health services, but the ACA will make some critical improvements. For example, starting in 2014, it will designate maternity coverage as an "essential health benefit," effectively closing a gap in coverage of that care in the plans sold to

individuals and the smallest employers. Another provision, already in place, requires most private plans to cover a set of recommended preventive care services without any copayments, deductibles or other out-of-pocket costs for patients. As of August 2012, that set of services includes an annual preventive care visit, the full range of contraceptive methods and services, Pap tests, screening and counseling for HIV and other sexually transmitted infections (STIs), prenatal care services, the human papillomavirus vaccine, counseling and equipment for breastfeeding, and domestic violence screening and counseling. The ACA also requires private plans to allow patients to access obstetric and gynecologic care without preauthorization or referral.

Abortion is the major exception in a law that otherwise expands access to needed reproductive health care. The ACA continues and extends bans on federal funding of abortion coverage, and includes provisions making it less likely that private plans will cover the service than it is now.

Medicaid's Future in Doubt

But on Medicaid, the Court's decision leaves the fate of the Medicaid expansion unclear, creating a potentially enormous missed opportunity. The ACA required states to participate in the expansion to Medicaid; states that refused would be in danger of losing some or all of their current Medicaid funds. The court ruled that the federal government could not use that leverage, effectively converting the Medicaid expansion into a state option.

One of the big impacts when it comes to reproductive health will be on individuals needing family planning services. Millions of low-income women who are above the state's regular Medicaid income ceiling could be deprived of the Medicaid coverage that could put effective contraception within reach, allowing them to space their pregnancies, to the benefit of themselves and their families. Society as a whole would lose out as well, foregoing the possibility of declines in unintended and teen pregnancy.

Also in jeopardy are vital services such as screening and treatment for cervical and breast cancer, and counseling, screening and treatment for STIs, including HIV.

Because the authors of the ACA assumed all states would join the expansion, millions of these women could find themselves caught between being too "rich" for Medicaid and too poor to qualify for subsidies to help defray the cost of private coverage. Under the statute, those subsidies are set on a sliding scale for people between 100% of poverty ($19,090 for a family of three) and 400% of poverty. So—unless the statute is amended, something that is currently politically unfeasible—most of the residents in a state that opts out who would have been eligible for Medicaid would also be excluded from the subsidies. Only two groups would be eligible: those with incomes between 100% and 138% of poverty, and legal immigrants in their first five years of residence (who were given access to the subsidies because they are barred from Medicaid). The Urban Institute projects that 11.5 million currently uninsured adults could end up in this "donut hole" [5].

Supporters of reproductive health can draw on numerous strong arguments in urging states to participate in the Medicaid expansion, starting, of course, with the fact that it would benefit millions of the most vulnerable Americans. Hospitals and other health care providers have particular reason to press, because expanded Medicaid coverage can help them pay for currently uncompensated care. And with the federal government set to pick up all of the cost of the expansion for the first 3 years (and then phasing down to "only" 90% by 2020) states that do not take up the expansion would be leaving billions of federal dollars on the table, dollars that could be spent to provide desperately needed care.

Nevertheless, conservative politics and perceived fiscal constraints have already led policymakers in a number of states—including most of the ones that joined the lawsuits against the ACA—to say they will not expand Medicaid, or that they have serious doubts. Others have made perhaps a greater danger clear, that they will use their new leverage to negotiate preferential new terms for their Medicaid programs—in

some cases, with the ultimate goal of converting the program's funding into a block grant. That could be disastrous in terms of undermining the guarantees under Medicaid today for coverage of family planning and maternity care without out-of-pocket costs and for recipients' freedom to see the family planning provider of their choice.

With the larger Medicaid expansion in doubt in some states, one potential saving grace for many women and men may be long-standing efforts to extend family planning coverage to people otherwise ineligible for the program through special expansions to Medicaid. Twenty-six states—including 14 of the 27 states that challenged the ACA—have such an expansion in place, typically extending eligibility to women, and sometimes men, with incomes up to around 200% of poverty. Eight of these states have expanded eligibility using new authority granted to them under the ACA, designed to make this option easier for states to take up. The remainder have done so through the more complicated process of obtaining a "waiver" from the Centers for Medicare and Medicaid Services. The federal government now has additional reason to agree to states' requests to either create new expansions or extend existing ones as they reach their scheduled expiration dates. These family planning expansions are no substitute for the full-fledged Medicaid expansion envisioned in the ACA, but they fill an important niche for low-income women and men in states that refuse or delay taking up the full expansion.

More Challenges Ahead

The uncertainty over the broad Medicaid expansion adds to a long list of legal, political and implementation challenges to realizing the full potential of the ACA. On the legal front, dozens of additional lawsuits challenging pieces of the ACA are still active. Notably, that includes the contraceptive coverage requirement, which has been attacked as a violation of religious liberty by a range of Catholic, evangelical Protestant and social conservative groups. That provision also remains a flashpoint politically, with the Republican-controlled House of Representatives, along with numerous state policymakers, pushing legislation to overturn or undermine the requirement. Lawmakers also continue to assert, contrary

to reality, that the ACA somehow expands federal funding for and involvement in abortion. House Republicans cited both issues, among many, in an essentially symbolic vote in July 2012 to repeal "Obamacare," and those arguments and attacks may be expected to continue through the November 2012 elections and beyond.

More quietly, federal and state officials, along with health care providers and insurers, face short deadlines to be ready for the ACA's major changes in 2014. They must set up the new exchanges, set standards for private and Medicaid plans, update enrollment systems, educate the public about their insurance options, upgrade health information technology, and take numerous other steps to turn health reform into a reality. The Supreme Court decision means that these steps will continue, but that the road ahead has become a good deal rockier.

Footnotes

* The law provides for a minimum income eligibility ceiling of 133% of poverty but counts income using a standard "disregard" of 5% of income, effectively setting that ceiling at 138% of poverty.

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