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The limits and potential of the Patient Protection and Affordable Care Act (ACA) in promoting women's health

by

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Introduction:

The Patient Protection and Affordable Care Act (ACA) holds the potential for greater access to public and private health care coverage including preventive care.¹ The ACA includes measures to decrease health disparities and improve the health status of many Americans. For women, there is an evidence-based link between access to reproductive health services, a reduction in health disparities, and an increase in health and well-being. This finding was affirmed in 2011 when the Institute of Medicine (IOM) issued a report, *Clinical Preventive Services for Women: Closing the Gap*, that concluded that contraception was a necessary preventive health care service.²

Through the implementation of the ACA, millions of currently uninsured women will have access to health insurance starting in 2014. Access will be gained through the expansion of the Medicaid program or through premium and cost-sharing subsidies that will enable them to purchase insurance through the newly established state Health Benefit Exchanges. According to the Kaiser Family Foundation, 55% of uninsured women will qualify for insurance either in Medicaid or the Exchanges. An estimated 19 million women lack insurance today, which means the ACA has the potential to insure more than 10 million women.³

Unfortunately, access to health insurance coverage does not always equate with access to needed services. While there are many barriers women face related to historical discrimination and geography, one particularly worrisome set of structural barriers are restrictions that limit services, coverage, or information based on ideological or religious beliefs. These ideological restrictions occur at three levels: the individual health provider, the institutional and health system, and the political.

¹ Patient Protection and Affordable Care Act, Pub. L. 111-148; 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010) [hereinafter ACA].

² INSTITUTE OF MEDICINE, *Clinical Preventive Services for Women: Closing the Gaps* (2011).

³ KAISER FAMILY FOUNDATION, *Women's Health Insurance Coverage* (Dec. 2011), available at <http://www.kff.org/womenshealth/6000.cfm>.

This paper briefly reviews the overall promise of the ACA for women and the role of health care ideological restrictions, particularly institutional restrictions, on access to needed care. It then provides a detailed analysis of how contraception is a core component of women's health and how health care refusal policies significantly compromise women's health and, if allowed to expand, will mitigate the overall potential of the ACA to improve health outcomes in women. The way in which abortion care coverage is restricted in the ACA is paired with a discussion of the known effect on women's health from this type of prohibition on abortion by institutions.

We end with reviewing the four particular junctures in Health Exchange formation at which ideological restrictions could significantly undermine the ability of women to access the health care services they need: (1) the scope of covered services, (2) the criteria for health insurance plans to be certified as "Qualified Health Plans" to participate in the Health Exchanges, (3) the definitions of "Network Adequacy," and (4) contracting with "Essential Community Providers."

The Promise of the ACA for Women

When fully implemented, the ACA will have a remarkable impact on health care delivery in the United States, and is potentially transformational for women in general and for low-income women in particular.

First, the ACA includes significant insurance reforms that will benefit women. Women cannot be charged more for their insurance than men just because they utilize more health care services.⁴ Insurers cannot refuse to cover an individual on the basis of pre-existing conditions, nor can they impose annual or lifetime caps on the amount of health care services for which they will pay. This is especially critical for women who experience significant health disparities, and for women of color whose rates of chronic conditions is much higher than white women. For instance, more than half of those diagnosed with diabetes (over 8 million people) in the U.S. are women, and women with diabetes are at higher risk of developing heart disease, the most frequent complication caused by diabetes, than men.⁵ In addition, the ACA prohibits discrimination on the basis of sex, race, disability, age, color or national origin.⁶

Second, the ACA has the potential to lower the cost of health care. This is critical for women as they are disproportionately poor compared to men, and less able to afford health insurance. In 2010, 42% of non-elderly low-income women were uninsured;⁷ 37% of all non-elderly Latinas were uninsured, as were 32% of American Indian/Alaskan Native women.⁸ These women have limited health care options. They rely on free and low-cost clinics, charity care, or pay for care out of pocket. Women of color of child-bearing age experience greater rates of poverty than non-Hispanic white women: 28.5% of African American women, 27.4% of Latinas, and 32.8% of Native American/Alaska Native women live below the poverty line compared to 11.9% of non-

⁴ ACA § 1201.

⁵ CENTERS FOR DISEASE CONTROL AND PREVENTION, *Diabetes and Women's Health Across the Life Stages* (May 2011), <http://www.cdc.gov/diabetes/pubs/women/index.htm#intro>.

⁶ ACA § 1557.

⁷ KAISER FAMILY FOUNDATION, *Women's Health Policy Facts: Women's Health Insurance Coverage* (Dec. 2011).

⁸ Id.

Hispanic white women.⁹ The ACA addresses affordability by expanding eligibility for the Medicaid program to 133% of the Federal Poverty Level (FPL) which for 2012 is \$19,090 for a family of three, and by providing premium and cost-sharing supports for individuals with higher incomes up to 400% FPL.

Third, the ACA expands opportunities for women to prevent and plan pregnancies through increased access to family planning services and comprehensive health care including maternity services (restrictions on abortion coverage is discussed later in this paper). The importance of the ability of women to make decisions for themselves to prevent or postpone pregnancy is well-established within the medical guidelines across a range of practice areas.¹⁰ In 2006, 49 percent of all pregnancies were unintended – meaning that they were either unwanted or mistimed.¹¹ Unintended pregnancy especially impacts women of color. For African American women, 67% of pregnancies are unintended; for Latinas, 53% of pregnancies are unintended; compared to White women for whom 40% of pregnancies are unintended.¹² Unintended pregnancy is often a consequence of poverty. Low-income women have higher rates of unintended pregnancy as they are least likely to have the resources to obtain reliable methods of family planning, and yet, they are most likely to be impacted negatively by unintended pregnancy.¹³ The Institute of Medicine associates unintended pregnancy with an increased risk of morbidity for women, insufficient prenatal care, low birthweight babies, an increase in health behaviors during pregnancy that are associated with adverse effects, as well as a negative impact on parenting by both mothers and fathers.¹⁴ Inaccessible and unaffordable contraceptive counseling and services contribute to these disparities.

Ideological Restrictions Will Limit the Potential of the ACA to Improve Women's Health

Ideological restrictions occur at three levels: the individual health professional, the institutional and health system, and the political. Refusal clauses are statutory or regulatory “opt out” provisions that allow individuals, institutions, and public systems to impede patient access to necessary and desired health care services and information. Collectively these health care refusals violate the essential principles of medical practice guidelines and standards of care that usually establish the boundaries of medical care that patients can expect to receive and that providers should be expected to deliver. Refusal clauses and denials of care undermine standards of care by allowing or requiring health care professionals and/or institutions to

⁹ Cara V. James, et al., *Putting Women's Health Disparities on the Map: Examining Ethnic and Racial Disparities at the State Level*, Kaiser Family Foundation (June 2009).

¹⁰ INSTITUTE OF MEDICINE *supra* at 2; Susan Berke Fogel & Tracy A. Weitz, *Health Care Refusals: Undermining Quality Care for Women*, National Health Law Program (2010); accessed at http://www.healthlaw.org/images/stories/Health_Care_Refusals_Undermining_Quality_Care_for_Women.pdf; CENTERS FOR DISEASE CONTROL AND PREVENTION, *Recommendations to Improve Preconception Health and Health Care --- United States: A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care*, 55 MMWR 1-23 (Apr. 21, 2006).

¹¹ Lawrence B. Finer & Mia R. Zolna, *Unintended Pregnancy in the United States, Incidence and Disparities*, 2006, 84 J. CONTRACEPTION, 478-485 (Nov. 2011).

¹² *Id.*

¹³ *Id.*

¹⁴ CENTERS FOR DISEASE CONTROL AND PREVENTION, *Unintended Pregnancy* (Apr. 4, 2004); <http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/index.htm>.

abrogate their responsibility to provide services and information that would otherwise be required by generally accepted practice guidelines.¹⁵

At the institutional level, the restrictions that have the greatest impact on access to care are those imposed by institutions controlled by religious entities, particularly Catholic-affiliated institutions which serve one in six Americans. Catholic hospitals, clinics and insurers are governed by the *Ethical and Religious Directives for Catholic Health Care Services* (“Religious Directives”), and are directly accountable to the Catholic Church hierarchy.¹⁶ The Religious Directives explicitly prohibit contraception, sterilization, some treatments for ectopic pregnancies, fertility treatments, and abortion – even to save the life of a woman. When Catholic health systems merge with community or non-denominational hospitals, they impose these religious restrictions on the new entity.

With the implementation of health care reform, religiously-controlled health systems are planning to expand. Catholic Healthcare West, for example, recently changed its name to Dignity Health in anticipation of national expansion, merging with hospitals across the country.¹⁷ Hospital leaders have stated publicly that they will eliminate abortion services at any health care facility they acquire, although they will retain contraceptive services if they were previously available. Moreover, the Catholic Health Association and the U.S. Conference of Catholic Bishops are actively lobbying for broad refusal clauses to be added to the ACA to allow institutions to refuse to comply with any mandated coverage of contraception and certain emergency care for pregnant women.¹⁸

Preventive Services and Contraception

The ACA requires that all health plans sold in and out of the Health Exchange must cover a range of preventive health services.¹⁹ Beginning August 1, 2012, most new health plans will have to cover eight gender-specific preventive services including contraception. A narrow range of religious employers consisting generally of houses of worship (churches, mosques and synagogues) and their closely aligned programs are exempt from this requirement.²⁰ The effect is that women who work for houses of worship, whether they are religious leaders, secretaries or janitors, will not have access to contraceptive coverage. President Obama also announced that new rules will be developed that will allow any religiously-affiliated non-profit organization, such as a hospital, a university or a social service agency, to refuse to provide contraceptive coverage to its employees, however, through an accommodation, women and students at those institutions still would be assured contraceptive coverage directly at no additional cost. HHS has

¹⁵ Susan Berke Fogel & Tracy A. Weitz, *supra* at 10.

¹⁶ UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, *Ethical and Religious Directives for Catholic Health Care Services*, Washington, D.C. (June 2001), available at www.usccb.org/bishops/directives.shtml.

¹⁷ DIGNITY HEALTH, *Catholic Healthcare West is Now Dignity Health*, www.dignityhealth.org, (Jan. 23, 2012), accessed at <http://www.reuters.com/article/2012/02/14/usa-contraception-catholics-idUSL2E8DE9KT20120214>.

¹⁸ Stephanie Simon, *US bishops plan aggressive expansion of birth-control battle*, Reuters (Feb. 14, 2012).

¹⁹ ACA § 2713.

²⁰ THE WHITE HOUSE, *Fact Sheet: Women’s Preventive Services and Religious Institutions* (Feb. 10, 2012), accessed at <http://www.whitehouse.gov/the-press-office/2012/02/10/fact-sheet-women-s-preventive-services-and-religious-institutions>; 45 CFR 147.130(b)(1).

solicited comments on the proposal.²¹ The Catholic Health Association and the U.S. Conference of Catholic Bishops responded vociferously in opposition to any accommodation and have insisted that a broad range of non-profit institutions be granted a full exemption from the law and the right to deny their employees and students contraceptive coverage in their insurance plans.²² At the same time, as of this writing, legislation has been introduced in the Congress to repeal the contraceptive coverage requirement for *any* employer who claims a moral or religious objection to contraception.²³

Unwanted pregnancy is associated with maternal morbidity and health behaviors that risk fetal development such as smoking. The World Health Organization recommends that pregnancies should be spaced at least two years apart.²⁴ Pregnancy spacing allows the woman's body to recover from the pregnancy. Further, if a woman becomes pregnant while breastfeeding, the health of both her baby and fetus may be compromised as her body shares nutrients between them. According to the American College of Obstetricians and Gynecologists, women who become pregnant less than six months after their previous pregnancy are 70 percent more likely to have membranes rupture prematurely, and are at a significantly higher risk of other complications.²⁵ Healthy People 2020 aims to increase the proportion of intended pregnancies and to improve pregnancy spacing. Specific indicators of goal achievement include increasing: (1) intended pregnancies from 51 percent to 61 percent, (2) increasing pregnancy spacing to 18 months, (3) the proportion of women at risk for unintended pregnancy who use contraceptives to 100 percent, and (4) increase the proportion of teens that use contraceptive methods that both prevent pregnancy and prevent sexually transmitted disease to 73.6 percent.²⁶

Further, millions of women live with chronic conditions such as cardiovascular disease, diabetes, lupus, and epilepsy, which if not properly controlled, can lead to health risks to the pregnant woman or even death during pregnancy. Medical practice guidelines and the CDC's Guidelines for Preconception Care recommend that women at risk for pregnancy use contraceptives while bringing their condition under control before they become pregnant.²⁷ Denying these women access to contraceptive information and services, therefore, violates the medical standards for these medical conditions, and exacerbates existing health disparities. Cardiovascular disease,

²¹ *Advanced Notice of Proposed Rulemaking for Certain Preventive Services Under the Affordable Care Act*, 77 Fed. Reg. 16,501 (Mar. 21, 2012) (to be codified at 45 C.F.R. pt. 147).

²² Joe Carlson, *CHA Joins Opposition to Reform Law's Birth Control Rule*, Modern Healthcare (June 15, 2012); accessed at <http://www.modernhealthcare.com/article/20120615/NEWS/306159974/breaking-cha-joins-opposition-to-reform-laws-birth-control-rule>.

²³ Religious Freedom Restoration Act of 2012, S. 2043, 112th Cong. (as introduced in the Senate, Jan. 31, 2012).

²⁴ Cicley Marston, *Report of a WHO Technical Consultation on Birth Spacing*, World Health Organization, (June 13-15, 2005).

²⁵ AMERICAN COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS, *Statement of the American College of Obstetricians & Gynecologists to the U.S. Senate, Committee on Health, Education, Labor & Pensions, Pub. Health Subcomm. on Safe Motherhood* (April 25, 2002).

²⁶ U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, *Healthy People 2020 Summary of Objectives: Family Planning*, <http://healthypeople.gov/2020/topicsobjectives2020/pdfs/FamilyPlanning.pdf>.

²⁷ U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, *Recommendations to Improve Preconception Health and Health Care*, 55 MMWR 1-23.

diabetes and lupus, for example, are chronic diseases that disproportionately impact women of color.²⁸

Heart Disease: Heart disease is the number one cause of death for women in the United States.²⁹ African American and Latina women have higher prevalence rates of hypertension, obesity, physical inactivity, diabetes, and metabolic syndrome than do white women.³⁰ Moreover, African American women have the highest rate of mortality from cardiovascular disease.³¹ The American College of Cardiology and the American Heart Association Task Force on Practice Guidelines issued specific recommendations for management of women with valvular heart disease.³² They conclude that individualized preconception management should provide the patient with information about contraception as well as maternal and fetal risks of pregnancy.³³

Diabetes: An estimated 7.8 percent of Americans have diabetes, the prevalence rate (the number of cases in a population at a specific time) is higher for women of color in all age groups, with obesity and family history being significant risk factors for Type II diabetes.³⁴ The American College of Obstetricians and Gynecologists and the American Diabetes Association have developed practice guidelines for the preconception care for women with pregestational diabetes. According to the American Diabetes Association, planned pregnancies greatly facilitate diabetes care. Their recommendations for women with diabetes with childbearing potential include: (1) use of effective contraception at all times, unless the patient is in good metabolic control and actively trying to conceive; (2) counseling about the risk of fetal impairment associated with unplanned pregnancies and poor metabolic control; and (3) maintain blood glucose levels as close to normal as possible for at least two to three months prior to conception.³⁵ The American College of Obstetricians and Gynecologists further recommends that “[a]dequate maternal glucose control should be maintained near physiological levels before conception and throughout pregnancy to decrease the likelihood of spontaneous abortion, fetal malformation, excessive fetal birthweight, intrauterine fetal death, and neonatal morbidity.”³⁶

Lupus: Similarly, contraception plays a critical role in preparing a woman with lupus for pregnancy. Lupus is an auto-immune disorder of unknown etiology which can affect multiple parts of the body such as the skin, joints, blood, and kidneys with multiple end-organ

²⁸ Holly Mead, et al., *Racial and Ethnic Disparities in U.S. Health Care: A Chart Book*, The Commonwealth Fund (2008).

²⁹ Lori Mosca, et al., *Tracking Women's Awareness of Heart Disease: An American Heart Association National Study*, 109 J. AM. HEART ASS'N 573 (Feb. 4, 2004).

³⁰ *Id.*

³¹ *Id.*

³² Robert O. Bonow, et al., *Guidelines for the Management of Patients with Valvular Heart Disease*, American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee on Management of Patients with Valvular Heart Disease), 98 J. AM. COLL. OF CARDIOLOGY 1949-1984 (Nov. 1998).

³³ *Id.*

³⁴ U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, NATIONAL DIABETES INFORMATION CLEARINGHOUSE, Diabetes Overview, <http://diabetes.niddk.nih.gov/dm/pubs/overview/#scope>; Ann S. Barnes, *The Epidemic of Obesity and Diabetes*, 38 TEX. HEART INSTITUTE J. 142 (2011).

³⁵ AMERICAN DIABETES ASSOCIATION, *Standards of Medical Care in Diabetes - 2006*, 29 DIABETES CARE S4, S28 (2006).

³⁶ THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, *ACOG Practice Bulletin No. 60: Pregestational diabetes mellitus*, 115 OBSTET. & GYNECOL. 675 (2005).

involvement. Often labeled a “woman’s disease,” nine out of ten people with lupus are women.³⁷ The incidence rate for lupus is three times higher for African American women than for Caucasian women.³⁸ Historically, women with lupus were discouraged by the medical community from bearing children. While this is no longer always true, pregnancy for women with lupus is always considered high risk, and should be undertaken when, if at all possible, the condition is under control. Women with lupus who become pregnant face particularly increased risks. A large review of United States hospital data found the risk of maternal death for women with lupus is twenty times the risk of non-lupus pregnant women.³⁹ These women were three to seven times more likely to suffer from thrombosis, thrombocytopenia, infection, renal failure, hypertension, and preeclampsia.⁴⁰ Women who suffer from moderate or severe organ involvement due to lupus are at significantly higher risk for developing complications during pregnancy, and the guidelines discussed above regarding chronic disease apply to women with those co-morbidities.⁴¹ This should be taken into consideration in the decision to become pregnant or to carry a pregnancy to term.⁴² The National Institute of Arthritis and Musculoskeletal and Skin Diseases (“NIAMS”) recommends that a woman should have no signs or symptoms of lupus.⁴³ In addition, NIAMS directs women as follows: “Do not stop using your method of birth control until you have discussed the possibility of pregnancy with your doctor and he or she has determined that you are healthy enough to become pregnant.”⁴⁴

Prescription Medications. Independent of the medical risk from the underlying health condition, a large number of commonly prescribed pharmaceuticals are known to cause impairments in the developing fetus or to create adverse health conditions if a woman becomes pregnant while taking them. Approximately 11.7 million prescriptions for drugs the FDA has categorized as Pregnancy Classes D (there is evidence of fetal harm, but the potential may be acceptable despite the harm) or X (contraindicated in women who are or may become pregnant) are filled by significant numbers of women of reproductive age each year.⁴⁵ Pregnancy for women taking these drugs carries risk for maternal health and/or fetal health.⁴⁶ Women taking these drugs who might be at risk for pregnancy are advised to use a reliable form of contraception to prevent pregnancy.⁴⁷ For example, the Food and Drug Administration’s iPledge program that governs the use of the drug Accutane® for severe acne treatment clearly states that women should use two forms of contraception and that “natural family planning” is not an accepted method.⁴⁸

³⁷ U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE ON WOMEN’S HEALTH, *Lupus: Frequently Asked Questions* 2 (June 13, 2001), <http://www.womenshealth.gov/publications/our-publications/fact-sheet/lupus.pdf>.

³⁸ *Id.*

³⁹ Megan E. B. Clowse, et al., *A National Study of the Complications of Lupus in Pregnancy*, 199 AM. J. OBSTET. & GYNECOL. 127e. 1, e.3 (Aug. 2008).

⁴⁰ *Id.* at 127e.3-e.4.

⁴¹ *Id.*

⁴² NATIONAL INSTITUTE OF ARTHRITIS AND MUSCULOSKELETAL AND SKIN DISEASES, *Lupus: A Patient Care Guide for Nurses and Other Health Professionals* 27-62, Patient Information Sheet 4-5 (3d ed. Sept. 2006).

⁴³ *Id.* at 45-46, Patient Information Sheet No. 11.

⁴⁴ *Id.* at Patient Information Sheet No. 4.

⁴⁵ Eleanor Bimla Schwarz MD MS, et al., *Documentation of Contraception and Pregnancy When Prescribing Potentially Teratogenic Medications for Reproductive-Age Women*, 147 ANNALS OF INTERNAL MEDICINE. (Sept. 18, 2007).

⁴⁶ David L. Eisenberg, et al., *Providing Contraception for Women Taking Potentially Teratogenic Medications: A Survey of Internal Medicine Physicians’ Knowledge, Attitudes and Barriers*, 25 J. GEN. INTERNAL MED. 291 (2010).

⁴⁷ *Id.* at 291-92.

⁴⁸ U.S. FOOD & DRUG ADMIN., Accutane® (isotretinoin) Questions and Answers (Oct. 28, 2005)

Effect of Refusal Clauses on Contraceptive Access. There is near universal agreement in medical practice guidelines that women should be given information about and access to contraceptives to prevent pregnancy. Yet, refusal clauses allow clinicians to refuse to prescribe contraception, emergency rooms to refuse to provide emergency contraception to victims of sexual assault, and pharmacists to refuse to fill prescriptions for contraception. According to the Guttmacher Institute, thirteen states have laws allowing refusals related to contraception.⁴⁹

Expanded health care refusals might allow a health care professional to refuse to advise a woman of the need to use an accepted method of contraception in violation of the medical standard of care. They also may allow workers with only a tangential relationship to health care delivery to erect barriers to care through their refusals, for example, by refusing to file an insurance form, refusing to provide written materials, or refusing to ring up a pharmacy sale for contraception.

Abortion

The ACA erects new barriers to insurance coverage for abortion. Currently, the vast majority of health insurance plans across the country cover abortion services, except Federal employees who only have coverage for abortions in extreme circumstances. The ACA sets out “Special Rules” on abortion coverage that govern the conditions under which abortion can be covered in insurance plans.⁵⁰ First, the legislation highlights that states can completely ban insurance coverage in their Health Exchanges without exceptions even for pregnancies that result from rape or incest or when an abortion is necessary to save the life of a woman. Since the passage of the ACA, eight states have passed new laws to limit or prohibit abortion coverage in all insurance, and 15 states limit or prohibit coverage in the state Exchange.⁵¹

If insurers do cover abortion services, they must collect a minimum of \$1 in premium from each enrollee in the plan, and must further segregate those funds so that abortion services are only paid out of the segregated funds. States are awaiting further guidance from HHS to determine whether this process will be burdensome and therefore discourage abortion coverage, or simple to implement in which case abortion coverage may continue unimpeded.

Effect of Refusal Clauses on Abortion Access. Documentation of the health impact of refusal clauses to date has been difficult, but what does exist suggests inappropriate care for women with ectopic pregnancies, miscarriages and other obstetrical emergencies.⁵² In an article published in the *American Journal of Public Health*, the authors studied miscarriage management in Catholic hospitals across the country and reported five situations in which pregnant women were put at serious risk when the hospitals refused to allow their physicians to treat them in accordance with

⁴⁹ GUTTMACHER INSTITUTE, *State Policies in Brief: Refusing to Provide Health Services as of February 1, 2012* (Feb. 1, 2012), accessed at http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf.

⁵⁰ ACA § 1303.

⁵¹ GUTTMACHER INSTITUTE, *Restricting Insurance Coverage of Abortion* (Feb. 2012), available at http://www.guttmacher.org/statecenter/spibs/spib_RIC.pdf.

⁵² Debra B. Stulberg et. al, *Religious Hospitals and Primary Care Physicians: Conflicts over Policies for Patient Care*, 25 J. GEN. INTERN. MED. 725-30 (Apr. 6, 2010); Tracy A. Weitz & Susan Berke Fogel, *Denials of Abortion Care Information, Referrals and Services Undermines Quality Care for U.S. Women*, 20 J. WOMEN’S HEALTH ISSUES 7-11 (2010).

the medical standard of care.⁵³ In one case, the physician reported a patient 19 weeks pregnant who was in sepsis. She had 106° fever, and the standard of care was to terminate the pregnancy to save her life. Yet, as he reports, “And so I put the ultrasound machine on, and there was a heartbeat, and [the ethics committee] wouldn’t let me because there was a heartbeat. This woman was dying before our eyes.”⁵⁴

Decisional Junctions that will Support or Impede Reproductive Health Access

The ACA provides for states to establish Health Benefit Exchanges (Exchanges) through which individuals and small businesses will purchase health insurance.⁵⁵ These Exchanges will be responsible for ensuring that insurance coverage is accessible, that consumers have good information upon which to make their insurance coverage choices, and for holding participating health plans accountable for following the law. Among other important functions, the Exchanges will develop criteria, with federal guidance, that all health plans sold through the Exchange will have to meet. Among those criteria are:⁵⁶

- Does the insurance plan comply with all of the insurance reforms required under the ACA?
- Does the plan cover all of the Essential Health Benefits?
- Does the plan have an adequate network to meet the health needs of its enrollees?
- Does the plan contract with Essential Community Providers?

Qualified Health Plans (QHP): In order to participate in the Exchange, each health plan must be certified as meeting all of the requirements established by federal law and regulation. These “Qualified Health Plans” will then be able to sell their insurance products through the Exchange. The way these criteria are crafted and enforced will have a significant impact on whether women have access to reproductive health services.

Essential Health Benefits: The ACA requires the Secretary of HHS to define the Essential Health Benefits that must be covered by all Qualified Health Plans, and which must include ten categories of care including “Maternity and Newborn Care” and “Preventive and Wellness Services and Chronic Disease Management.”⁵⁷ Despite the clear language of the statute, HHS has delegated this responsibility to the states. The breadth or narrowness of these coverage categories will be essential to women’s health and well-being. In addition, a number of states have enacted broad refusal clauses that allow almost any participant in the health care system to refuse to participate in, cover, refer for, or pay for a service to which the individual or institution has an objection. It is unclear whether states will be allowed to include refusal clauses that would allow plans to attain QHP status but be exempted from covering certain reproductive health services.

Network Adequacy: Qualified Health Plans must demonstrate that their networks of providers are sufficient to meet the health needs of the population served by the plan.⁵⁸ The network of

⁵³ Lori Freedman, et al., *When There’s a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. OF PUBLIC HEALTH 1774-1778 (Aug. 13, 2008).

⁵⁴ Id. at 1776.

⁵⁵ ACA § 1311.

⁵⁶ ACA § 1311(c).

⁵⁷ ACA § 1302(b)(1).

⁵⁸ ACA § 1311(c)(1)(B).

providers available to enrollees will determine whether covered services are actually available to the women who need them. The traditional measure of network adequacy relies on documenting the numbers and types of providers. This methodology is inadequate and could be misleading when ensuring whether a network is adequate to meet the reproductive health needs of the population. If a network consists only of Catholic-affiliated hospitals that prohibit most reproductive health services, or if the health care providers in the network refuse to prescribe contraception or perform sterilizations, the network should not be deemed as adequate.

Essential Community Providers: The ACA requires that Qualified Health Plans contract with “Essential Community Providers” identified as providers who serve predominantly low-income underserved individuals.⁵⁹ As religiously-affiliated health systems operate or align with local community clinics, it will be critical to ensure that the Essential Community Providers include family planning clinics and other trusted sources of reproductive health services.

Conclusion

The public expects health care decisions to be based on scientific evidence and good economic policy. Health care refusals and denials of care, also known as “conscience” clauses, are laws and policies that allow health care professionals, institutions, or public entities to refuse to offer care that would otherwise be required under the law, health care standards, and accepted medical practice. Refusals and denials of care are based on ideological and political justifications.

Refusal clauses and institutional denials of care threaten to undermine the promise of the ACA Act to ensure affordable, accessible, and quality health care for women. Broadly-defined and widely-implemented refusal clauses undermine access to basic health services for all, but particularly harm low income women. The burdens on low-income women can be insurmountable when women and families are uninsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services or travel to another location. In rural areas there may simply be no other sources of health and life preserving medical care.

The role of ideological restrictions in decisions about the implementation of the ACA should be highly scrutinized. Of particular importance are the four decision points related to the health care exchanges: (1) the scope of covered services, (2) the criteria for health insurance plans to be certified as “Qualified Health Plans” to participate in the Health Exchanges, (3) the definitions of “Network Adequacy,” and (4) contracting with “Essential Community Providers.” In each of these cases, refusal clauses should be evaluated using the same measurements used to evaluate quality generally, with the goal of providing care that is evidence-based, patient-centered, and preventive. All women should have access to the health care services they need based on medical evidence and sound practice, their personal health needs, and their own beliefs. Employers, insurers, hospital corporations, and governments should not be allowed to impose their ideology on women’s health.

⁵⁹ ACA § 1311(c)(1)(C).