The Affordable Health Care Act and Female Livelihood: The Implications of the Medicaid Expansion on U.S. Abortion Rates

Katie Kelbrants

Abstract:

Implemented into Congress in 2010, the Affordable Healthcare Act, also known as Obamacare, introduced new provisions that served to extend additional federal financing to states, covering young adults up to 138 percent of the federal poverty level. Young women were able to benefit from various aspects such as the young adult provision and the expulsion of cost sharing that allowed them to engage in preventative care treatments and avoid unintended pregnancy. I employ state-by-state data from 2010-2019 and run a cross-sectional and two-way fixed effect regression to estimate the impact on ACA rollout on abortion rates. Data supports significant results that illustrate a decrease in overall abortion rates with the adoption of the ACA with subsequent increases in Medicaid enrollment rates per state. The research provides insight on economic indicators of healthcare policy rollout, while simultaneously discussing the further implications and importance of research focused on women specific data in the United States.

Introduction

In the wake of recent news surrounding the overturning of Roe v. Wade, the discussion of women's healthcare and livelihoods is nothing less than a pressing subject. The now buzzword "abortion" has become a point of focus for policymakers and political debates nationwide. According to the Guttmacher Institute on the journal of Perspectives on Sexual and Reproductive Health, 73 percent of women who chose to get an abortion do so because they cannot afford to raise a child. Younger women, in particular, reported that they were unprepared for the transition to motherhood pursued an abortion (Finer et al., 2005). Prior to the enactment of the Affordable Care Act (ACA) in 2010, access to health care and amongst low-income individuals under private or public health insurance plans like Medicaid was harder to attain; higher cost sharing plans, the expulsion of coverage after age 18, and out of pocket spending was pushing many from accessing healthcare (Simas, 2014).

The implementation of the ACA in 2010, also commonly known as Obamacare, introduced new provisions that would serve to increase access to healthcare and served to expand Medicaid positions for low-income adults (Wherry et al., 2016). Medicaid is a Unites States health insurance program that helps low-income and disabled individuals with healthcare costs (Mazurenko et al., 2018). As of 2021, Medicaid itself has funded over $748 billion by the federal government and has insured over 20% of the U.S. population (KFF, 2022). The rollout of the Medicaid provision under the ACA extended additional federal financing to states to cover nonelderly adults (> age 65) with income up to 138 percent of the federal poverty level (KFF, 2022).

Historically, insurers have conflated the gender female with a "preexisting condition" (Collins et al., 2017) that constitutes a higher health insurance premium based on the assumption

of higher healthcare costs in comparison to their male counterparts (U.S. Government Accountability Office, 2013). In conjunction with higher billed premiums, women have also exhibited a higher and closer interaction with the healthcare system over their lifetimes (Altman et al., 2019); further justifying their need for healthcare in relation to childbearing whether it is contraception education, equitable access to abortion, or preventative care screening methods. Young women in specific are more prone to lacking insurance needs when not covered by their parents' healthcare; stipulated by prior insurance enrollment laws that barred young people from being on insurance plans past age 18, in many cases (U.S. Dept. of Labor, 2022). The young adult provision (YAP) of the ACA allowed children to remain on their parents' health insurance until the age of 26, being a critical determinant of development and health outcomes for young adults aged 18-26 (Cantor et al., 2012). An estimated three million young adults were now able to gain coverage because of the YAP (Sommers et al., 2013). Not only were millions of young adults now able to benefit from the ACA, but women in specific were now able to gain more access to birth control; being more equipped to avoid pregnancy and abortion.

The rollout of the ban on benefit limits, expulsion of cost-sharing under private health insurance plans, and the expansion of preventative care screenings all served to facilitate the furtherment of women's health initiatives (Collins et al., 2017 and Becker & Polsky 2015). Women who did have children could rely on the reauthorization of the Child Health Insurance Program (CHIP) in 2009 which provides low-cost health insurance coverage to children in families that do not earn enough to buy private insurance but make too much money to be considered for Medicaid (KFF, 2014). In 2015, CHIP was the central source of coverage for low-income children and pregnant women in the U.S., largely due to stability measures put in place

by the ACA that barred states from making reductions in CHIP eligibility (Brooks and Miskell, 2016).

In accordance with the expansion in healthcare access, my question asks whether the rollout of the Medicaid provision under the ACA effected total abortion rates per state; various researchers such as Abramowitz, Becker, and Lee have analyzed the ACA's effects on woman livelihood and have found compelling evidence that emphasizes the link between the rollout of ACA and an increase in healthcare utilization among thousands of women across the U.S. The enactment of the Medicaid expansion under ACA omitted common denominators of reluctance to healthcare such as cost sharing that equipped women with legislative-backed options to plan for children and the future. Expanding coverage predominantly to low-income Americans, the Medicaid expansion of ACA opened doors to those who had not had prior means to provide sufficient healthcare to themselves and their futures. Burlone et al. (2012) conducted an analysis that found the primary outcome of the ACA was an increase in pregnancy and birth aversions. Abramowitz (2018) and Heim et al. (2017) found that the young adult provision decreased the probability of abortion and childbirth while simultaneously increasing the use of long-term contraceptives. This exemplified concrete differences in outcomes before and after the implementation of the ACA; facilitating my interest in pursuing the relevant issue and discussion in the following paper.

Economic Relevancy

In defining female livelihood, it important to recognize various factors come into play and many may fluctuate on an individual basis. It is assumed that unintended pregnancy resulting in abortions may be a major indicator in negative mental health and well-being among women

and their families (Tschann & Soon, 2015). The medical costs of unplanned pregnancies and one year of life of the child, according to the Brookings Institute, amasses to average $12 billion every year from taxpayers of publicly funded unintended pregnancies (Monea & Thomas, 2011). The suspension of cost sharing under private health insurance and the YAP provided to eliminate a financial hindrance in accessing birth control and preventative screening methods. Becker and Polsky found that women using the oral birth control pill saved an average of $255 per year after ACA removed cost sharing, with all out-of-pocket spending for oral contraceptives and intrauterine devices dropping by 20 percent in 2012, just two years after the rollout of the ACA (Becker and Polsky, 2015). According to the Kaiser Family Foundation, funding for the Medicaid expansion under the ACA in 2019 totaled $85 billion dollars from the federal government where the expansion represented 16 percent of overall Medicaid spending, and 20 percent of Medicaid enrollment in the U.S.

In 2018, Joelle Abramowitz conducted a difference-in-difference framework that served to examine the effect of the Medicaid expansion under ACA on total out-of-pocket expenditures. She concluded that the expansion was associated with lower healthcare expenditures for women under the federal poverty line. I will employ a two-way fixed effect framework to discuss the effects of the Medicaid expansion of the ACA on total abortion rates in the United States. Previous studies have analyzed ACA's effect on cost sharing, out of pocket expenditures, and Medicaid enrollment rates, but not necessarily abortion rates themselves. Abortion rates tend to be looped into various healthcare procedures and not isolated as its own indicator of woman's health. The magnitude of the true effect of the ACA on woman's' health initiatives cannot be fully captured due to the mere recency of the act and the limitations our data may hold, as discussed further in the paper.

Empirical Methods

As priorly discussed, women have historically been more prone to higher insurance premiums because of their gender and likelihood of childbearing in comparison to their male counterparts. (U.S. Government Accountability Office, 2013) This has imminent effects on the ability to fund personal health insurance plans, which can implicate later livelihood trajectories if a woman is unprepared for motherhood (Abramowitz, 2017). Previous literature emphasizes the economic and social importance of the Medicaid expansion as it played an enormous role in increasing access to contraception and preventative care for women across the U.S. (Marchi et al., 2020 & Heim et al. 2017). To understand the innerworkings of the economic significance of the effect of the Medicaid Expansion under ACA on abortion rates, we must run regressions to interpret our data further. In hopes to capture a greater scope of the impact of the ACA rollout on female livelihood, I include four controls; the total increase in coverage under the young adult provision, decrease in depression, and increases in preventative care methods such as mammograms and Papanicolaou smears as illustrated below. I will use both a cross-sectional and a two-way fixed effect framework, illustrated as follows:

Cross Sectional Regression:

$$
\begin{aligned}
Abortion\ Rate_i &= \beta_0 + \beta_1 ACA_{i1} + \beta_2 Uninsured\ Rate_{i2} + \beta_3 MedicaidRate \\
&+ \beta_4 Total\ Increase\ in\ coverage\ after\ YAP \\
&+ \beta_5 Female\ Decrease\ in\ Depression \\
&+ \beta_6 Female\ Increase\ in\ Mammograms + \beta_7\ Increase\ in\ Pap\ Smear + \varepsilon_i
\end{aligned}
$$

Two-Way Fixed Effect Regression:

$$Abortion\ Rate_i = \beta_1 ACA_{it1} + \beta_2 Uninsured\ Rate_{it2} + \beta_3 MedicaidRate + \gamma_i + \gamma_t + \varepsilon_{it}$$

I have included more indicators of woman's' health in the cross-sectional abortion in hopes to capture a wider variety of effect on total abortion rates, as it has been proven that greater access to healthcare serves as an indicator to woman's' health outcomes. Our two-way fixed effect regression is denoted by $\gamma_i + \gamma_t$ being state and year, respectively. Panel data allows us to account for entity effects and time effects, denoted by *it* subscripts. ACA, whether a state enrolled in the Medicaid expansion under the ACA, is regressed along with both the Uninsured and Medicaid rate as controls per state against the total Abortion Rate.

The total number of abortions per state cannot be based solely in response to the Medicaid expansion under the ACA, thus there is good chance that abortion rates could be affected by outside factors such as political or social beliefs in each state or area; thus, the instrumental variable accounts for the endogenous effect x may pose. In hopes to remove potential omitted variable bias from my regression, I employ a Fixed Effects two stage least squares estimator to denote ACA as an instrumental variable. I use the uninsured rate as a control in the first stage, where the regression is denoted as follows:

$$Medicaid\ Rate = \alpha_0 + \alpha_1 ACA_i + + \alpha_2 Uninsured\ Rate_i + \varepsilon_i$$

In the second stage, we use the predicted Medicaid rate from part one into our abortion specific regression:

$$Abortion\ Rate = \beta_0 + \beta_1 \widehat{Medicaid\ Rate}_i + \varepsilon_i$$

When using instrumental variables, it is important to define the intuition behind the chosen variable. The rollout of the Medicaid provision under ACA is a significant indicator of Medicaid rates per state, and in hopes to employ and element of randomness to this extra measure, we must consider that ACA rollout may not be a predictor of the total abortion rate.

Data Description

Data were gathered on four different platforms on a state-by-state basis to incorporate various facets of the impacts of the Affordable Health Care act on female livelihoods and the greater U.S. population. I employed data from the Center of Disease Control's (CDC) abortion surveillance program for years 2010-2019 with state-by-state incidences of abortions. There are 500 observations and 11 variables that include out-of-country abortions, abortions in out of state residences and unknown residences, etc. It is important to include that abortion data was not provided for five of the 50 states; being California, Florida, Maryland, New Hampshire, and Wyoming. The omitted states pose a threat to the internal validity of our sample as the differential statistics in their populations could have implicated our further findings. State legislations could have different opinions and rulings on the legality of abortion following the overturning of Roe v. Wade, thus it is important to remember that the data of the omitted States still hold major relevancy.

Data providing information for state-specific enrollment in the Medicaid Expansion of the Affordable Health Care Act (ACA) was provided by the non-profit Kaiser Family Foundation (KFF) that provides data and statistics on national health issues. Before merged to the prior panel data, this dataset provides 599 observations of enrollment in ACA per state as an indicator variable (0=not enrolled, 1=enrolled from that point on) from 2010 to 2021. Each state is observed 11 times, hence the 599 observations. The District of Colombia is not included.

The third dataset includes economic indicators; Medicaid enrollment rates and uninsured rates per state. These data are employed by the KFF with 51 observations by state from 2010 to 2019. The rates are per thousand individuals in the U.S. and provide the enrollment in Medicaid/private insurance, Medicaid only, and the total uninsured rate for that year in the corresponding state. Data on Women-specific health outcomes such as preventative care methods and increases in coverage under the Medicaid expansion were gathered from the ASPE from the Office of the Assistant Secretary for Planning and Evaluation. For our purposes, I employed 5 variables; increases in mammograms and pap smears as preventative care, decreases in depression, women with lifetime limits on care post ACA, and the total increase in women covered under the young adult provision. The ASPE data is merged with our Panel dataset. The final data has 610 observations and 30 variables.

As seen in graph 1, there are certain states such as Utah, New York, and Delaware that averaged over 60,000 abortions over the course of nine years, being major outliers in this dataset. Image 1 shows the rollouts per state to provide more insight of information on a per state basis.

Results

Cross Sectional Method

The null hypothesis is that there is no relationship between our x's of interest and total abortion rates as given in the cross-sectional regression. As seen in output in table 2, we see that the implementation of the ACA was associated with a statistically significant decrease of approximately 0.3% in the abortion rate per state. We observed a small p-value of 0.038, thus we have enough evidence at the 5% significance level to reject the null hypothesis that there is no observed relationship between our x variables and the total abortion rate. We see a clear depiction of the decrease in abortion rates for those states that expanded the Medicaid provision under ACA, furthermore, serving to supplement our tests of significance. Graph 4 illustrates this result with a side-by-side bar graph including a spread of variability in estimates.

I test for multicollinearity and robustness and find mean VIF of 1.40; not worrying me of multicollinearity. Robust reweights the standard errors and makes sure our β of interest remains constant across different versions of the primary regression; for our purposes we should not be worried about homoskedasticity.

Two-Way Fixed Effect

Our β of interest, whether the State is enrolled in the Medicaid provision of the ACA, tells us that for every state that is enrolled in the ACA, there is a subsequent unit increase of 0.07% in the abortion rate abortions for that state (as observed by all states' data combined). As

observed in table 2, this result is significant at the 5% significance level; thus, we have enough evidence to reject our null hypothesis that there is no relationship between the total abortion rate and the Medicaid expansion under the ACA. Although this result is statistically significant, it estimates that the abortion rate increased by 0.07% when we theorized it would decrease. We do see a general trend in decreasing abortion rates as seen in table 2, after the year of 2014 when the Medicaid expansion under ACA was first adopted by various states. The differentiation in results from our cross-sectional analyses and decrease in abortion rates over time leads me to conclude that we may have a contamination effect with our two-way effect model. The two-way fixed effect model serves as a difference-in-difference estimator when comparing states that enacted the policy rollout and those that did not; but estimation issues arises when the timing and intensity of treatment and varies between states. Graph 2 provides a visual of the mean abortion rate for enrolled and non-enrolled states where we see a distinct decrease in abortion rates once a state enacted.

Robustness checks prove to not worry us of homoskedasticity and we check for correlation and do not find high enough numbers or consistent outliers to indicate suspicion.

Instrumental Variable Method

According to Table 3, we find a negative relationship of abortions to the Medicaid rate per state, further supporting previous discussion that Medicaid Rate is a good predictor of total abortions. We illustrated a cross-sectional regression with Medicaid and Uninsured rates against the overall abortion rate to compare our results alongside our instrumental variable and find similar results in comparison to our instrumental regressions. We observe a similar magnitude of

variables and run robustness checks that do not pique suspicion across all three specifications. Our results for all three regression specifications are statistically significant at the 1% level. We have enough evidence to reject our null hypothesis that ACA has no effect on abortion rates. Because of this rejection, we are highly suspect it does not pass exclusion restriction; that our z instrument, ACA cannot have any effect on abortion rates, except through our x, the Medicaid rate. The instrument may not be valid in our cases due to the exclusion restriction.

This result is economically significant in that it shows large decreases in abortion rates (1.2%, 1.4% and 1.2%, respectively) when measured against to the state's Medicaid rate. We employ instrumental variables to eliminate the effect on endogeneity and see if z, ACA, has any outside effect on total abortions that we may not be considering in our sphere of data. Both our first and second phase regressions fail the weak identification tests with large F-Stats of 79.60 and 104.23, further in stating that Medicaid Rates per state is not a weak identifier of total abortions. In our first phase, we see that the uninsured rate is associated with a decrease in the abortion rate by a significant 4.6%, being statistically and economically significant in that we tend to see lower access and usage of healthcare systems (i.e., having an abortion) when uninsured rates are high. Graph 3 exemplified the distinction between Medicaid rates and Uninsured rates; appearing to move in an extremely opposite direction.

Discussion

Overall abortion rates per state fluctuate with policies and laws on state-by-state basis. Our cross-sectional regression data explained a significant decrease in the total abortion rate once ACA was implemented and provided us with enough evidence to reject our null hypothesis that there is no relationship between our x's of interest and total abortions per state. The two-way

fixed effect framework allowed us to account for time invariant effects and exemplified the fact that ACA rollout was initially associated with an increase in abortion rates per state but proceeded to decrease over time with true significance from the years 2011-2019. Our model provides nuances for economic significance as we see large and significant decreases in abortion rates when regressed against Medicaid rates as seen in table 1 & 3 which deserves ample consideration. According to the Congressional Budget Office's latest estimates, ACA expansion will cost an astounding $204 billion dollars, with $116 billion being from the Medicaid expansion in 2022. As seen in the third graph, as uninsured rates trended down, those enrolled in Medicaid increased which serves as a significant indicator to the aims of ACA's implementation.

Abortions are specific to sex thus our findings can be generalized to those that identify as women. There are limitations in internal and external validity as our methods are specific to public policy rollout in the United States; so, they would not be as easily applicable to other neighboring nations, but similar framework could be applied when conducting hypothesis tests on the impact of similar policies.

Limitations

There are five states in our dataset that do not provide abortion data. This inhibits our ability to measure rollout measures and their effectiveness on reducing abortion rates on a nation-wide basis. Some states, as pictured in Graph 1, average very large amounts of reported abortions from 2010-2019 which could cause our data to be biased in the direction of one of the states that accounts for a large portion of abortions. Nation-wide abortion data can neglect the variability and trends of individual state data and further implicate our p-values. Amassing such a large dataset can lead to a generalization of results which is not always desirable. Additionally, the

abortion rate was calculated as the product of the total woman's population, which poses a threat to our sample because most women who receive an abortion are between the age of 20 and 29 (KFF, 2021).

There is potential for omitted variable bias, known as a threat to internal validity, that could further implicate our results; but because we are observing panel data, we hope to limit this with entity fixed effects. However, fixed effects cannot address trends that are state-specific that change over time which introduces the issue of omitted variable bias. Political leadership on a state-by-state basis fluctuates and could influence abortion rates and legalizations that we are not able to capture with our two-way fixed effect model. Our instrumental variable regressions are also subject to internal validity threats; states who chose to expand the Medicaid expansion under the ACA could have had more liberal policy measures which could also very well open potential for omitted variable bias.

External validity is threatened as we are observing policy change to different states in the U.S., thus States may have other laws and prohibitionary measures against abortion that are not explained well when only considering the implementation of ACA and the uninsured/Medicaid rates. There is also the possibility of reporting bias; being that the social and political implications of receiving an abortion can be very different based on the state you live in due to the recent overturning of Roe v. Wade. Under HIPAA and medical privacy, nonprofit organizations known to provide abortions such as Planned Parenthood may not report all instances of abortion (Planned Parenthood, 2022) thus further limiting our ability to measure causal effects of policy and healthcare rollout.

Conclusions

The Medicaid expansion under the ACA can implicate female livelihoods in many ways that our data did not specifically capture. Our cross-sectional approach saw a significant decrease in the total abortion rate per state after ACA implementation, a downward trend in those uninsured, and an upward trend those enrolled in Medicaid per state. Our data served to provide economically significant discussions surrounding the use of instrumental variable framework that accounted for endogeneity while illustrating a negative relationship between the total abortion rate and uninsured rates. The two-way fixed effect framework provided ability to control for unobserved trends that are time invariant and revealed a significant increase in the abortion rate that decreased over time with the implementation of the ACA rollout, being an opposite expectation based on prior hypotheses. From a policy perspective, the implementation of the Medicaid expansion served to decrease the overall uninsured rate in the United States and provide women with more support to engage in healthcare systems. The expulsion of cost sharing and the instatement of the Young Adult Provision equipped women with governmental support that could serve to increase preventative care and screening methods while simultaneously decreasing out of pocket expenses.

Future research should conduct analyses on a state-by-state basis in hopes to capture true effects of the enactment of the ACA on abortion rates. The Medicaid Expansion under the ACA has served to improve the health and livelihood of thousands of women across the nation; and its efforts and results should not go unrecognized.

Tables

Table 1; Descriptive Statistics

VARIABLES	N	Mean	Std. Dev.	Min	Max
Increase in Mammograms	50	6,352	8,932	100	42,100
Increase in Pap Smears	50	10,258	14,998	100	74,200
Decrease in Depression	50	15,580	22,117	1,000	109,000
Adult Fem Lifetime Limits on Benefits	50	788,860	825,812	69,000	4.448e+06
Total Increase in Coverage YAP	50	46,140	53,123	5,000	294,000
Medicaid and Private Insurance Rate	500	0.0182	0.00462	0.0080 0	0.0320
Medicaid Rate	500	0.133	0.0358	0.0546	0.262
ACA	584	0.421	0.494	0	1
Total Abortions per State	489	13362.97	19294.44	0	115724
U.S. Women Population	500	3235401	3588584	276702	19,900,000
Abortion Rates	479	0.00804	0.01445	0	0.092770

Table 2; Cross-Sectional and Two-Way Fixed Effect Regression Output

VARIABLES	Cross-Sectional Reg Abortion Rate	Two-Way FE Reg Abortion Rate
Uninsured Rate	-0.0425***	0.00487
	(0.0145)	(0.00928)
Medicaid Rate	-0.109***	0.0128
	(0.0164)	(0.00915)
ACA	-0.00300**	0.000779**
	(0.00144)	(0.000341)
Year = 2011		-0.000750**
		(0.000341)
Year = 2012		-0.00123***
		(0.000345)
Year = 2013		-0.00170***
		(0.000347)
Year = 2014		-0.00224***
		(0.000447)
Year = 2015		-0.00230***
		(0.000543)
Year = 2016		-0.00246***
		(0.000591)
Year = 2017		-0.00257***
		(0.000579)
Year = 2018		-0.00247***
		(0.000591)
Year = 2019		-0.00239***
		(0.000585)
Total Increase in Coverage YAP	0.0000000349	
	(0.0000000272)	
Decrease in Depression	0.00000118	
	(0.00000264)	
Increase in Mammograms	0.00000190	
	(0.00000237)	
Increase in Pap Smears	-0.000000420	
	(0.00000378)	
Constant	0.0256***	0.00617***
	(0.00353)	(0.00222)
Observations	460	460
R-squared	0.143	0.173
Controls	YES	YES

Standard errors in parentheses
*** p<0.01, ** p<0.05, * p<0.1

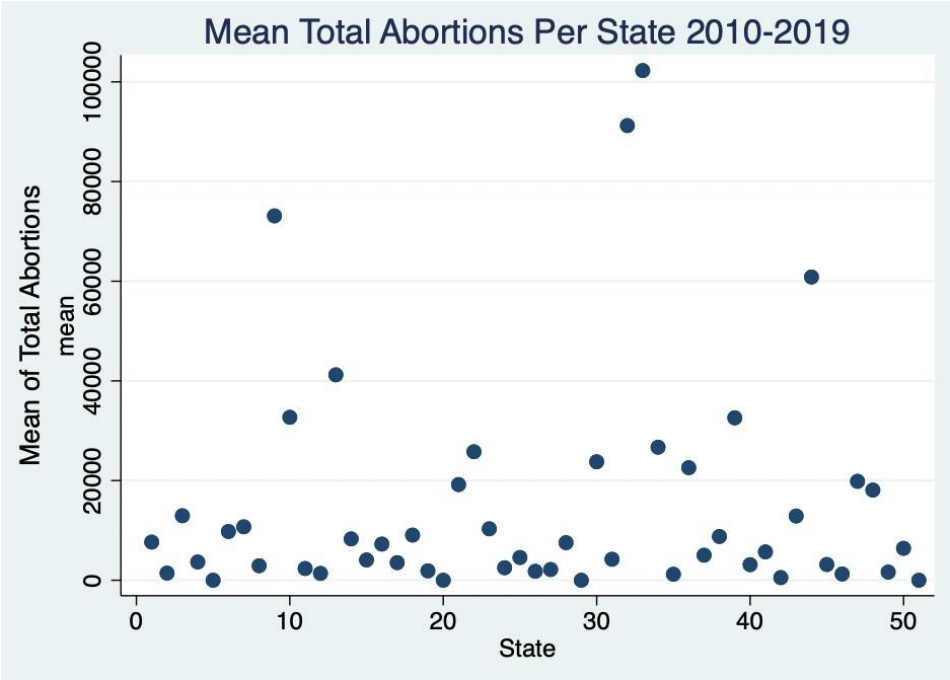
Table 3; Regression output for Instrumental Variable

VARIABLES	IV Reg Phase 2 Abortion Rate	IV Reg Phase 1 Abortion Rate	Cross-Section Reg Abortion Rate
Uninsured Rate	-0.0426***		-0.0269**
	(0.0147)		(0.0126)
Medicaid Rate	-0.122***	-0.141***	-0.122***
	(0.0178)	(0.0346)	(0.0151)
Constant	0.0289***	0.0255***	0.0260***
	(0.00318)	(0.00462)	(0.00271)
Observations	479	460	460
R-squared	0.094	0.110	0.124
Controls	YES	YES	YES

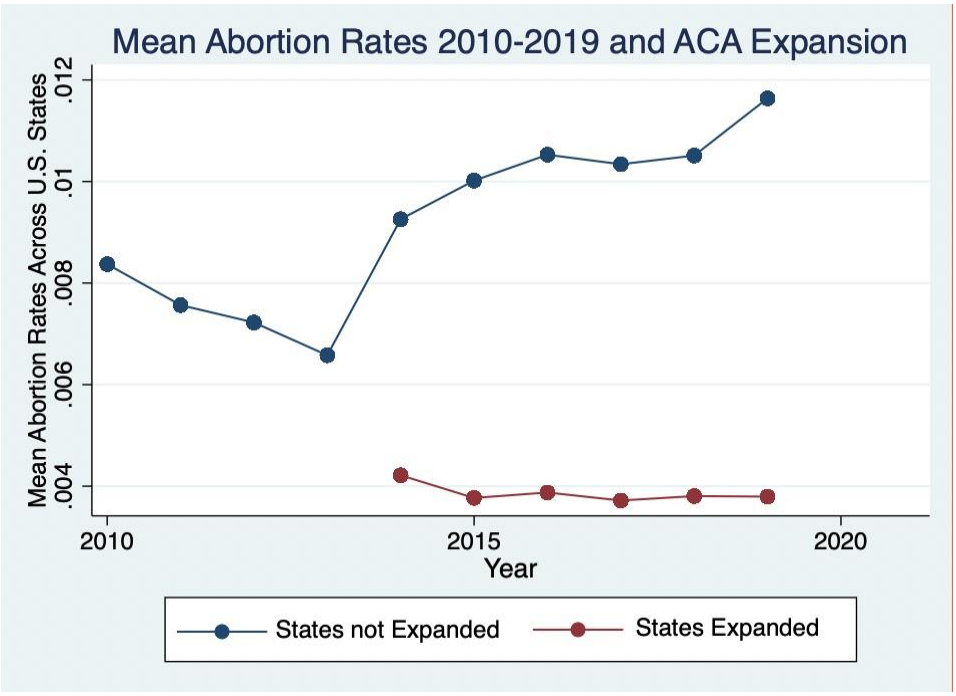
Standard errors in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Graphs

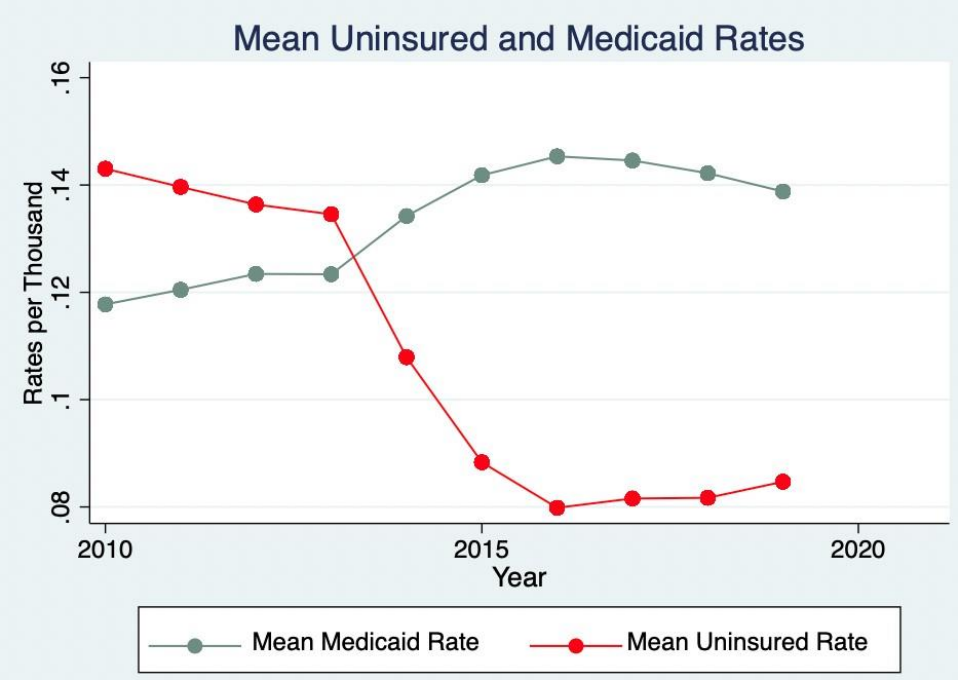
Graph 1: scatter of Year and Total Abortions across all U.S. States Under Cross-Sectional Model



Graph 2: Total abortions and ACA expansion under Fixed Effects



Graph 3: Medicaid Rate and Uninsured Rates per State with Mean Distribution



Graph 4: Abortion Rates alongside State Expansion

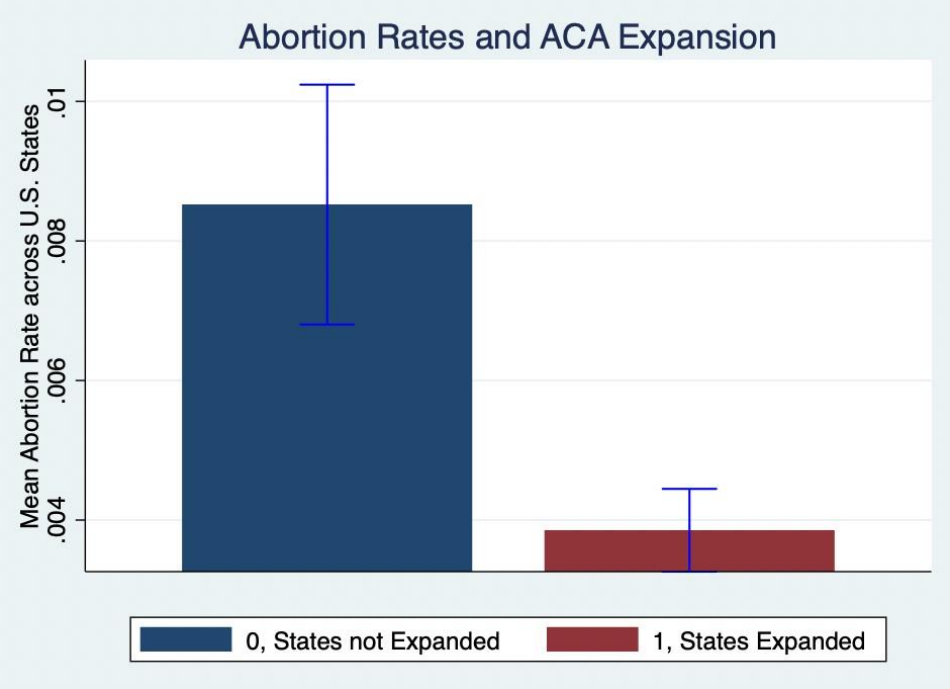
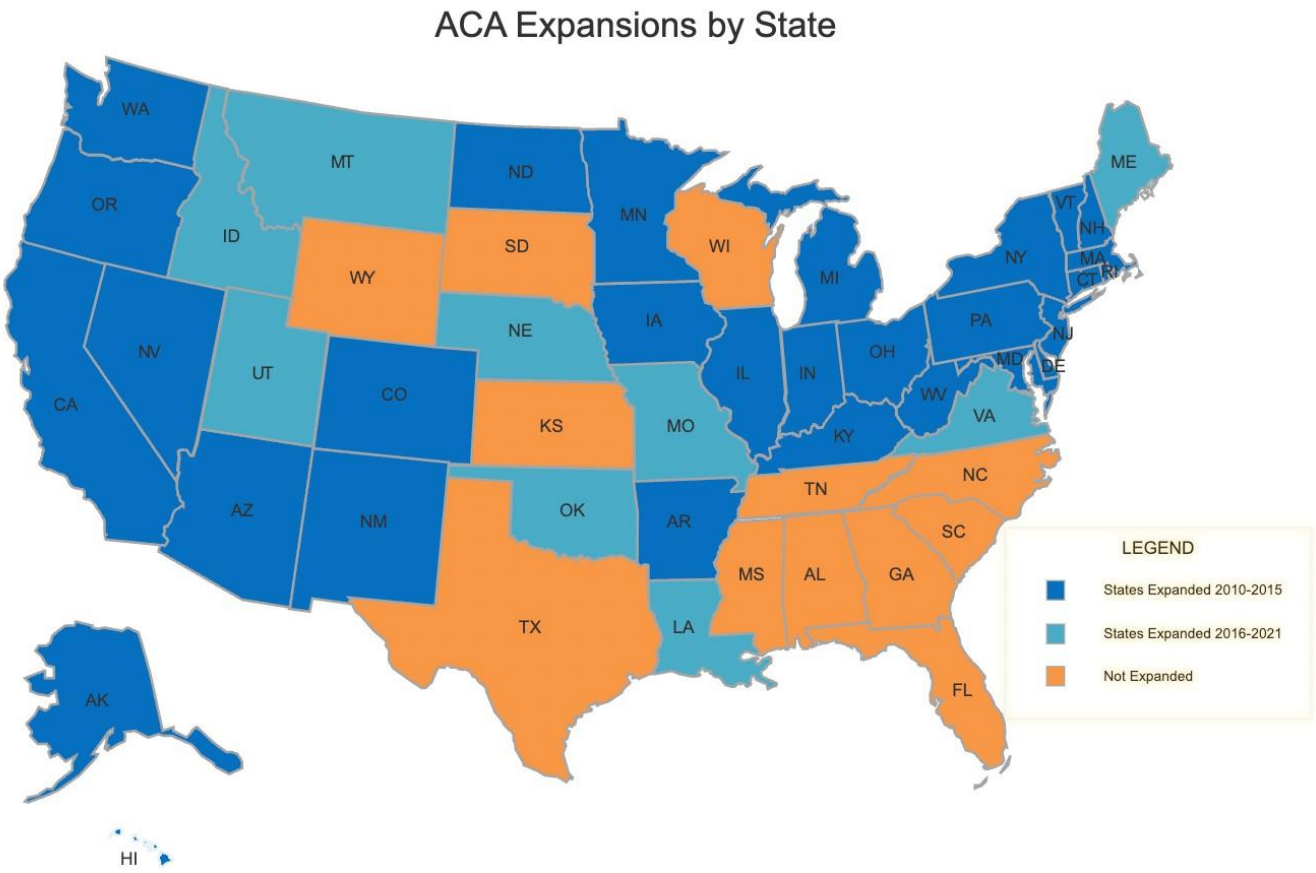


Image 1: ACA Expansions by State



Bibliography

Abramowitz, Joelle. “Planning Parenthood: The Affordable Care Act Young Adult Provision and Pathways to Fertility.” *Journal of Population Economics*, vol. 31, no. 4, 2017, pp. 1097–1123., https://doi.org/10.1007/s00148-017-0676-6.

Altman, M. R., Oseguera, T., McLemore, M. R., Kantrowitz-Gordon, I., Franck, L. S., & Lyndon, A. (2019). Information and power: Women of color's experiences interacting with health care providers in pregnancy and birth. *Social Science & Medicine, 238*, 112491. doi: 10.1016/j.socscimed.2019.112491

Becker, N. V., & Polsky, D. (2015). Women saw large decrease in out-of-pocket spending for contraceptives after ACA mandate removed cost sharing. *Health Affairs, 34*(7), 1204-1211. doi:10.1377/hlthaff.2015.0127

Burlone, S., Edelman, A. B., Caughey, A. B., Trussell, J., Dantas, S., & Rodriguez, M. I. (2013). Extending contraceptive coverage under the Affordable Care Act saves public funds.
Contraception, 87(2), 143-148. doi: 10.1016/j.contraception.2012.06.009

Brooks, T., Sean Miskell, S., Artiga, S., & Cornachione, E. (2016). (rep.). Kaiser Family Foundation. Retrieved December 8, 2022, from https://ccf.georgetown.edu/wpcontent/uploads/2016/01/report-medicaid-and-chip-eligibility-enrollment-renewal-and-costsharing-policies-as-of-january-2016-findings-from-a-50-state-survey.pdf

CBO. (2022, June 30). *Affordable care act*. Congressional Budget Office. Retrieved December 8, 2022, from https://www.cbo.gov/topics/health-care/affordable-care-act

Cantor, J. C., Monheit, A. C., DeLia, D., & Lloyd, K. (2012). Early impact of the affordable care

act on health insurance coverage of Young Adults. *Health Services Research, 47*(5), 1773-1790. doi:10.1111/j.1475-6773.2012. 01458.x

Collins, S. R., Doty, M. M., Beutel, S. B., & Gunja, M. Z. (2017). How the affordable care act has helped women gain insurance and improved their ability to get health care. *Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016*. doi:10.15868/socialsector.28134

Finer, L. B., Frohwirth, L. F., Dauphinee, L. A., Singh, S., & Moore, A. M. (2005). Reasons U.S. women have abortions: Quantitative and qualitative perspectives. *Perspectives on Sexual and Reproductive Health*, *37*(03), 110–118. https://doi.org/10.1363/3711005

Gao-13-712R, Private health insurance: The range of Base Premiums in Base Premiums in the Individual Market by State in January 2013. (2013, July 23). Retrieved October 7, 2022, from https://www.gao.gov/assets/gao-13-712r.pdf

Guttmacher Organization. (2022, December 1). *Abortion*. Guttmacher Institute. Retrieved December 8, 2022, from https://www.guttmacher.org/united-states/abortion

Heim, Bradley, et al. "The Impact of the Affordable Care Act Young Adult Provision on Childbearing, Marriage, and Tax Filing Behavior: Evidence from Tax Data." *NATIONAL BUREAU OF ECONOMIC RESEARCH; WORKING PAPER SERIES*, 2017, https://doi.org/10.3386/w23092.

Kaiser Family Foundation. (2021, December 1). *Reported legal abortions by age group within the state of occurrence*. KFF. Retrieved December 8, 2022, from https://www.kff.org/womens-health-policy/state-indicator/distribution-of-abortions-byage/?currentTimeframe=0&sortModel=%7B%22colId%22%3A%22Location%22%2C%

22sort %22%3A%22asc%22%7DLee, L. K., Chien, A., Stewart, A., Truschel, L., Hoffmann, J.

Portillo, E., Pace, L. E., Clapp, M., & Galbraith, A. A. (2020). Women's coverage, Utilization, affordability, and healthafter the ACA: A review of the literature. *Health Affairs*, *39*(3), 387–394. https://doi.org/10.1377/hlthaff.2019.01361

Marchi, K. S., Dove, M. S., Heck, K. E., & Fan, C. (2020). The Affordable Care Act and changes in women's health insurance coverage before, during, and after pregnancy in California. *Public Health Reports*, *136*(1), 70–78. https://doi.org/10.1177/0033354920962798

Mazurenko, O., Balio, C. P., Agarwal, R., Carroll, A. E., & Menachemi, N. (2018). The effects of Medicaid expansion under the ACA: A systematic review. *Health Affairs*, *37*(6), 944– 950. https://doi.org/10.1377/hlthaff.2017.1491

Medicaid & Chip. KFF. (n.d.). Retrieved December 8, 2022, from https://www.kff.org/state-category/medicaid-chip/

Monea, E., & Thomas, A. (2011). (rep.). *The High Cost of Unintended Pregnancy*. Washington, DC: Brookings Institute.

Parenthood, P. (n.d.). *Planned parenthood Mar Monte*. Planned Parenthood: HIPAA Policies and Abortion. Retrieved December 8, 2022, from https://www.plannedparenthood.org/planned-parenthood-mar-monte/hipaa

Published: Oct 03, 2022, & Percent of People Covered by Medicaid/CHIP, 2022. (2022, December 8). *Medicaid State Fact Sheets*. KFF. Retrieved December 8, 2022, from https://www.kff.org/interactive/medicaid-state-fact-sheets/

Published: Nov 09, 2022. (2022, November 9). *Status of state Medicaid Expansion Decisions:*

Interactive Map. KFF. Retrieved December 8, 2022, from https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisionsinteractive-map/#:~:text=The%20Affordable%20Care%20Act's%20(ACA,FMAP)%20for%20their%20expa nsion%20populations.

Simas, D. (2014, January 23). *Health coverage before the ACA, and why all Americans are better off now*. National Archives and Records Administration. Retrieved December 8, 2022, from https://obamawhitehouse.archives.gov/blog/2014/01/23/health-coverage-aca-and-why-allamericans-are-better-now

Sommers, B. D., Buchmueller, T., Decker, S. L., Carey, C., & Kronick, R. (2013). The Affordable Care Act has led to significant gains in health insurance and access to care for young adults. *Health Affairs, 32*(1), 165-174. doi:10.1377/hlthaff.2012.0552

Total Medicaid spending. KFF. (2022, August 22). Retrieved December 8, 2022, from https://www.kff.org/medicaid/state-indicator/total-medicaid-spending/?currentTimeframe=0&sortModel=%7B%22colId%22%3A%22Location%22%2C%22sort%22%3A%22asc%22%7D

Tschann, M., & Soon, R. (2015). Contraceptive coverage and the Affordable Care Act. *Obstetrics and Gynecology Clinics of North America*, *42*(4), 605–617. https://doi.org/10.1016/j.ogc.2015.07.001

Wherry, L. R., & Miller, S. (2016). Early coverage, access, utilization, and health effects associated with the Affordable Care Act Medicaid expansions. *Annals of Internal Medicine, 164*(12), 795. doi:10.7326/m15-2234

Young adults and the affordable care act: Protecting young adults and eliminating burdens on

businesses and families FAQs. United States Department of Labor. (2022). Retrieved December 8, 2022, from https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resourcecenter/faqs/young-adult-and-aca