Contraceptive Coverage and the Affordable Care Act

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KEYWORDS

• Affordable Care Act • Contraception • Mandate • Medicaid • Contraceptive access • Legal challenges

KEY POINTS

- The Patient Protection and Affordable Care Act (ACA) was signed into law by President Obama on March 23, 2010, with the primary goals of expanding access to insurance coverage and reducing health care spending.
- A major underpinning of the legislation was shifting the focus of both health care and insurance providers away from reactive medical care toward preventive care, and to meet this goal, the ACA required health insurers to provide preventive health care, including the full range of contraceptives, to patients without cost sharing.
- This article describes both the current landscape of contraceptive coverage in the United States after the implementation of the contraceptive mandate and the delays and inconsistencies related to its implementation to date.

INTRODUCTION

The Affordable Care Act, Preventative Health Care, and Contraception

The ACA was signed into law by President Obama on March 23, 2010, with the primary goals of expanding access to insurance coverage and reducing health care spending. A major underpinning of the legislation was shifting the focus of both health care and insurance providers away from reactive medical care toward preventive care.

Public health advocates have long recognized that the most successful health care systems are those that focus on primary prevention of disease, rather than on treatment of acute illnesses. Specifically, an analysis in the United States of preventive health care services, such as tobacco cessation screening and immunizations, showed that these programs saved 2 million life-years at minimal cost.[1] Such studies serve as the foundation for the ACA's goal of pivoting the US health

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care system toward prevention of disease and promotion of overall health and well-being.

To actualize this goal, the ACA stipulated that insurers may not apply cost sharing (co-pays, co-insurance, or deductibles) to a panel of preventive services. These services include high blood pressure and cholesterol screening, testing for sexually transmitted infections, alcohol misuse and abuse screening and counseling, and a variety of cancer screenings and immunizations. The ACA preventive services coverage mandate also included specific preventive care for women.

When the ACA was signed in 2010, the value of covering preventive health care services was well recognized. Many private sector insurance payors were already covering preventive services: all 50 states required plans to cover mammography screening, and 29 states required plans to cover cervical cancer screening.[2]

After the signing of the ACA, the Department of Health and Human Services (HHS) tasked the Institute of Medicine (IOM) with determining which services should be included as preventive health care services under the ACA. The IOM convened the Committee on Preventive Services for Women, which comprised experts from diverse fields in medicine, public health, and health policy. In 2011, this committee released its recommendations on which services should be covered by the ACA.[2] This list included "the full range of Food and Drug Administration (FDA)-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity." The HHS adopted these recommendations, and implementation of this provision began in August 2012.

Although some question the need for including contraception as a component of general preventive services for women, the public health benefits of preventing unintended pregnancy are pronounced and well established. Every year in the United States, 600 to 700 women die because of complications associated with pregnancy,[3] and the maternal mortality ratio (MMR) in the United States continues to increase.[3] In a recent examination of US pregnancy-related mortality, the MMR was 16.0 per 100,000 live births for the period 2006–2010.[3] Another analysis of global maternal mortality found that the US MMR in 2013 was 18.5 per 100,000 live births, which is comparable to the ratio in countries with fewer health care resources, including Turkey, Russia, Iran, and Romania.[4] Reducing unintended pregnancy is an important element of addressing the unacceptably high MMR in the United States.

In addition, there are well-established negative health and socioeconomic outcomes associated with unplanned births. Unplanned pregnancies are associated with delayed initiation of prenatal care and a decreased likelihood of breast-feeding.[5] Short spacing between pregnancies increases the risk of negative birth outcomes, namely, preterm birth and low-birth-weight babies.[6,7] Moreover, the ability to plan pregnancies allows women the time and finances to invest in their own education and careers and participate more fully in the workforce, benefitting not only themselves and their families but also the society as a whole.[8,9]

Unintended pregnancies may risk the health and well-being of women and their families, and the financial implications of unintended pregnancy are also substantial. Including only the medical costs of an unplanned pregnancy and 1 year of life of the child, the Brookings Institute, a nonpartisan public policy group, estimated that the cost to taxpayers of publicly funded unintended pregnancies and the infants born of those pregnancies averaged $11 billion annually.[10]

Although the contraceptive coverage mandate has proved to be a highly divisive issue, it is not a provision unique to the ACA. By the time the ACA was signed, government-funded insurance had already been covering contraception for decades. More than half of states had laws requiring that insurance plans cover contraceptive

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