

Developing a Comprehensive Contextual Model of Reproductive Health Policy: Implications of the Affordable Care Act of 2010

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SHORT ABSTRACT

Reproductive health policies in the United States constitute a complicated mix of determinants that vary geographically, politically, economically, and institutionally. The recent Affordable Care Act of 2010 (ACA) included a set of reproductive health policies that increase the complexity of the existing reproductive health policy system. Many scholars have demonstrated the effects of specific policies on diverse reproductive health outcomes. The first objective of this analysis is to review, characterize, and synthesize the existing literature that accounts for policy-related contextual effects on reproductive health behavior. The review enables development of a policy model incorporating the range of factors needed to predict variation in reproductive health. We then evaluate how reproductive health provisions of the ACA are likely to increase the complexity of the policy system. The result is a conceptual framework of contextual factors, along with the presentation of appropriate empirical indicators to assess reproductive health outcomes and behaviors.

EXTENDED ABSTRACT

Introduction

Does the United States have a population policy? Can we infer its *de facto* population policy from legal and institutional frameworks? Unlike in most countries—both developed and developing—to attempt to characterize the United States as having a uniform population policy is a quixotic quest. In fact, US population policy is a complicated mix of macro and meso level determinants that vary geographically, politically, institutionally, and economically. These “population policies” are not the result of intentional policy design, in part due to American exceptionalism related to not guaranteeing universal health care. The recent Affordable Care Act of 2010 (ACA) included a set of reproductive health related policies that affect the extant complexity of the American reproductive health policy “system.” Many scholars have accounted for specific aspects of reproductive policy complexity in fertility models; however, a full model has not been developed to illustrate the range of state-level factors that should be included in a comprehensive contextual model related to fertility behavior. Therefore, the first objective of this analysis is to review, characterize, and synthesize the existing literature that accounts for policy-related contextual factors in determining fertility behavior. Then, given the results of the review, we evaluate how reproductive health provisions of the ACA affect the complexity already illustrated by the existing literature. The result is a conceptual framework and state-level data to assist reproductive health researchers working with US data in theorizing

contextual factors and developing appropriate empirical indicators for their inclusion in models of fertility behavior.

Background

In its attempt to develop a comprehensive, universal package of reproductive health benefits for women, the ACA touched on multiple fault lines in the nation's sensibilities (Bailey et al. 2013). These political fault lines—all of which existed long before Obama was elected—created fissures in the original policy design. During implementation, the fissures developed into fractures that continue to ripple through the system. The result is that even this ostensibly comprehensive federal health care reform is being implemented in a fragmented fashion, particularly as it relates to reproductive health policy. Our conceptual approach owes much to a recent review by Brindis and Moore (2014) in which they develop a policy framework for theorizing about state-level policy factors affecting adolescent health. In this work, we propose to study contraceptive insurance coverage and abortion access. Each of these indicators is affected by a mix of federal, state, and private policies, including: Medicaid, Title IX and private insurance. Although these policy mechanisms pre-date the ACA, provisions of the ACA affect Medicaid and private insurance in particular. In addition, recent state-level legislative action to regulate abortion is having negative impact on the administration of the decades old Title IX program as well.

Cases

Contraceptive coverage

Early in the development of the ACA, there was general agreement that there would be some variant of an essential benefits package, and widespread consensus that any such essential benefits package would include contraceptive coverage. The Supreme Court's 2012 decision on the constitutionality of health care reform continues to affect implementation of the ACA (National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services), including effects of differential insurance expansion at the state level (Kenney et al. 2012). The crucial aspect of that decision affecting reproductive health policy was the finding that the federal government could not compel states to expand Medicaid, one of the backbones of reproductive health services provision in the country. Currently, the country is divided evenly between Medicaid expansion states and those that did not, resulting in *de facto* state policy experiments.

Because contraceptives are considered wrong by members of some religious groups, legal challenges to the private insurance essential benefits mandate started immediately. In its most recent 2014 decision, the Supreme Court allowed private companies to exclude contraceptive coverage on religious grounds (Burwell, Secretary of Health and Human Services v. Hobby Lobby Stores, Inc., et al.), adding such private firms to religious institutions that already were allowed to exclude contraceptive coverage through executive powers. In lieu of the employer

providing such coverage, the insurance company is required to provide it. At this point, it is unclear whether this compromise leads to problems at the level of the patient in getting contraception covered. It certainly increases the complexity of the system. Therefore, even in states that expanded Medicaid, access to contraceptive coverage will vary between states based on the religious affiliations of institutions and beliefs of private owners within a state exercising the exclusion. Finally, additional challenges to ACA on religious grounds are proceeding through the courts in an attempt to eliminate the contraceptive compromise routed through insurance companies; it is highly likely that there will be additional Supreme Court cases on the topic. Depending on the result, there could be additional complexity added whereby employees may have to obtain contraceptive coverage on their own.

To summarize, a researcher interested in understanding determinants of contraception coverage needs to know a variety of factors at the state level, including the state-level insurance requirements, its Medicaid expansion status, legislative actions against Title IX providers in the state, and the prevalence of employers with the potential to refuse coverage on religious grounds. The purpose of the case is to provide the legislative and policy history that demographic researchers need to sort through the complexity theoretically and empirically.

Abortion

The Democratic legislators developing the ACA excluded abortion coverage from the final bill, a compromise made for Democrats opposed to abortion. This continued longstanding federal policy: Prior to the ACA, no federal financing of abortion had been allowed since the Hyde Amendment of 1977. A state-level contextual factor that introduces variation, however, is that individual states may choose to pay for abortion from non-federal funds, and they may require private insurance to cover the procedure. Therefore, abortion is publicly subsidized in some states and not others, and required by some state insurance regulators and not others. The ACA Medicaid expansion described above also results in the populations of some states obtaining improved access to abortion coverage through the state part of the funds.

In general, the US Supreme Court has prevented states from eliminating abortion, but since the *Webster v. Reproductive Health Services* case of 1989, it has allowed states increasing latitude in regulating abortion. This adds an additional layer of complexity at the state level, with some states engaged in minimal regulation of publicly financed abortion, while others have successfully defended increasing restrictions before the Supreme Court. In the meantime, recent years have been characterized by a proliferation of state-level legislation further restricting abortion. This state-level variation is currently working its way through the federal courts, and will surely result in another Supreme Court case. Finally, a late-breaking story is the allegation that the separate abortion riders on private insurance are not in fact being implemented uniformly, leading to allegations that the Obama Administration is failing to enforce that part of the law.

To summarize, a researcher interested in understanding policy factors that may affect US abortion rates would need to consider the status of federal abortion law in any year, whether or not abortion can be publicly funded, whether or not it must be included in private insurance plans, and the details of state-level abortion law. With respect to this latter point—the details of state-level abortion law—there are many different legal ways to restrict abortion; some states are comprehensive in their limitations, employing all policy levers while others employ none; still others choose some levers but not others. Rigorous prior research has demonstrated that aspects of these policies have observable effects on abortion rates. Note that this complexity existed at the time the ACA was signed into law. What, then, are the implications of the ACA for researchers interested in evaluating the effects of policy instruments on abortion rates? The news is not good: The ACA policy introduces new aspects of complexity, and its implementation is leading to still further levels of complexity.

Findings

The first part of the paper is a history and policy review of contraceptive coverage and abortion in the United States, with a particular focus on how the ACA affects those reproductive health domains. In addition, a thorough review of literature on these indicators will demonstrate that accounting for state-level complexity is an essential feature of policy analysis focused on these indicators even before the ACA was passed. A final objective of the research is to utilize data from extant data sources to create a state-level data table of what is happening with respect to contraceptive coverage and abortion, taking into account state-level differences in ACA implementation. Extant data will be derived from the US Census (population structure), Department of Labor (employer characteristics), the Guttmacher Institute (state-level abortion regulations), Planned Parenthood (state-level Title IX action), state insurance commissioners (state insurance regulation), and Medicaid expansion details (Kaiser Family Foundation and the Commonwealth Fund). It is our hope that the resulting table can be used by other researchers who want to adjust for such factors in their individual-level analyses of contraceptive prevalence and abortion incidence.

Conclusion

The Affordable Care Act constitutes a significant reform of the American health care system, but it is not an overhaul. Indeed, at the health care delivery and financing system, the ACA adds complexity to an already bewildering situation. Although the contraceptive mandate was originally viewed as something that would simplify access to reproductive health care, the reality is that continuing action at the state and federal levels complicate even this. The purpose of this research is to create an analytic policy primer targeted to demographic researchers, combined with a comprehensive state-level data set that will enable researchers to develop and test rigorous models adjusting for potential state-level effects.

References

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