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Authors

Brindis, Claire D
Freund, Karen M
Baecher-Lind, Laura
[et al.](#)

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Commentary

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



Claire D. Brindis, DrPH^{a,*}, Karen M. Freund, MD, MPH^b,
 Laura Baecher-Lind, MD, MPH^c, C. Noel Bairey Merz, MD^d,
 Molly Carnes, MD, MS^e, Martha Gulati, MD, MS, FACC, FAHA, FASPC^f,
 Hadine Joffe, MD, MSc^g, Wendy S. Klein, MD, MACP^h, Carolyn M. Mazure, PhDⁱ,
 Lydia E. Pace, MD, MPH^{g,j}, Judith G. Regensteiner, PhD^k, Rita F. Redberg, MD, MSc^l,
 Nanette Kass Wenger, MD^m, Lorie Younger, MSW^d

^a Bixby Center for Global Reproductive Health, University of California, San Francisco, San Francisco, California

^b Tufts Medical Center, Boston, Massachusetts

^c Tufts University School of Medicine, Boston, Massachusetts

^d Barbra Streisand Women's Heart Center, Cedars-Sinai Heart Institute, Los Angeles, California

^e Center for Women's Health Research, University of Wisconsin-Madison, Madison, Wisconsin

^f Banner University Medical Center Cardiovascular Institute, University of Arizona, Phoenix, Arizona

^g Mary Horrigan Connors Center for Women's Health and Gender Biology, Brigham and Women's Hospital, Harvard Medical School, Boston, Massachusetts

^h VCU Institute for Women's Health, Virginia Commonwealth University School of Medicine, Richmond, Virginia

ⁱ School of Medicine, Women's Health Research, Yale University, New Haven, Connecticut

^j Division of Women's Health, Brigham and Women's Hospital, Boston, Massachusetts

^k Center for Women's Health Research, University of Colorado Anschutz Medical Campus, Aurora, Colorado

^l University of California, San Francisco, San Francisco, California

^m Emory University School of Medicine, Atlanta, Georgia

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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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* Correspondence to: Claire D. Brindis, DrPH, 3333 California St., Suite 265, San Francisco, CA 94143. Phone: 415-476-5255; fax: 415-476-0705.

E-mail address: Claire.Brindis@ucsf.edu (C.D. Brindis).

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 (Guttacher 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; Guttacher 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 (Guttacher 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 (Guttacher 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

program. As a result, millions of low-income women and men may lose vital access to contraceptive care and be at increased risk of unintended pregnancies.

Risks to Other DHHS Programs to Support Young Women

Leaders within DHHS are also working to eliminate other programs that directly benefit young women and men, specifically related to access to comprehensive sex education. Funding under the auspices of the federal Office of Adolescent Health, established by President Obama, was precipitously eliminated for 81 organizations that were implementing and evaluating evidence-based programs geared to parents, adolescents, and other stakeholders (Kappeler & Farb, 2014; Kay, 2017). In July 2017, the House Appropriations Committee defeated proposals to restore grant funding of \$213 million dollars; the purported rationale for these cuts has been that the programs have not been shown to be effective, even though programs were still being evaluated and these cuts would prevent the completion of these evaluations. It is anticipated that a substantial proportion of these funds will be reallocated to abstinence-only programs education. Comprehensive sexual education is supported by the American Medical Association, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and others, who deem it to be both evidence based and ethically sound compared with abstinence-only sexual education programs. Eleven of the 13 most commonly used abstinence-only curricula included false or misleading information about reproductive health, including distorted information about risks of contraception and of abortion (Santelli, 2008; Waxman, 2004). Valerie Huber, now Chief of Staff to the Assistant Secretary for Health, but previously director of Ascend, an abstinence education organization, is driving much of the effort to redeploy approximately \$277 million into abstinence education (Johnson, 2017; U.S. DHHS, n.d.). The administration has indicated the desire to eliminate the Office of Adolescent Health altogether, even though data support its programmatic outcomes, in contrast to negative findings associated with the majority of abstinence-only education programs (Santelli, Kantor & Grilo, 2017).

The Need to Engage and Educate the Public

The ACA and other federally funded efforts have made vital gains for women's access to high-quality preventive services and care, and it is critical for us all to mobilize to preserve these before they are lost. As clinicians, public health practitioners, and health policy experts, we can have a significant impact by speaking out to our state and national representatives and the public (Gardner & Brindis, 2017) about the value of women's health services and the potential effect of cutting or reducing access to these essential services for women, their families, communities, and the health care industry.

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Author Descriptions

Claire D. Brindis, DrPH, is Professor and Director, Bixby Center for Global Reproductive Health and Director, Philip R. Lee Institute for Health Policy Studies at the University of California, San Francisco. Her research focuses on reproductive health and access to care.

Karen M. Freund, MD, MPH, is a Professor and Vice Chair of Medicine at Tufts University School of Medicine, and faculty member in the Institute for Clinical Research and Health Policy Studies at Tufts Medical Center, Boston, Massachusetts.

Laura Baecher-Lind, MD, MPH, is Associate Professor, Tufts University School of Medicine; and Division Director, Division of General Ob/Gyn at Tufts Medical Center, Boston, Massachusetts. She is active in medical education, leading the pre-clerkships and clerkships at the School of Medicine.

C. Noel Bairey Merz, MD, is Director of the Barbra Streisand Women's Heart Center at Cedars-Sinai Medical Center in Los Angeles, California. Her research interests are focused on women and cardiovascular disease.

Molly Carnes, MD, MS, is a Professor in the Departments of Medicine, Psychiatry, and Industrial & Systems Engineering at the University of Wisconsin-Madison. She studies interventions to diversify the academic medicine, science, and engineering workforce by helping faculty “break the bias habit.”

Martha Gulati, MD, MS, FACC, FAHA, FASCP, is a Professor of Medicine and the Chief of Cardiology at the University of Arizona-Phoenix. Her clinical and research interests are women and ischemic heart disease, in addition to heart disease prevention in women.

Hadine Joffe, MD, MSc, is Executive Director, Mary Horrigan Connors Center for Women's Health and Gender Biology, Brigham and Women's Hospital; and Associate Professor of Psychiatry in Women's Health, Harvard Medical School. Her research focuses on female reproductive hormones on neuropsychological symptoms.

Wendy S. Klein, MD, MACP, is Emeritus Associate Professor of Internal Medicine, Obstetrics and Gynecology at Virginia Commonwealth University School of Medicine and co-founder of the VCU Institute of Women's Health. She currently serves on the Virginia Board of Health.

Carolyn M. Mazure, PhD, is the Norma Weinberg Spungen and Joan Lebson Bildner Professor of Psychiatry and Psychology, and the Director of Women's Health Research at Yale, the university's interdisciplinary research center on the influence of sex and gender on health.

Lydia E. Pace, MD, MPH, is research faculty, Division of Women's Health, Brigham and Women's Hospital, and Instructor in Medicine, Harvard Medical School. Her research interests include access to and uptake of preventive health care services for women.

Judith G. Regensteiner, PhD, is Professor of Medicine, Judith and Joseph Wagner Chair of Women's Health Research, and Director of the Center of Women's Health Research at the University of Colorado Anschutz Medical Campus.

Rita F. Redberg, MD, MSc, is a Professor of Medicine and Director of Women's Cardiovascular Services at University of California, San Francisco (UCSF) Medical Center and Core Faculty at the Philip R Lee Institute for Health Policy Studies.

Nanette Kass Wenger, MD, is Professor of Medicine, Division of Cardiology, Emory University School of Medicine; consultant, Emory Heart and Vascular Center; and Founding Consultant, Emory Women's Heart Center. Heart disease in women is among her major clinical, research, and advocacy interests.

Lorie Younger, MSW, is the Community Education Coordinator for the Barbra Streisand Women's Heart Center at Cedars-Sinai Medical Center, Los Angeles, California.