NARAL Pro-Choice America

Health-Care Law Is a Giant Advancement for Women's Reproductive-Health Care

In March 2010, Congress passed landmark health-reform legislation known as the Patient Protection and Affordable Care Act (the Affordable Care Act).[1] The law represents an historic step forward for America's health-care system, which was woefully inadequate from a reproductive-health perspective.

The Affordable Care Act brought more than 30 million Americans into a better health-care system than existed previously. The law includes specific provisions that improved women's access to reproductive-health care; it ensures, for example, that health plans cover maternity care as an essential health benefit and requires coverage of family-planning services, including contraception, at no cost to the consumer. Additionally, the law's expansion of Medicaid family-planning programs improved low-income women's access to contraceptive services by allowing states to expand their state Medicaid family-planning programs more easily. The Affordable Care Act also made important and long-overdue progress toward ending insurance companies' discriminatory coverage policies, which had profound consequences for women's reproductive-health care.

Despite these improvements, the Affordable Care Act is far from perfect. The law imposes unacceptable restrictions on access to abortion care and affects abortion coverage in private insurance plans in an unprecedented manner. Fortunately, the final law did not include the Stupak-Pitts amendment, which would have made it virtually impossible for women to purchase plans with abortion coverage in state insurance exchanges.[2] The law does, however, contain onerous provisions that were added to gain the vote of anti-choice former Sen. Ben Nelson (D-NE). The Nelson restrictions impose significant constraints on insurance companies that want to include abortion services in their benefit plans and have the potential to create obstacles for consumers seeking comprehensive coverage.

Following is a summary of the law's key provisions affecting reproductive-health care:

The Law Makes Family-Planning Services More Affordable

Under the law, most health plans issued after March 23, 2010 must cover family-planning services, including the full range of Food and Drug Administration-approved methods of contraception.[3] Plans must cover—with no cost-sharing requirements—certain preventive-health services recommended by the U.S. Preventive Services Task Force (USPSTF). Through a provision known as the Women's Health Amendment, the health-reform law extended the list of preventive-care services to include certain health services specific to

women.[4] In order to implement this provision, the Department of Health and Human Services (HHS) commissioned the Institute of Medicine (IOM) to conduct a study on preventive care for women. In July 2011, the IOM officially recommended that family-planning services, including the full range of FDA-approved contraceptive methods, be recognized as a women's preventive-health service that should be covered by insurance plans without additional costs to individuals.[5]

HHS adopted the IOM recommendations in full and in May 2015, the administration released guidance clarifying that plans are required to cover at least one form of contraception within each of the 18 methods, as defined by FDA.[6] However, the administration explicitly exempted religious houses of worship from the contraceptive-coverage requirement. Moreover, the policy provides an accommodation to religiously *affiliated* non-profit employers that oppose offering their employees contraceptive coverage. Under the accommodation, these organizations—such as hospitals, universities, and social-service organizations—are allowed to opt out of the policy by either submitting a form to their insurers or by sending a letter to HHS directly—but in those cases, insurance companies will be responsible for covering birth control directly, ensuring that women who work at these organizations will receive coverage of contraceptives seamlessly, confidentially, and without a co-pay. The first phase of this momentous policy went into effect on August 1, 2012. In August 2014, the administration announced a modification to the contraceptive-coverage policy in which it solicited comments on permitting closely held, for-profit corporations to avail themselves of the same accommodation arrangement and released final rules for this policy in July 2015. The change in policy was in response to the U.S. Supreme Court's *Hobby Lobby* decision, which ruled that closely held, for-profit organizations may deny their employees birth-control coverage, citing religious objections. The modification is an attempt to ensure that women who work for these employers will enjoy the same level of coverage.

Near-universal coverage of family-planning services removed significant financial obstacles for women seeking reproductive-health care and enhanced access to contraception.

- It is estimated that 38 million women in the United States are in need of contraception.[7] Prior to passage of the Affordable Care Act, birth control was simply too expensive for many women. A 2010 study found that one in three women struggled with the cost of prescription birth control, a number that increased significantly among women of color: 57 percent of Latinas ages 18-34 and 54 percent of African-American women in that same age group struggled with the cost of birth control at some point.[8] Because of the longstanding connection between racial discrimination and economic disadvantage, women of color are represented disproportionately among those affected by increases in such health-care costs.

- Research has shown that even small cost-sharing requirements can drastically reduce use of preventive care, including family-planning services, particularly for low-income women.[9] Moreover, costs associated with birth control obstruct women's ability to

access highly effective contraceptive methods, such as intrauterine devices (IUDs), leading them to use methods with higher failure rates.[10] Conversely, removal of cost barriers such as co-pays or deductibles results in a shift toward the most effective contraceptive methods. It follows, then, that removing cost barriers is a critical step to increasing the use of highly effective contraception and reducing unintended pregnancy rates.[11] In fact, recent studies bear this out; one St. Louis-based study shows that no-cost contraception indeed resulted in substantially lower rates of abortion and teen pregnancy, and authors posited that nationwide implementation of no-cost coverage coupled with methods counseling could reduce abortion rates by 41 to 71 percent. [12]

- Multiple studies have found that, as a result of the health-reform law's new no-cost birth-control benefit, women in the United States are saving a significant amount of money in out-of-pocket health-care costs. For instance, a 2015 study found that women using birth control saved an average of $255 the year after the contraceptive policy went into effect.[13] A 2014 study estimated that collectively women saved $438 million in out-of-pocket costs for oral contraceptives alone.[14]

The decision to make family planning a no-cost preventive-health service is founded not only in science, but is consistent with existing federal policy. The Medicaid program currently labels family planning as a preventive service and requires that it be covered without cost-sharing.[15] TRICARE and the Peace Corps also cover approved contraceptives free of cost,[16] and the Federal Employee Health Benefits program requires all participating plans to cover family-planning care, including contraception. Moreover, nine in 10 Americans support public funding for family planning,[17] and nearly three out of four support covering contraception as a preventive health-service with no out-of-pocket costs.[18]

This historic policy has important benefits for women's health and contributes to healthy childbearing. Family-planning services have been shown to reduce unintended pregnancy rates and the negative health outcomes strongly associated with unplanned pregnancy. These outcomes include delayed or inadequate prenatal care, increased fetal exposure to tobacco and alcohol, increased likelihood of low birth weight and death in the first year of life, and higher risk of abuse and failure to receive sufficient resources for healthy development.[19] When women are able to afford family-planning services, they can avoid unplanned pregnancies, and rates of low-birth-weight births, infant deaths, and neonatal deaths significantly decrease.[20] (For further information on the contraceptive coverage requirement, please see the fact sheet, *Landmark Law Guarantees Access to Birth Control Without Copay*.)

The Law Expands Medicaid Family-Planning Programs

Although the Centers for Medicare and Medicaid Services has identified family-planning services as important, cost-saving care, states had to go through a cumbersome waiver process to expand family-planning coverage in their Medicaid programs prior to the Affordable Care Act. These waivers were time-limited demonstration projects that had to be evaluated and renewed at regular intervals. Recognizing the importance of expanded access to family-

planning services, the Affordable Care Act gave states the option to amend their Medicaid plans permanently to create a new family-planning eligibility group that will allow low-income women who otherwise do not qualify for Medicaid to obtain Medicaid family-planning services, eliminating the need to renew the program periodically.[21]

Currently, 27 states have expanded eligibility for coverage of Medicaid-funded reproductive-health services. Fifteen states operate their Medicaid family-planning program through a waiver obtained from the federal government: AL, FL, GA, IA, MD, MN, MS, MO, MT, NC, OR, PA, RI, WA, WY.[22] As of October 2015, 12 states have expanded eligibility for Medicaid family-planning services through a permanent State Plan Amendment authorized under the health care law: CA, CT, IN, LA, NH, NM, NY, OH, OK, SC, VA, and WI.[23]

Studies have shown that expanding access to family-planning services improves reproductive-health outcomes while saving states millions of dollars:

- In 2003, the Centers for Medicare and Medicaid Services commissioned a study of six family-planning program expansions. The report found that states improved access to and availability of services, and each saved at least $15 million a year.[24]

- Studies show that every $1 invested in family-planning services saves nearly $5.68 in Medicaid expenditures.[25] In 2010, an estimated $1.8 billion was spent on publicly funded family-planning care; an investment that resulted in an estimated $7.6 billion in Medicaid savings.[26]

- The cost of one Medicaid-covered birth in the United States, including the full range of prenatal, delivery, postpartum, and infant care services, was $12,613 in 2008. Comparatively, the national cost per client for contraceptive care that same year was $257.[27]

- In 2008, combined federal and state government expenditures on births resulting from unintended pregnancies were $12.5 billion—$7.3 billion federal and $5.2 billion state. The Guttmacher Institute estimates that an absence of publicly funded family-planning services would result in a 100-percent increase in the annual public costs of births from unintended pregnancies—raising government expenditures to an estimated $25 billion.[28]

Maternity Care Covered as an Essential Health Benefit

The Affordable Care Act specifically identifies "maternity and newborn care" as essential health benefits that must be offered by plans participating in the health-insurance exchanges.[29] As an essential health benefit, maternity care must be covered with low cost-sharing for the consumer.[30] While prenatal and newborn care are some of the most common types of medical services that women receive, many women have difficulty finding an insurance plan that covers maternity care.[31] A 2008 study found that only 12 percent of the 3,500 individual health plans sold nationwide offered any maternity coverage.[32] Requiring qualified health plans to cover

maternity care with low cost-sharing requirements greatly improves access to these services for millions of women.

Expansion of maternity coverage is particularly important for women of color. Nearly 24 percent of black women and 23 percent of Latina women initiate prenatal care late or do not seek prenatal care at all—a rate more than twice as high as that of white women.[33] Moreover, reports demonstrate that black women experience shockingly higher rates of maternal and infant mortality and low infant birth weight as compared to white women.[34] These disparities are perhaps linked to the fact that women of color, who disproportionally work in low-wage jobs that do not offer health benefits, are more likely to lack health insurance, making the reforms in the new law of particular importance for these communities.[35]

Preventive Maternity-Care Services Covered at No Cost

The health-care law also ensures that preventive care needed during a pregnancy is covered by health plans at no cost.[36] As mentioned above, health plans are now required to cover certain women's preventive-health services at no additional cost to the consumer. While a number of maternity-care services were on the USPSTF's original preventive-service list prior to passage of the Affordable Care Act, the Women's Health Amendment allowed for the inclusion of other maternity-care services.[37] The Department of Health and Human Services identified screening for pregnancy-associated diabetes, lactation counseling, and the cost of renting breastfeeding equipment as additional maternal-health services that should be considered preventive care.

Direct Access to OB/GYN Care Required

The Affordable Care Act requires that most plans issued on or after March 23, 2010 permit women to access obstetrical and gynecological specialists directly.[38] Under the law's requirements, plans are prohibited from forcing women first to secure prior approval from a primary-care provider before seeking this specialized care. Ensuring direct access improves women's ability to obtain maternity and reproductive services in a timely manner.

The Health-Care Law Includes Important, Overdue Insurance Reforms

In addition to ensuring coverage and affordability of comprehensive-health services, the Affordable Care Act also prohibits health plans from overcharging women for their health insurance and bans discrimination on the basis of health status. Beginning in 2014, insurance companies are no longer able to refuse coverage to or establish special eligibility for individuals with pre-existing conditions, such as being a victim of domestic violence or having a Caesarean-section birth.[39] Moreover, insurance companies are not be able to charge higher premiums to women than they do to men, as the Affordable Care Act explicitly bans premium-rating based on gender for plans sold in the individual and small business markets.[40] Prior to the passage of the health-care law, most states charged women higher premiums than men for the same coverage until the age of 55. One study found that women at age 25 were charged between six

and 45 percent more than men for comparable coverage, and that women at age 40 were charged between four and 48 percent more than men.[41]

Finally, insurance companies are prohibited from rescinding health-insurance policies, unless there has been fraud or an intentional misrepresentation of fact,[42] and no longer are permitted to impose lifetime limits on plans.[43] The law's ban on lifetime limits will particularly benefit women with chronic conditions or serious illnesses.

The Affordable Care Act Unacceptably Restricts Access to Abortion Care

While the health-reform law promises to improve health coverage for women in many respects, it fails to ensure that women will be able to receive *comprehensive* reproductive-health care. By placing onerous restrictions on abortion coverage in the new health system, the Affordable Care Act impedes women's ability to access a constitutionally protected, basic health-care service. While the final law did not include the House-passed Stupak-Pitts amendment, which would have made it virtually impossible for women to purchase plans with abortion coverage in state insurance exchanges, it did include the unacceptable Nelson provisions set forth in the Senate version of the bill. Consequently, the health-care law unfairly treats abortion coverage as a separate and distinct—even stigmatized—benefit, and imposes significant disincentives on insurance companies that want to include abortion services in their coverage.

The Nelson Provisions Restrict Women's Ability to Access Comprehensive Care

The Nelson stipulations impose unnecessary burdens on consumers who purchase and plans that offer abortion coverage. The law requires that insurance plans participating in the exchanges segregate monies used for abortion services from all other funds, and also that individuals purchasing a plan with abortion coverage make separate premium payments—one for their abortion coverage, and one for all other benefits.[44]

These unnecessary restrictions, which compel both individuals and insurance companies to incur increased administrative burdens, threaten insurers' willingness to offer full reproductive-health coverage and can severely limit women's ability to obtain abortion coverage within the exchange.[45] (For further information on the Nelson restrictions, please see the *Nelson Provisions in Health-Care-Reform Law Could Jeopardize, Stigmatize Women's Access to Abortion Services* fact sheet.)

The Nelson Requirements Invite States to Block Abortion Coverage

The Nelson language also includes a provision explicitly inviting states to ban, or enact their own Stupak-like restrictions on, abortion coverage in their state health-insurance exchange.[46] At the time the Nelson restrictions were adopted, six states already prohibited abortion coverage in the private insurance market: ID, KY, MO, ND, OK, RI.[47] (Rhode Island had two separate insurance prohibition laws; courts have declared one unconstitutional and unenforceable and the other partially unconstitutional and unenforceable.) And, as feared, passage of the

Affordable Care Act with this provocative language triggered a flood of activity in state legislatures across the country. As a result, since the law's enactment, 23 more states have enacted abortion-coverage bans: AL, AZ, AR, CO, FL, GA, IL, IN, KS, LA, MA, MI, MS, NE, NC, OH, PA, SC, SD, TN, UT, VA, WI.[48] Additionally, Idaho, Missouri, and Oklahoma passed laws expressly extending their private-market bans to their state's health-insurance exchange.[49] All told, now 29 states ban abortion coverage either in their health-insurance exchange, in the statewide private insurance market, or for public employees.[50]

Insurance-Company Compliance with Abortion Coverage Restrictions

In September 2010, the Department of Health and Human Services and the Office of Management and Budget released model guidelines for state insurance commissioners to use in monitoring insurance-company compliance with the Affordable Care Act's abortion-funding restrictions.[51] The guidelines were specifically intended to help state insurance commissioners ensure that insurance companies completely separate federal funds from all private dollars that are used for abortion care.

In March 2012, HHS issued a final rule adopting the model guidelines, which advises state insurance commissioners to require all health plans participating in state insurance exchanges to:

- submit plans that detail the accounting processes they intend to use to segregate funds;
- submit annual assurance statements declaring that they have segregated funds; and
- include the segregation requirement as part of plans' regular, periodic financial audits.[52]

Conclusion

Undeniably, the Affordable Care Act fails to protect a woman's right to choose abortion care—a key component of comprehensive health care for women. By imposing new restrictions on insurance companies who offer and individuals who buy abortion coverage, the law impedes women's ability to access the full health coverage they need. However, in ensuring coverage and affordability of maternity care, family-planning services, and other reproductive-health services in the new health system, the Affordable Care Act greatly improves women's access to basic health care. For this reason, supporters of reproductive rights will continue to advocate for repealing or fixing the abortion restrictions, while steadfastly supporting the law's many beneficial provisions. Progress towards improving health coverage for all Americans should not come at the price of restricting women's access to comprehensive health care.

January 1, 2017

Notes:

[1] P.L. 111-148, 111th Cong. (2010).

[2] NARAL Pro-Choice America Foundation, *The Stupak-Pitts Amendment Goes Far Beyond Current Law, Imposes Unprecedented Restrictions on Abortion Coverage for Millions of Women* (July 2010).

[3] Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 Fed. Reg. 149 (proposed August 3, 2011) (to be codified at 45 C.F.R. pt. 147).

[4] P.L. 111-148, 111th Cong. (2010) § 2713(a)(4).

[5] INST. OF MED., CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS (2011).

[6] Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 Fed. Reg. 149 (proposed August 3, 2011) (to be codified at 45 C.F.R. pt. 147). FAQs About Affordable Care Act Implementation (Part XXVI), May 11, 2015.

[7] Guttmacher Institute (GI), *Contraceptive Needs and Services, 2013 Update* (July 2015) *at* http://www.guttmacher.org/pubs/win/contraceptive-needs-2013.pdf (last visited Nov. 13, 2015).

[8] Press Release, Planned Parenthood Federation of America, *Survey: Nearly Three in Four Voters in America Support Fully Covering Prescription Birth Control* (Oct. 12, 2010).

[9] Adam Sonfield, *Contraception: An Integral Component of Preventive Care for Women*, 13 GUTTMACHER POL'Y REV. (2010) *at* http://www.guttmacher.org/pubs/gpr/13/2/gpr130202.html (last visited Nov. 13, 2015).

[10] Kelly Cleland, et al., *Family Planning as a Cost-Saving Preventive Health Service*, NEW ENG. J. MED (2011) *at* http://www.nejm.org/doi/full/10.1056/NEJMp1104373 (last visited Nov. 13, 2015).

[11] Kelly Cleland, et al., *Family Planning as a Cost-Saving Preventive Health Service*, NEW ENG. J. MED(2011) *at* http://www.nejm.org/doi/full/10.1056/NEJMp1104373 (last visited Nov. 13, 2015).

[12] Jeffrey Peipert, *Preventing Unintended Pregnancies by Providing No-cost Contraception* 120 AM. J. OBSTETRICS & GYNECOLOGY 6, (Dec. 2012). See also Diana G. Foster, et al., *Estimating the fertility effect of expansions of publicly funded family planning services in California*. WOMEN'S HEALTH ISSUES 21-6 (2011), 418–424.

[13] Nora Becker, et al., *Women Saw Large Decrease in Out-Of-Pocket Spending for Contraceptives After ACA Mandate Removed Cost sharing,* HEALTH AFFAIRS (2015) *at* http://content.healthaffairs.org/content/34/7/1204.abstract (lasted visited Nov. 13, 2015).

[14] IMS Institute for Healthcare Informatics, *Medicine use and shifting costs of healthcare: A review of the use of medicines in the United States in 2013* 16 (April 2014), *at* http://www.imshealth.com/cds/imshealth/Global/Content/Corporate/IMS%20Health%20Institute/Reports/Secure/IIHI_US_Use_of_Meds_for_2013.pdf (last visited Nov. 13, 2015).

[15] Kaiser Family Foundation, *State Medicaid Coverage of Family Planning Services: Summary of State Survey Findings* (Nov. 2009) *at* http://www.kff.org/womenshealth/upload/8015.pdf (last visited Nov. 13, 2015).

[16] TRICARE, *Costs* (Oct. 2011) *at* http://www.tricare.mil/Costs/PrescriptionCosts.aspx (last visited Oct. 1, 2014). Peace Corps, *Medical Benefits* (Sept. 2011) *at* http://www.peacecorps.gov/volunteer/learn/whyvol/during/ (last visited Nov. 13, 2015).

[17] Rachel Benson Gold, *Title X: Three Decades of Accomplishment,* GUTTMACHER REP. ON PUB. POL'Y, Feb. 2001, at 8.

[18] Hart Research Associates, *Findings From Recent National Survey On Coverage for Prescription Birth Control* (June 20, 2012).

[19] Committee on Unintended Pregnancy, Institute of Medicine, THE BEST INTENTIONS: UNINTENDED PREGNANCY AND THE WELL-BEING OF CHILDREN AND FAMILIES (Sarah S. Brown & Leon Eisenberg, eds. 1995).

[20] Guttmacher Institute (GI), *Fact Sheet: Unintended Pregnancy in the United States* (Dec. 2013), *at* http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html (last visited Nov. 13, 2015).

[21] P.L. 111-148, 111th Cong. (2010) § 2303.

[22] Guttmacher Institute (GI), *State Policies in Brief: Medicaid Family Planning Eligibility Expansions* (Oct. 2014) *at* http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf (last visited Nov. 13, 2015).

[23] Guttmacher Institute (GI), *State Policies in Brief: Medicaid Family Planning Eligibility Expansions* (Oct. 2014) *at* http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf (last visited Nov. 13, 2015).

[24] J. Bronstein Edwards, et al., *Evaluation of Medicaid Family Planning Demonstrations* (Alexandria, V: The CNA Corporation, Nov. 2003), cited in National Women's Law Center, *Reform Matters: What Women Need to Know About Health Reform: Access to Reproductive Health Services* (June 2010).

[25] Guttmacher Institute (GI), *Facts on Publicly Funded Contraceptive Services in the United States* (Aug. 2014) *at* http://www.guttmacher.org/pubs/fb_contraceptive_serv.html (last visited Nov. 13, 2015).

[26] Kelly Cleland, et al., *Family Planning as a Cost-Saving Preventive Health Service*, NEW ENG. J. MED (2011) *at* http://www.nejm.org/doi/full/10.1056/NEJMp1104373 (last visited Nov. 13, 2015).

[27] Kelly Cleland, et al., *Family Planning as a Cost-Saving Preventive Health Service*, NEW ENG. J. MED (2011) *at* http://www.nejm.org/doi/full/10.1056/NEJMp1104373 (last visited Nov. 13, 2015).

[28] Guttmacher Institute (GI), *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy and Infant Care: Estimates for 2008* (October 2013) *at* https://www.guttmacher.org/pubs/public-costs-of-UP.pdf (last visited Nov. 13, 2015).

[29] P.L. 111-148, 111th Cong. (2010) § 1302(b)(1)(D).

[30] P.L. 111-148, 111th Cong. (2010) § 1302(a)(2).

[31] National Women's Law Center, *Reform Matters: Making Real Progress for Women and Health Care* "What Women Need to Know About Health Reform: Access to High-Quality Maternity Care" (June 2010).

[32] Adam Sonfield, *The Potential of Health Care Reform to Improve Pregnancy-Related Services and Outcomes*, 13 GUTTMACHER POLICY REVIEW (2010) *at* http://www.guttmacher.org/pubs/gpr/13/3/gpr130313.html (last visited Nov. 13, 2015).

[33] Adam Sonfield, *The Potential of Health Care Reform to Improve Pregnancy-Related Services and Outcomes*, 13 GUTTMACHER POL'Y REV. (2010) *at* http://www.guttmacher.org/pubs/gpr/13/3/gpr130313.html (last visited Nov. 13, 2015). *See also* Kaiser Family Found., *Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level* (June 2009) 62, *at* https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7886.pdf (last visited Nov. 13, 2015).

[34] Amnesty International, *Deadly Delivery: The Maternal Health Care Crisis in the USA* (2010) *at* http://www.amnestyusa.org/dignity/pdf/DeadlyDelivery.pdf (last visited Nov. 13, 2015).

[35] Kaiser Family Found., *Racial and Ethnic Disparities in Women's Health Coverage and Access to Care: Findings from the 2001 Kaiser Women's Health Survey* (Mar. 2004), *at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/racial-and-ethnic-disparities-in-women-s-health-coverage-and-access-to-care.pdf (last visited Nov. 13, 2015). *See also* Kaiser Family Found., *Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level* (June 2009), *at* https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7886.pdf (last visited Nov. 13, 2015).

[36] P.L. 111-148, 111th Cong. (2010) § 2713(a)(4).

[37] National Women's Law Center, *Reform Matters: Making Real Progress for Women and Health Care* "What Women Need to Know About Health Reform: Access to High-Quality Maternity Care" (June 2010). Relevant services listed on the USPSTF include Rh (D) blood typing and antibody testing for pregnant women, folic acid supplementation, smoking cessation counseling, STI testing for pregnant women, and interventions intended to promote breastfeeding.

[38] P.L. 111-148, 111th Cong. (2010) §2719A(d).

[39] P.L. 111-148, 111th Cong. (2010).

[40] P.L. 111-148, 111th Cong. (2010).

[41] National Women's Law Center, *Reform Matters: Making Real Progress for Women and Health Care* "The Individual Insurance Market: A Hostile Environment for Women" (2008).

[42] P.L. 111-148, 111th Cong. (2010) §2712.

[43] P.L. 111-148, 111th Cong. (2010) §2711(a)(1)(A).

[44] P.L. 111-148, 111th Cong. (2010), *at* § 1303(b)(2).

[45] NARAL Pro-Choice America, *Nelson Provisions in Health-Care-Reform Law Could Jeopardize, Stigmatize Women's Access to Abortion Services* (January 1, 2015).

[46] P.L. 111-148, 111th Cong. (2010), *at* § 1303(a)(1).

[47] NARAL Pro-Choice America & NARAL Pro-Choice America Foundation, *Who Decides? The Status of Women's Reproductive Rights in the United States* (26th ed. 2017), at www.WhoDecides.org.

[48] Guttmacher Institute (GI), *State Policies in Brief: Restricting Insurance Coverage of Abortion* (Sept. 1, 2014) *at* http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf (last visited Nov. 13, 2015).

[49] Guttmacher Institute (GI), *State Policies in Brief: Restricting Insurance Coverage of Abortion* (Sept. 1, 2014) *at* http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf (last visited Nov. 13, 2015).

[50] NARAL Pro-Choice America & NARAL Pro-Choice America Foundation, *Who Decides? The Status of Women's Reproductive Rights in the United States* (26th ed. 2017), at www.WhoDecides.org.

[51] Pre-Regulatory Model Guidelines Under Section 1303 of the Affordable Care Act (PL-111-148): Issued Pursuant to Executive Order 13535 (March 24, 2010) (Sep. 20, 2010) *at* http://www.whitehouse.gov/sites/default/files/omb/assets/financial_pdf/segregation_2010-09-20.pdf (last visited Nov. 13, 2015).

[52] 45 C.F.R. § 156.280.