Top Ten Threats to Women's Reproductive Health Under the Senate's Bill to Repeal the Affordable Care Act: Implications for California

By Amy Chen and Emily Hayes[1]

On June 26, Senate Republicans updated the bill to repeal the ACA and eliminate the current financing structure of Medicaid (misleadingly titled "Better Care Reconciliation Act" (BCRA)).[2] This bill is a revised version the Senate discussion draft released on June 22, and is likely to change again in the coming days. Regardless, it highlights the Senate's desire to decimate the Medicaid program. Even if minor changes are made before the actual vote, BCRA strikes a death blow to Medicaid as we know it. The independent Congressional Budget Office (CBO) analysis found that BCRA would cut $772 billion from Medicaid.[3] This means 15 million low-income people—including kids, seniors, and people with disabilities—will lose their health coverage. In California, 4.1 million people enrolled in the Medicaid Expansion could lose their coverage.[4] The State's own analysis concludes that the current federal proposal represents a significant shift of costs from the federal government resulting in nearly $3 billion in costs to California in 2020, growing to $30.3 billion by 2027.[5] The State General Fund share is estimated to be $3 billion in 2020, increasing to $24.3 billion in 2027.[6] This fact sheet addresses how BCRA impacts reproductive health access in California.

1. **Slashes Medicaid Funding for Reproductive Health Services by Implementing a Per Capita Cap.** Medicaid is a critical source of reproductive health services for low-income women, covering half of all births in the United States and three quarters of all publicly funded family planning services.[7] Since 1965, Medicaid has operated as a federal-state partnership where states receive, on average, 63% of the costs of providing Medicaid from the federal government.[8] Currently, the federal share is based on the actual costs of services. BCRA limits the federal contribution based on a state's historical expenditures inflated at a rate that is projected to be less than the yearly growth of Medicaid health care costs.[9] Starting in 2025, states would be limited to an even stingier growth rate than in the initial per capita cap (PCC) years. BCRA also imposes a penalty on states that spend above the national mean, starting in 2022. It would not matter if a state spends more because care is more costly due to geography or other factors or because enrollees are older or sicker than in another state. If a state spends 25% more than the national mean for a particular eligibility group (e.g. pregnant women as part of the adult group), it could lose up to 2% of its aggregate cap amount for the applicable group for that year. Federal funding for Medicaid would shrink significantly

over time. In response, states would be forced to cut coverage and services for all Medicaid enrollees, including the 13 million women of reproductive age enrolled in Medicaid.[10] States could also reduce Medicaid eligibility, for example, by lowering income eligibility levels for pregnant women in optional eligibility categories.[11] The result is that Medicaid would cover fewer women and provide less comprehensive reproductive health services to those who remain enrolled.

***California Impact*:** California stands to be a big loser in the Medicaid financial restructuring scheme of the BCRA's PCC. And since the BCRA cost cap trend is significantly lower beginning in FY 2025, the impact to California will be even more catastrophic in the out years. The State estimates it will be responsible for an increased state share of approximately $2.6 billion in 2020, growing to $11.3 billion by 2027.[12] Cumulatively over the course of 2020 through 2027, the impact to California is estimated to be $37.3 billion.[13] California would also be disproportionately impacted by PCCs, since it spends less per Medicaid beneficiary than most other states, and only receives 50% of the cost of providing Medicaid from the federal government, less than the national average of 64%.[14] Medi-Cal, California's Medicaid program, finances more than half of all births in the state and 83% of the state's publicly funded family planning services.[15] Women make up 54% of the 13.4 million Californians enrolled in Medi-Cal and people of color represent 68%.[16] PCCs would jeopardize the health and financial security of these millions of women, including women of color, who benefit from Medi-Cal each year. California's population of people with disabilities is growing faster than the national average, and this is a group that also receives reproductive health care coverage. Faced with growing demands for Medi-Cal services, it will be increasingly difficult for the state to maintain costs under the PCC amount.

2. **Reduces Access to Care for Low Income Women by Gutting and then Ending Medicaid Expansion.** The expansion of Medicaid enacted in the ACA has provided a significant source of coverage for millions of women, and has been critical to improving both maternal and child health outcomes by providing access to comprehensive health care services, including family planning services, for women who will or who are planning to conceive.[17] BCRA guts protections for those in the Medicaid expansion population effective January 1, 2020 by eliminating the requirement that states provide them with at least the ten essential health benefits, among them preventive and wellness services, mental health coverage, and maternity and newborn services. It also requires those in the Medicaid expansion population to submit eligibility renewal paperwork every six months just to stay on Medicaid, beginning October 1, 2017. The bill reduces the enhanced federal funding to states for all expansion enrollees from 90% to 75% over a three-year period from 2021 through 2023. BCRA then effectively repeals Medicaid expansion on January 1, 2024 by reducing federal funding for the expansion population as of that date to only regular federal contribution rates. Expansion states are unlikely to be able to make up the difference in federal funding with state funds.

***California Impact*:** California's expansion of Medi-Cal has brought coverage to nearly 4 million low-income individuals, including more than 1.8 million nonelderly adult women.[18] Additionally, the program has directed an estimated $2.2 billion each year into the

state's health care safety net.[19] Beginning in 2024, the federal matching rate will be reduced to a state's traditional 50% federal matching rate. This means that in order to maintain the expansion (notwithstanding the effects of the per capita limits) California would need to spend five times as much as originally estimated.[20] By 2027 the cost to California is $18.0 billion ($12.6 billion state general fund), and cumulatively from 2021 through 2027 it is $74.1 billion ($51.9 billion state general fund).[21] In addition, California law contains a "trigger" that directs the State to address the funding reduction through the state legislature. It is not entirely clear when or how this proposal would go into effect if BCRA is enacted as currently proposed. But if the state moved forward with a repeal of the Expansion, approximately 4 million low-income Californians stand to lose their coverage.[22]

3. **Jeopardizes the Economic Stability of Individuals and Families by Eliminating Medicaid Retroactive Eligibility.** Medicaid has long provided coverage for up to three months before the month an individual applies for coverage. This "retroactive coverage" protects individuals from medical expenses they incurred before they applied for Medicaid. An individual may not be able to apply for Medicaid immediately due to hospitalization, a disability, or other circumstances. Retroactive coverage has thus saved millions of individuals and families from the burden of unexpected medical debt and possible financial bankruptcy. BCRA repeals this coverage for all Medicaid enrollees starting October 1, 2017.

   California Impact: Under current law, Medi-Cal applicants may receive up to three months of retroactive coverage for care received prior to their application, if they would have been eligible for Medi-Cal.[23] Eliminating the retroactive eligibility requirements penalizes Californians who did not or were not able to complete the enrollment process before needing medical care, and who could potentially face significant financial distress because of the medical expenses that had been incurred. When combined with new requirements that eligibility be renewed every six months, women and girls may face gaps in coverage during which Medi-Cal may not pay for reproductive health services that would have been covered otherwise.

4. **Allows States to Implement Medicaid Work Requirements for Most Adult Enrollees, Including Women Who Have Recently Given Birth.** BCRA allows states to institute a work requirement for most adult Medicaid enrollees beginning October 1, 2017. Currently, nearly 8 in 10 Medicaid enrollees are part of a working family. Another 14% of Medicaid enrollees are currently looking for work. Yet this BCRA option would require work as a condition of eligibility, including enrollees who are caring for a parent or spouse, as well as both parents in a two-parent household. Further, individuals receiving mental health or substance use disorder services who are eligible through Medicaid expansion (rather than a disability category) would also be required to work as a condition of receiving treatment, which could undermine their progress and recovery. In addition to running counter to the very purpose of Medicaid, work requirements have also proven ineffective in either decreasing poverty or increasing employment.[24] On the contrary, Medicaid makes it easier for people find and sustain work.[25] The only enrollees exempt from the work requirement are children, older adults, people with disabilities, pregnant women through the postpartum period, certain single parents and

caretakers, and certain categories of students. Notably, while pregnant women are exempt, a woman who has recently given birth would still be required to fulfill the work requirement immediately after a postpartum period which could be as short as eight to nine weeks, a fact which contradicts what we know about postpartum recovery and the importance of newborn bonding.[26]

California Impact:
A work requirement would burden and exclude many Californians from accessing affordable health care services. While some people are categorically excluded from a work requirement, many people who may not fit into those categories are still unable to work. These people, whose inability to work may be related to a health condition that does not meet the qualifications for disability or to caregiving responsibilities, will be unable to retain their Medi-Cal health insurance. Almost half (47%) of Medi-Cal expansion enrollees were currently working in 2015, and another 12% were actively seeking work.[27] It is unlikely that a work requirement in California would meet its intended goal of increasing the prevalence of consistent, stable employment among Medi-Cal beneficiaries. As demonstrated in a recent study by the Center on Budget and Policy Priorities, the effect of a work requirement on the actual incidence of work over a five-year period among cash assistance recipients in Riverside, CA was minimal. [28]

The impact of a work requirement on California women of reproductive age, who must return to work upon the end of their legal postpartum period to continue to receive health care would be harmful for those women, for their newborns, and for other children in the family. The impact of a Medi-Cal work requirement on the one in five women in California who experience prenatal or postpartum depression would be even more damaging.[29] These women would be required to work to receive coverage for their post-partum mental health needs, but may not be able to effectively care for their children and seek work while experiencing postpartum depression.

5. **Prevents Women on Medicaid from Obtaining Services at Planned Parenthood.**
BCRA prevents Planned Parenthood from participating in the Medicaid program for one year, starting on the date of the bill's enactment. This would mean many Medicaid enrollees would no longer be able to receive Medicaid-covered services from their trusted provider of choice. Excluding Planned Parenthood from the Medicaid program reduces access to essential preventive care, such as contraception, tests and treatment for sexually transmitted infections, and breast and cervical cancer screenings. Other safety-net providers such as community health centers lack the capacity to serve all the Medicaid enrollees who could no longer receive care at Planned Parenthood. As a result, in some areas of the country, particularly rural areas, people would lose access to critical reproductive health services.

California Impact: Planned Parenthood is a critical provider of basic health care services in California, serving an estimated 850,000 men and women in California each year, 600,000 of which are Medi-Cal or Family PACT beneficiaries, at 110 health clinics throughout the state.[30] Planned Parenthood Affiliates of California receives nearly $250 million in total funding.[31] Barring them from participation in Medi-Cal for one year would

be devastating for reproductive health access. In the absence of additional state funds, this provision would prevent Medi-Cal enrollees from seeing their provider of choice for essential preventive care such as family planning services, abortion, tests and treatment for sexually transmitted infections, and breast and cervical cancer screenings.

6. **Allows States to Slash Medicaid Funding for Reproductive Health Services by Operating Medicaid as a Block Grant for Certain Populations.** BCRA also gives states the option to operate their Medicaid program as a block grant for people who are not elderly, disabled, pregnant, or expansion adults. States would be locked in for a five-year period and the growth rate would be lower than the initial per capita cap growth rate. Federal funding for Medicaid under a block grant structure would fail to meet the demand and shrink over time, both because of the lower growth rate and because a block grant does not increase with enrollment. This cut to Medicaid funding would force states to cut coverage and services for all enrollees, including women who rely on Medicaid for access to reproductive health services.

   California Impact: If California chose to proceed with a block grant structure, funding for Medicaid would be cut even more drastically than under the PCC. While pregnancy-related Medicaid is not included in the block grant, this cut would have a devastating impact on the availability of family planning and abortion services in Medi-Cal because it would necessarily result in major cuts to benefits and/or already low provider reimbursement rates. With less funding, the state may no longer be the leader for individuals who seek all types of reproductive health care. Less funding will also mean that individuals who seek family planning services will have less access to Medi-Cal providers. As family planning services are time-sensitive, it is critical that individuals have immediate access to a large pool of providers.

7. **Makes Private Coverage for Women Less Affordable.** Nearly 7 million women and girls selected a private insurance marketplace plan during the 2016 open enrollment period.[32] The majority relied on the ACA's federal subsidies to help make the coverage more affordable. BCRA maintains the ACA's current income-based premium tax credits through 2019, but effective January 1, 2020 replaces them with less generous tax credits available only to individuals with incomes up to 350 percent of the federal poverty level. The bill ties the federal subsidies to a less comprehensive benchmark plan with 58% actuarial value, significantly lower than the 70% actuarial value of the current benchmark, effectively reducing the value of the tax credits overall. BCRA repeals the ACA's cost-sharing subsidies, which help lower-income marketplace enrollees afford coverage, on January 1, 2020. The bill also limits immigrant eligibility for the tax credits to merely "qualified aliens," a much narrower category than immigrants "lawfully present in the United States" who currently qualify for tax credits under the ACA. Taken together, these changes would raise premiums, increase deductibles, and make it harder for all women, including immigrant women, to afford high-quality comprehensive health care that meets their needs.

   California Impact: BCRA would raise total out-of-pocket health costs—including premiums, deductibles, copays, and coinsurance. Since BRCA eliminates the ACA's

cost-sharing reductions, low-income Californians would be even worse off, with their out-of-pocket costs increasing substantially. BCRA would result in fewer Californians being able to afford health insurance altogether, including the millions of women who currently rely on the ACA's federal tax credits and cost sharing subsidies to afford coverage through Covered California. Lawfully present immigrants in California will also be impacted by the restriction of lawful, non-qualified immigrants from purchasing Covered California plans. Immigrants who do not fit into the "qualified" categories include student and work visas and those in the process of applying for a "qualified" visa type.

8. **Restricts Access to Abortion Care in Private Plans.** BCRA includes restrictions that prohibit individuals and small employers, effective January 1, 2018, from using federal tax credits to purchase private health insurance plans that include abortion coverage beyond the Hyde exceptions.[33] The bill also prevents insurers from accessing any funds in the State Stability and Innovation Program if they offer abortion coverage beyond the Hyde exceptions.[34] Taken together, these provisions could cause insurance companies to stop offering plans that include abortion coverage altogether, thereby putting abortion access further out of reach for women in the private market.

   California Impact: The Senate GOP repeal bill's abortion restriction is of particular concern for California, which requires abortion coverage in most of its private plans.[35] The restriction stands as a direct challenge to the state's longstanding commitment to provide women with comprehensive reproductive health coverage. It would force California into the absurd situation of either having to alter its longstanding policies on abortion coverage, or run the risk of dramatically reducing the number of state residents who are eligible for federal tax credits.

9. **Allows States to Waive Essential Health Benefits Requirements Which Guarantee Coverage for Maternity and Newborn Care.** BCRA outright eliminates essential health benefits (EHBs) for the Medicaid expansion population on December 31, 2019. It then goes further by encouraging states to drop the ACA's requirement that all plans in the individual and small group markets must cover EHBs by removing restrictions to the 1332 innovation waivers. The list of EHBs includes maternity and newborn care, as well as other services essential to basic reproductive health such as preventive and wellness services, mental health and substance use disorder services, and prescription drugs. Prior to passage of the ACA, only 12% of individual health plans across the country covered maternity care, resulting in high out-of-pocket costs for pregnant women.[36] Elimination of the EHB requirement would again leave many women without adequate maternity care or force them to incur debt to obtain care. It would also effectively allow plans to practice gender discrimination by requiring women to pay more for plans that do include maternity care.

   California Impact: California has aligned the benefits the Medi-Cal Expansion population receives with the State's approved state plan benefits. This means that *all* Medi-Cal populations receive the same benefits. Since the state's essential health benefits benchmark plan for the private market offered additional mental health and substance use disorder services from those offered in Medi-Cal, as of January 1, 2014,

the state added the additional benefits to the coverage received by all Medi-Cal populations, not just the Expansion.[37] Without the EHB requirement for the Medi-Cal Expansion, Medi-Cal enrollees could lose health coverage for critical basic health services including maternity care, mental and behavioral health, and preventive services.

10. **Allows States to Weaken Protection for People with Pre-Existing Conditions.** Prior to passage of the ACA, insurers regularly charged women higher premiums, or outright denied them coverage, based on preexisting condition exclusions such as being cancer survivors, having had a cesarean section, having received medical treatment from domestic violence or sexual assault, or for being pregnant.[38] The ACA changed all this, by prohibiting health plans from either denying coverage or charging higher premiums to people with pre-existing conditions. Under the BCRA, a state can waive EHBs, undermining this key ACA protection. Health plans in states that choose to modify or eliminate EHBs would likely offer health coverage that is considerably less comprehensive. People with pre-existing conditions would then be forced to pay higher premiums for more comprehensive coverage that includes their needed services. One study found that if a state eliminated the EHB requirement to cover maternity care, the premium for a maternity care rider would cost a pregnant woman an additional $17,320 in 2026.[39] If a state eliminated all EHB requirements, a rider to cover treatment for breast cancer could cost $28,660.[40] The result would be an end run around the ACA's prohibition on discriminating against people with pre-existing conditions.[41] Elimination of this ACA protection could prevent pregnant women and women with chronic and other pre-existing conditions from obtaining health insurance that meets their needs, or indeed from obtaining health insurance at all.

California Impact: There are an estimated 16.1 million Californians with pre-existing conditions.[42] In the absence of protections ushered in by the ACA, these Californians could once again be legally charged higher prices for less comprehensive coverage.

ENDNOTES

[1] NHeLP 2017 summer intern.
[2] Better Care Reconciliation Act of 2017, H.R. 1628, 115th Cong. (1st Sess. 2017).
[3] CONGRESSIONAL BUDGET OFFICE, H.R. 1628, BETTER CARE RECONCILIATION ACT OF 2017 COST ESTIMATE (June 26, 2017), https://www.cbo.gov/publication/52849.
[4] MARC TAYLOR, LEGISLATIVE ACCOUNTABILITY OFFICE, THE 2018-18 BUDGET: ANALYSIS OF THE MEDI-CAL BUDGET 9 (Mar. 9, 2017), http://www.lao.ca.gov/reports/2017/3612/medi-cal-budget-030917.pdf.
[5] Memorandum from Jennifer Kent, Director, Department of Health Care Services & Mari Cantwell, Chief Deputy Director & State Medicaid Director, Department of Health Care Services, to Diana S. Dooley, Secretary, Department of Health Care Services, Summary and Preliminary Analysis of the Medicaid Provisions in the Better Care Reconciliation Act (June 27, 2017), http://www.dhcs.ca.gov/Documents/BCRA_Impact_Memo_062717.pdf.
[6] *Id.*
[7] Anne Rossier Markus et al., Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform, 23-5 WOMEN'S HEALTH ISSUES e273, e275 (2013), http://www.whijournal.com/article/S1049-3867%2813%2900055-

8/pdf; ADAM SONFIELD & RACHEL BENSON GOLD, GUTTMACHER INSTITUTE, PUBLIC FUNDING FOR FAMILY PLANNING, STERILIZATION, AND ABORTION SERVICES, FY 1980-2010, at 8 (2012), https://www.guttmacher.org/pubs/Public-Funding-FP-2010.pdf.

[8] KAISER FAMILY FOUND., FEDERAL AND STATE SHARE OF MEDICAID SPENDING (Jan. 2017), http://kff.org/medicaid/state-indicator/federalstate-share-of-spending.

[9] BCRA's growth rate from the state's base year through 2019 is the medical component of the Consumer Price Index (CPI-M). For 2019-2025, the growth rate would be CPI-M plus 1% for elderly enrollees and enrollees with disabilities and CPI-M for adults and children. Beginning in 2025, the growth rate would lower to the "regular" CPI which grows even slower than CPI-M and does not include long term care costs.

[10] GUTTMACHER INSTITUTE, UNINSURED RATE AMONG WOMEN OF REPRODUCTIVE AGE HAS FALLEN MORE THAN ONE-THIRD UNDER THE AFFORDABLE CARE ACT (Nov. 2016), https://www.guttmacher.org/article/2016/11/uninsured-rate-among-women-reproductive-age-has-fallen-more-one-third-under.

[11] States are required to cover pregnant women up to at least 133 percent of the poverty level, and in some states the upper limit is even higher. However, many states have voluntarily set eligibility limits for pregnant women at much higher levels. For a chart of the current state income limits for Medicaid coverage for pregnant women, alongside the minimum income eligibility level below which the state cannot drop, see AMY CHEN & MARISA SPALDING, NATIONAL HEALTH LAW PROGRAM, STATE CREATION OF SPECIAL ENROLLMENT PERIODS FOR PREGNANCY at Appendix A (Jan. 2017), http://www.healthlaw.org/issues/reproductive-health/pregnancy/state-creation-of-sep-for-pregnancy.

[12] Memorandum from Jennifer Kent to Diane S. Dooley, *supra* note 5 at 2.

[13] *Id.*

[14] MEDICAID & CHIP PAYMENT & ACCESS COMM'N, MACSTATS: MEDICAID AND CHIP DATA BOOK 56 (2016), https://www.macpac.gov/wp-content/uploads/2016/12/MACStats_DataBook_Dec2016.pdf (the Georgetown Center for Children & Families provided some initial analysis of the impact of a per capita cap on California that informed this section); ASS'T SECT'Y PLANNING & EVAL., U.S. DEP'T HEALTH & HUMAN SERVS., ASPE FMAP 2017 REPORT 5 (2015), https://aspe.hhs.gov/basic-report/fy2017-federal-medical-assistance-percentages.

[15] KAISER FAMILY FOUND., BIRTHS FINANCED BY MEDICAID (2013), http://kff.org/medicaid/state-indicator/births-financed-by-medicaid; ADAM SONFIELD ET AL., GUTTMACHER INSTITUTE, PUBLIC FUNDING FOR FAMILY PLANNING, STERILIZATION AND ABORTION SERVICES, FY 1980-2006 (Jan. 2008), https://www.guttmacher.org/sites/default/files/pdfs/pubs/2008/01/28/or38.pdf.

[16] CAL. DEP'T HEALTH CARE SERVS., MEDI-CAL MONTHLY ENROLLMENT FAST FACTS 2-3 (Dec. 2017), http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_December_2016.pdf.

[17] *See* AMY CHEN & DAPHNE WILSON, NATIONAL HEALTH LAW PROGRAM, HOW MEDICAID EXPANSION BENEFITS MATERNAL AND CHILD HEALTH (Apr. 2017), http://www.healthlaw.org/publications/browse-all-publications/how-medicaid-expansion-benefits-maternal-and-child-health.

[18] CAL. DEP'T HEALTH CARE SERVS. *supra* note 16 at 8.

[19] CAL. PUB. HOSPITALS & HEALTH SYS., IMPACT OF MEDI-CAL EXPANSIONS: CALIFORNIA'S PUBLIC HEALTH CARE SYSTEMS 1 (2017), http://caph.org/wp-content/uploads/2017/02/ca-phs-aca-impact.pdf.

[20] Memorandum from Jennifer Kent to Diane S. Dooley, *supra* note 5.

[21] *Id.*

[22] CAL. LEG. ANALYST'S OFFICE, RISKS TO FEDERAL HEALTH CARE FUNDING 6 (2017), http://www.lao.ca.gov/handouts/health/2017/Health-Care-Funding-022217.pdf.

[23] Cal. Welf. & Inst. Code § 14019; 22 CCR § 50197.

[24] LADONNA PAVETTI, CENTER ON BUDGET AND POLICY PRIORITIES, WORK REQUIREMENTS DON'T CUT POVERTY, EVIDENCE SHOWS (Jun. 2016), http://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows. For more on Medicaid work requirements, *see* JANE PERKINS ET AL., NATIONAL HEALTH LAW PROGRAM, MEDICAID WORK REQUIREMENTS - NOT A HEALTHY CHOICE (Mar. 2017), http://www.healthlaw.org/publications/browse-all-publications/medicaid-work-requirements-not-a-healthy-choice and JANE PERKINS, NATIONAL HEALTH LAW PROGRAM, MEDICAID WORK REQUIREMENTS - LEGALLY SUSPECT (Mar. 2017), http://www.healthlaw.org/publications/browse-all-publications/medicaid-work-requirements-legally-suspect.

[25] OHIO DEP'T MEDICAID, MEDICAID GROUP VIII ASSESSMENT, http://medicaid.ohio.gov/portals/0/resources/reports/annual/group-viii-assessment.pdf (last accessed June 28, 2017).

[26] The postpartum period extends through the last day of the month in which the 60th day following the end of the pregnancy occurs.

[27] MIRANDA DIETZ ET AL., ACA REPEAL IN CALIFORNIA: WHO STANDS TO LOSE? 2, (Dec. 2016), http://laborcenter.berkeley.edu/pdf/2016/ACA-Repeal-in-California.pdf.
[28] LADONNA PAVETTI, CENTER ON BUDGET AND POLICY PRIORITIES, WORK REQUIREMENTS DON'T CUT POVERTY, EVIDENCE SHOWS tbl.B-1 (Jun. 2016), http://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows.
[29] Jennifer Joynt, *Maternity Care in California: Delivering Data*, CALIFORNIA HEALTH CARE FOUNDATION (June 2016), http://www.chcf.org/publications/2016/06/maternity-care-california.
[30] PLANNED PARENTHOOD, PLANNED PARENTHOOD STATEMENT ON GOV. BROWN'S NAMING OF REP. BECERRA TO AG POST (Dec. 2, 2016), https://www.plannedparenthood.org/about-us/newsroom/press-releases/planned-parenthood-statement-on-gov-browns-naming-of-rep-becerra-to-ag-post; PLANNED PARENTHOOD, HEALTH CENTERS IN CALIFORNIA, https://www.plannedparenthood.org/health-center/CA; Memorandum from Jennifer Kent to Diane S. Dooley supra note 5 at 4.
[31] Memorandum from Jennifer Kent to Diane S. Dooley supra note 5 at 4.
[32] U.S. DEP'T HEALTH & HUMAN SERVS., OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING AND EVALUATION, HEALTH INSURANCE MARKETPLACES 2016 OPEN ENROLLMENT PERIOD: FINAL ENROLLMENT REPORT (March 2016) https://aspe.hhs.gov/system/files/pdf/187866/Finalenrollment2016.pdf.
[33] The Hyde exceptions are abortions that are necessary to save the life of the mother, or to terminate pregnancies that are the result of rape or incest.
[34] The State Stability and Innovation Program is a pool of money intended to help states stabilize their insurance markets by allowing them to make payments directly to health insurers.
[35] Letter from Michelle Rouillard, Director of Department of Managed Health Care to Mark Morgan, California President of Anthem Blue Cross, RE: Limitations or Exclusions of Abortion Services (Aug. 22, 2014).
[36] NATIONAL WOMEN'S LAW CENTER, WOMEN AND THE HEALTH CARE LAW IN THE UNITED STATES (May 2013), https://nwlc.org/wp-content/uploads/2015/08/us_healthstateprofiles.pdf.
[37] Letter from Gloria Nagle, Associate Regional Administrator, Department of Medicaid & Children's Health Operations to Toby Douglas, Director, Department of Health Care Services (Mar. 28, 2014), http://www.dhcs.ca.gov/formsandpubs/laws/Documents/13-035_ACA_Alt_Benef_Plan.pdf.
[38] NATIONAL WOMEN'S LAW CENTER, supra note 36.
[39] SAM BERGER & EMILY GEE, CENTER FOR AMERICAN PROGRESS, SENATE HEALTH CARE BILL COULD DRIVE UP COVERAGE COSTS FOR MATERNITY CARE AND MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT (Jun. 2017), https://www.americanprogress.org/issues/healthcare/news/2017/06/20/434670/senate-health-care-bill-drive-coverage-costs-maternity-care-mental-health-substance-use-disorder-treatment.
[40] *Id.*
[41] The Senate bill contemplates putting some individuals into high-risk pools, but in the past these have proven to be more expensive and provide people with less comprehensive coverage. EDWIN PARK, CENTER ON BUDGET AND POLICY PRIORITIES, TRUMP, HOUSE GOP HIGH-RISK POOL PROPOSALS A FAILED APPROACH (Nov. 2016), http://www.cbpp.org/blog/trump-house-gop-high-risk-pool-proposals-a-failed-approach.
[42] U.S. DEP'T HEALTH & HUMAN SERVS., OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING AND EVALUATION, COMPILATION OF STATE DATA ON THE AFFORDABLE CARE ACT (Dec. 2016), https://aspe.hhs.gov/compilation-state-data-affordable-care-act.