



Commentary

The Risk of Remaining Silent: Addressing the Current Threats to Women's Health



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The Affordable Care Act (ACA) has provided a major impetus to improving the health of women throughout the United States, through both its expanded coverage to those previously uninsured, and its provisions that specifically ensure high-quality care and coverage for women's health, including preventive services, reproductive health, and chronic disease care. However, many of these benefits and the reimbursements for services to care for women's health, as well as grant funding not specific to the ACA, are at risk of losing federal support. Increased awareness and advocacy by the public and providers will be required to preserve these important benefits and programs.

The Continued Risks to the ACA

Multiple attempts to revise and replace the ACA through the budget reconciliation process that would only require 50 votes in

the Senate have been unsuccessful. At first glance, this seems to maintain the ACA and its provisions that benefit women's health. However, many threats remain to resources that benefit the health of women. The Department of Health and Human Services (DHHS) can reduce support for health services to women in a number of ways, first through reducing funding to support the ACA in general, second through reductions to specific women's health services, and third through decreasing other non-ACA activities and grants that support health services for women. Potential efforts to undermine the ACA's private insurance provisions include 1) no tax penalties for individuals who do not sign up for health insurance coverage, 2) removal of a tax penalty for companies that do not provide insurance, 3) significant reductions in available funding for community enrollment outreach and navigation programs, including restrictions on access to the enrollment website (Galewitz, 2017), likely reducing the number of additional beneficiaries who sign up and expand the insurance pool, and 4) the elimination of insurer payments that are key to stabilizing the health insurance industry and the ACA. Collectively, these efforts would effectively reduce vital funding of the ACA, decreasing the relatively healthy, low-risk pool that insurance companies rely on and forcing insurers to increase premiums to a point of unsustainability. After having

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made payments to insurers to offset cost-sharing reductions through September 2017, the administration announced in mid-October that it would cease making the payments. As a result, the individual insurance marketplace remains unsettled, premiums are likely to rise further, and insurers may exit some geographic areas (Goldstein & Eilperin, 2017). A number of governors and senators are exploring options for stabilizing the marketplace in the upcoming year (Kodjak, 2017). For the purposes of this article, we examine the specific effects of repealing the ACA on aspects of access to contraceptive care.

The Risks to Contraception Coverage

Fifty-five million women benefited in 2016 from the ACA's mandate that commercial insurers cover preventive health care services, including contraception, without patient cost-sharing (The White House, 2016). The number of women paying out of pocket for contraceptive care decreased from 22% to 3% (Sobel, Salganicoff & Rosenzweig, 2016). Dr. Tom Price, who served as DHHS Secretary until his resignation in late 2017, was opposed to coverage by insurers of contraceptives under the ACA's required essential benefits (Keyes & Waldron, 2012). There continues to be a significant risk that DHHS will eliminate the regulation that mandates no co-payments or out-of-pocket costs for contraceptive methods approved by the U.S. Food and Drug Administration. As an initial significant step, on October 6, 2017, the DHHS issued a rule allowing employers greater latitude in their ability to exclude contraception from employer-sponsored coverage owing to either religious or moral objection. This policy change builds on a previous Supreme Court case, brought by the retailer Hobby Lobby (*Burwell v Hobby Lobby*, 2014), in which the court ruled that "closely held" private companies asserting religious objections could opt to exclude contraception coverage (Rosenbaum, Sonfield & Gold, 2014). During the Obama administration, DHHS created an accommodation that enabled religious entities to simply inform DHHS of their objection, identifying their insurer or third-party administrator. DHHS then took responsibility for ensuring that the provision of contraceptive services was covered by the insurer or administrator without involvement of the religious organization (U.S. Department of Labor, 2017). The Trump Administration regulation immediately expands the exclusion to a wider set of entities and eliminates the previous "accommodation" policy through which women accessed contraception even if not included in their employee benefits. As of this writing, a number of law suits have been filed by the ACLU and individual states—specifically California, Massachusetts, and New York—to prevent the policy from being implemented (Hackman & Radnofsky, 2017).

The Impact of Losing Contraception Coverage

Repealing contraception coverage is projected to cost women \$1.4 billion dollars per year in co-payments (Burns, 2017), presenting a significant barrier to contraceptive access and effective use (Pace, Dusetzina & Keating, 2016). This move would exacerbate our country's high rate of unintended pregnancies. Currently, 45% of pregnancies are unintended and 95% of unintended pregnancies occur among women either not using or inconsistently using contraception (Guttmacher Institute, 2016b). When women, particularly low-income women, are required to cover co-payments and services related to contraception provision, the number of unintended pregnancies in this country will surely increase. A special group at risk are

adolescents, where the lifetime economic consequences of unintended pregnancies, in terms of education lost and life changes, are highest. In the 5-year period from 2007 to 2012, teen pregnancies (including both births and abortions) decreased by 28%, which is attributed to increased contraception use as well as increased use of highly effective contraceptive methods among adolescents (Lindberg, Santelli & Desai, 2016; Guttmacher Institute, 2016b). It is estimated that the U.S. teen pregnancy rate would be 73% higher if not for publicly funded contraception and family planning programs (Guttmacher Institute, 2016a).

The Risks to Planned Parenthood and Title X

One in five women in the United States use Planned Parenthood for care at least once in their lifetime and more than 1.5 million women receive care through Planned Parenthood each year, including 32% of low-income women ("Planned Parenthood at a Glance," 2017). The impact of Planned Parenthood extends far beyond its provision of reproductive care. For example, a recent study demonstrated that proximity to Planned Parenthood was associated with higher rates of high school completion among adolescent girls, one of the major drivers in preventing poverty (Charo, 2017).

Planned Parenthood receives federal funding to support its reproductive and preventive health services from two sources. Medicaid reimburses Planned Parenthood for preventive health services, including screening and treatment for sexually transmitted infections, cancer screening, and contraception services similar to other providers ("Medicaid and Reproductive Health," 2017). The second source is Title X family planning funds that support services at Federally Qualified Health Centers (FQHCs), Planned Parenthood clinics, other private clinics, and student health services, among other sites. Planned Parenthood has never received federal dollars to pay for any aspect of abortion services due to the Hyde Amendment (Silverman, 2016).

Although attempts to eliminate Planned Parenthood funding through repeal of the ACA were unsuccessful, the administration and legislative branches are working to eliminate federal support to Planned Parenthood with proposed legislation that would effectively not reimburse Planned Parenthood or its clinicians for health care that could be covered at any other clinical setting. In April 2017, President Trump signed a bill that allows states to withhold federal money from organizations that provide abortion services (U.S. Congress, n.d.), reversing an Obama-era regulation that prohibited states from withholding money from facilities that perform abortions, because many of these facilities also provide other essential family planning and medical services. Policymakers in Arkansas and Texas have already legislated restrictions that would eliminate any Medicaid funding for Planned Parenthood family planning services (Guttmacher Institute, 2017). Women in need of family planning services would purportedly be shifted to FQHCs for this care. However, health centers do not have the capacity to assume care for such a significant surge in new clients; the Congressional Budget Office estimates that 5% to 25% of the patients served by Planned Parenthood would not be able to establish care at FQHCs (Hall, 2015; Rosenbaum, 2017), including 13% in areas with no FQHCs available (Hasstedt, 2017; Rosenbaum, 2015). Separately, the administration is also in favor of eliminating the Title X program as reflected in the administration's budget proposal to eliminate all funding for the

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