



Health Reform and Reproductive Health: Positive and Negative Effects

March 25, 2010

Positive

1. **Of the 12.4 million uninsured women of reproductive health age (15 to 44) in the United States, 94% would qualify for either Medicaid or federal subsidies to help them buy health insurance.**¹ They will receive, among other things, contraceptive counseling and services, STI prevention, Pap smears, mammograms and complete maternity coverage. Effective in 2014.
 - a. **Slightly more than half of these women (55% or 6.7 million) would qualify for Medicaid coverage.** Medicaid eligibility is expanded up to 133% of poverty (29,327 annual income for a family of four). Most reproductive health care is included, but not abortion coverage, except in case of rape, incest or life endangerment, unless the state pays for it. (See “negative effects” for further discussion.)
 - b. **Another 4.8 million women of reproductive health age will qualify for federal subsidies to help them purchase private health coverage.** Individuals and families with incomes up to 400% of poverty (\$88,400 for a family of four) will be eligible for federal subsidies. Women living in some states will be able to buy abortion coverage. (See “negative effects” for further discussion.)
2. **Young adults will be able to stay on family health insurance policies until their 26th birthdays, thus providing them access to reproductive health care.** Effective 2010.
3. **Almost \$75 million per year will go to states over five years for a “personal responsibility education program” that will largely focus on preventing pregnancy and STIs through a combination of abstinence and contraceptive education.**²
4. **States will be more easily able to expand Medicaid coverage to both men and women solely for family planning services up to almost the same eligibility level as for pregnancy-related care (200% of poverty).** Some 21 states have done this already. The rest will be able to do so without having to go through a time-consuming and costly federal waiver process.³
5. **Community health centers, where many low-income women and undocumented immigrant women receive primary and reproductive health care, will receive \$11 billion in new funding.** In addition, insurance plans will be required to contract with

- community health centers and other essential community providers such as family planning centers, public hospitals and HIV/AIDS clinics. Effective beginning in 2010.
6. **Insurance companies will not be able to cancel our policies if we get sick, including with ovarian cancer, cervical cancer, breast cancer or HIV.** Effective in 2010.
 7. **Insurance companies will not be able to deny us coverage for such “pre-existing conditions” as pregnancy or having had a c-section delivery in the past.** Effective 2014, except for 2010 for children.
 8. **All private insurance plans will be required to offer a package of women’s preventive and screening services, such as such as pap smears and mammograms, without requiring co-pays.** Effective January 1, 2011.
 9. **Licensed practitioners serving women using free-standing birthing centers will be eligible for Medicaid reimbursement.** Effective within 90 days of enactment. Some states may have to adopt new laws or policy to implement this provision.
 10. **New funds (\$1.5 billion over five years) are appropriated for maternal, infant and early childhood home visiting programs.**
 11. **New funds (\$50 million a year) are appropriated for school-based health programs, which often provide STI and birth control counseling and services.**
 12. **Medicaid reimbursements for primary care doctors will be increased, making it easier for Medicaid recipients (including women of reproductive health age) to get preventive office visits with more physicians.** Effective 2013.
 13. **Insurance companies will no longer be able to set lifetime or unreasonable annual limits on the amount of medical care they will cover.** This is especially important for women who have expensive maternity care or abortion services, or treatment for such illnesses as breast cancer, ovarian cancer or cervical cancer, which can costs thousands of dollars. Effective 2010

Negative

1. **There *still* will be no use of federal funds for abortion services (except in cases of rape, incest or threat to the life of the woman).** This provision was included in the health reform bill and restated in an Executive Order issued by President Obama on March 24, 2010.
 - a. **Women on Medicaid and those who will become eligible for Medicaid in 2014 will not be able to use their coverage for abortion services in most cases,** except in the circumstances stated above, or if they live in one of the 17 states that use state-only dollars to provide abortion coverage under Medicaid.
 - b. **Low-income women receiving care at Community Health Centers still will not be able to receive federally-subsidized abortion services, making it more difficult for CHCs to provide this care.** The health centers will have to continue to scrupulously segregate federal funds from any other funds that are

used to provide abortion services. Women may be asked to use their own money to pay for abortion services if no non-federal subsidies are available.

- c. **No federal subsidies can be used toward abortion coverage in any private health insurance plans purchased through insurance exchanges.**
2. **States could prohibit abortion coverage in health insurance plans offered in new insurance “exchanges” that will become available in 2014.** While states already are able to prohibit abortion coverage in private health insurance (5 states have done so to date), the advent of the state insurance exchanges may present new opportunities for anti-choice forces to advocate for abortion bans. Reproductive justice advocates will be forced to fight these proposed prohibitions state by state.
 3. **In states where abortion coverage is allowed in the exchanges, women will have to send in two checks – one for abortion coverage and one for everything else.** This requirement (the “Nelson language”) is burdensome and unnecessary, since insurers will be required to segregate federal funds from private payments going to abortion coverage. Moreover, experts predict it could lead insurance companies to simply drop abortion coverage, rather than comply with the requirements.⁴
 4. **There is a one-sided “conscience clause” that requires health insurers to protect providers that refuse to provide or refer for abortions, but does not protect those who do.**
 5. **New funding for ineffective abstinence-only sex education.** Title V, the federal abstinence-only-until-marriage program is resuscitated and given \$50 million a year for five years.
 6. **Undocumented immigrants, including women of reproductive health age, are excluded from health reform.** They are not eligible for Medicaid or federal subsidies to help them buy insurance and *are even prohibited from using their own money to buy health insurance through the exchanges.*
 7. **Legal immigrants, including women of reproductive health age, still must wait five years to become eligible for Medicaid.** Some states already provide Medicaid coverage to legal immigrants, especially pregnant women and children, within their first five years, and may continue to do so.⁵

¹ Kaiser Family Foundation, Abortion and Health Reform, January 2010.

² Guttmacher Institute analysis, March 2010.

³ Guttmacher Institute analysis, March 2010.

⁴ Analysis by Sara Rosenbaum of the George Washington University School of Public Health.

⁵ New York Immigration Coalition, March 2010

This fact sheet was developed using resources and guidance from The Guttmacher Institute, the ACLU Reproductive Freedom Project, Legal Voices, the Kaiser Family Foundation, Community Catalyst, the New York Immigration Coalition, the National Physicians Alliance, the National Institute for Reproductive Health, the Southwest Women’s Law Center and the American Association of Birth Centers.. Thanks for all their generous assistance.