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The Patient Protection and Affordable Care Act and Reproductive Health: Harnessing Data to Improve Care

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Abstract

The Patient Protection and Affordable Care Act (PPACA) has great potential to improve reproductive health through several components: expanded coverage of people of reproductive age; required coverage of many reproductive health services; and insurance exchange structures that encourage individuals and states to hold plans and providers accountable. These components can work together to improve reproductive health. But in order for this to work, consumers and states need information with which to assess plans. This review article summarizes state contracting theory and argues that states should use this structure to require health plans to collect and report meaningful data that patients, providers, plans, payers, and third-party researchers can access. Now that the Supreme Court has upheld the PPACA and states must set up health insurance exchanges, populations can benefit from improved care and outcomes through data transparency.

The reproductive health status of people in the United States is significantly poorer than in many other countries. Comparing countries by maternal mortality ratio, the United States ranks forty-sixth, just below Turkey and Croatia (World Health Organization [WHO] 2012a). Despite stated efforts to improve maternal health (US House of Representatives 2008), pregnancy-related mortality in the United States appears to be rising (WHO et al. 2012b). We also have high rates of unintended pregnancy (Finer and Zolna 2011), sexually transmitted infections (Centers for Disease Control and Prevention [CDC] 2011b), and premature birth (March of Dimes et al. 2012).

In the US population, the burden of reproductive disease is not evenly distributed; it disproportionately affects people of color and those with lower incomes. Unintended pregnancy (Finer and Zolna 2011), premature birth (CDC 2012), sexually transmitted infections (CDC 2011b), breast cancer mortality (US National Program of Cancer Registries 2012), and human immunodeficiency virus (HIV) (CDC 2011a) are all more common among African Americans than among whites. African American women are also more likely to die of pregnancy-related causes—including preventable causes—than are white and other women (Berg et al. 2005, 2010). Variation and inadequacy in the quality of reproductive health care is one factor contributing to these poor and unequal reproductive health outcomes. For example, women from racial and ethnic minority groups are less likely to receive appropriate breast cancer screening (Smith-Bindman et al. 2006), adequate prenatal care (Alexander, Kogan, and Nabukera 2002), and patient-centered family planning services (Dehlendorf et al. 2010). Many problems that could theoretically be prevented with optimal care—such as unintended pregnancy (Finer and Zolna 2011) and new HIV infections among young people (Prejean et al. 2011)—have risen or continued at stable rates for years.

This article explores the potential for the Patient Protection and Affordable Care Act (PPACA) to improve the quality of reproductive health care in the United States. Specifically, it addresses the question: Are there opportunities in how states implement health exchanges that will affect the quality and accessibility of reproductive health care? Prior to the passage of PPACA, legislators considered different models of health reform. The structure that Congress adopted in the act, and that will be implemented now that it has been upheld by the Supreme Court, is based on state health exchanges. This model has been debated and weighed against alternatives on many aspects, and my purpose here is not to argue in favor or opposition. Instead, knowing that this structure will shape health care for years to come, I explore how states can make the most of it to benefit the reproductive health of their populations. I first discuss measures in the PPACA that are likely to benefit reproductive health care access, regardless of how states implement their health exchanges. For example, the individual and employer mandates will lead more people of reproductive age to have health insurance coverage, and the preventive services coverage mandate will make sure their plans include many evidence-based reproductive health services. I then turn to an element of the PPACA that is not well recognized: its potential to expand the collection and dissemination of health care data. I describe how state-based insurance exchanges and Medicaid expansion under the PPACA create opportunities for health care consumers and states to hold health plans accountable for the quality of services they provide, including reproductive health services, using this data. I summarize existing literature on contracting theory and apply it prospectively to the PPACA and reproductive health care. I argue that if states use the contracting structure of their insurance exchanges to require health plans to collect and report meaningful information about reproductive health services and outcomes, multiple actors will be able to use this data to improve care. Finally, I propose the types of data that health plans should be required to report and who should be allowed to access that data.

Expanded Coverage of (Most) Reproductive Health Services under the PPACA

One of the groups most likely to benefit from the PPACA is young adults.¹ This group has historically had high rates of uninsurance in the employer-based US health insurance system (Callahan and Cooper 2005). Furthermore, young adults' lower overall health risk has created less personal incentive to opt in to the private insurance market. Several measures of the PPACA promise to dramatically expand the proportion of this group that carries health insurance. First, young adults will be guaranteed the right to stay on their parents' health insurance until age 26. Second, employer and individual mandates will shift the incentives so that more young adults are likely to opt in to health insurance. Third, in some states Medicaid eligibility will be extended to all people with incomes less than or equal to 133 percent of the federal poverty level. This allows men and women to receive Medicaid regardless of whether they have children, filling an important gap in previous Medicaid policy. Finally, plans offered through new state health insurance exchanges, with premiums subsidized for people making up to 400 percent of the federal poverty level, will cover a large share of previously uninsured working adults. Prior to the PPACA's implementation, more than one in four women aged 18–64 lacked health insurance or were covered on an individual plan not sponsored through the government or an employer (Kaiser Family Foundation 2011). Thus while many women will keep their employer-based insurance,

¹The group I call “young adults” can be defined in various ways, most broadly consisting of people too old to qualify for State Children's Health Insurance Plans (SCHIPs) and too young for Medicare—a population that includes most of the group traditionally considered of reproductive age, 15 to 44 years old.

under the PPACA a sizable minority of young women are likely to be covered under a state-based health exchange or Medicaid program.

The experience in Massachusetts after implementation of similar health reforms confirms the a priori impression that these reforms led to expanded coverage for young adults. After implementation of reform, the uninsured rate among 19- to 26-year-olds in Massachusetts fell from 21 percent to 8 percent, a drop of more than 60 percent. By comparison, older adults' uninsured rate fell by approximately 45 percent (Long, Yemane, and Stockley 2010).

However, the experience in Massachusetts also points to a problem that newly covered individuals may face: reproductive health services, such as contraception, were excluded from at least some insurance plans targeting young adults (Agenor et al. 2009). In other words, the very population that most needed reproductive health services was at highest risk for enrolling in plans that did not cover these services.

Under the PPACA, some reproductive health services are guaranteed coverage. In qualified plans, for example, services that are recommended by the US Preventive Services Task Force (USPSTF) must be covered without cost sharing. These include screening for cervical cancer and sexually transmitted infections (STIs), counseling to promote breast feeding, and providing folic acid supplements for women prior to conception. In addition, the PPACA required the Department of Health and Human Services (DHHS) to adopt a list of preventive services for women (beyond those recommended by the USPSTF) that must also be covered without cost sharing. In August 2011 DHHS announced that these would include all FDA-approved contraceptives, counseling about domestic violence and STIs, and screening for human papillomavirus, HIV, and gestational diabetes. The PPACA allows state exchange plans to offer abortion services, but people opting for these plans must pay a separate premium for abortion care so as to strictly segregate the portion of the plan subsidized by federal dollars and the portion that includes abortion care (Annas 2010). Furthermore, every state must offer one plan that does not include abortion, and states can opt to ban abortion coverage in their exchange plans. Thus the PPACA promises to dramatically increase coverage of reproductive health services for the US population. However, not all services are guaranteed to be covered, and the quality of services provided may vary significantly. Consumers will need relevant information to distinguish among offered plans.

Health Insurance Exchanges: State Contracts to Improve Accountability

The PPACA requires states to do many things, but most prominent among them is to establish health insurance exchanges. The main job of a health insurance exchange is to contract with private insurance companies (or health organizations) to provide a set of plans for exchange consumers to choose from. Contracting with health plans allows the possibility for states to hold plans accountable for providing quality reproductive health care.² To understand how states could hold plans accountable, it is useful to briefly review the theoretical arguments for why one might expect state contracting to improve quality of care.

Contracting theory

The traditional theoretical justification for contracting out public services is efficiency (Donahue 1989; Arnould, Rich, and White 1993; Handler 1996). However, an additional theoretical benefit to this approach is its potential to improve individuals' access to services and the quality of services provided. This can be achieved through two mechanisms: output-

²My argument about how state contracting can improve care is not unique to reproductive health care. However, since many people outside the reproductive health age span are covered by pre-PPACA programs (SCHIP and Medicare), the act's expanded coverage of young reproductive-age adults offers a novel opportunity to improve care in this area.

based and input-based contracting. Output-based contracting relies on the power of consumer choice to improve the quality of services. Government contracting with health plans theoretically creates a competitive market in which health plans compete over premiums, access, and quality of care, and consumers select the plan with the best value for the money. Proponents of health exchanges often point to increased accountability under a competitive market as an advantage of exchanges compared with (in their words) large, bureaucratic, and unresponsive state agencies (Handler 1996; Davidson and Somers 1998). For output-based contracting to improve access to and quality of reproductive health services, two mechanisms must exist: first, consumers must value these services to create an incentive for plans to compete on this basis; second, the state must contract with plans to set up a fair and competitive marketplace. This requires that consumers have adequate information on which to base decisions about their health plans. When these conditions are met, the consumer can theoretically enforce health plan accountability by using her power to choose another plan in a competitive marketplace (Handler 1996; Davidson and Somers 1998).³

Although recent polls indicate that women value reproductive health coverage (Kaiser Family Foundation 2012a; Public Religion Research Institute 2012), consumer choice may not be adequate to hold health plans accountable for the quality of reproductive health services. Some scholars argue that because information about quality health care is difficult for consumers to obtain, interpret, and evaluate, output-based contracting is risky and morally questionable (Handler 1996). States rarely rely on output-based mechanisms as their primary way to hold public service providers accountable (Donahue 1989; Davidson and Somers 1998; Brennan and Berwick 1996; Freund 1993). Instead, accountability in most contracting arrangements is assessed on the basis of inputs. Prospective contracting allows states to require plans to meet specific requirements (or inputs) in order to qualify for a contract. This arrangement also requires adequate information, usually provided by plans to state agencies, to assess whether plans are meeting their contractual obligations.

Contracting under Medicaid—States already have recent experience contracting with health plans under Medicaid managed care (MMC). Rosenbaum and Johnson (1998) show how states rely primarily on input-based contracting under MMC. Indeed, the federal government requires states to impose a number of health plan network requirements to ensure adequate access for Medicaid enrollees. For example, to provide some assurances on access to care, state MMC programs typically create access regulations through the use of county and specialty-specific physician-to-patient ratios. To be awarded a Medicaid contract, health plans must demonstrate that their Medicaid provider networks meet specific ratio requirements. In addition, under an expanded membership base the plan must demonstrate that it continues to meet the ratio requirements. Under some states' contracting rules, if a plan's membership expands beyond the number of physicians necessary to meet the ratio requirement, the plan's membership is frozen in the relevant county. Moreover, in an effort to increase continuity of care as well as preventive services, all states require health plans to assign a primary care provider to each of their Medicaid members. These contracting rules have great potential for expanding access to reproductive health services. For example, states could adopt rules requiring at least one family planning clinic in each county or a specific ratio of maternity care providers to the population of reproductive-age women.

³For many new enrollees, the federal government will subsidize all or a portion of the premium; in the case of full subsidies, enrollees do not consider price in their plan selection.

Contracting under the PPACA—By design, states have significant flexibility in how they create their health insurance exchanges under the PPACA. This maintains the multimarket structure that can create challenges for providers who wish to implement quality improvement initiatives under uniform rules; however, it creates opportunities for states that want to take a proactive approach to health care quality. The law requires every state to have a fully operational exchange, governed by a board with state oversight, in place by January 1, 2014. But each state will decide the structure, governance, financing, and contracting mechanisms of the exchanges. States can mandate that the exchange governing board take a hands-off approach and allow any qualified health plan meeting basic criteria to participate in the exchange. In this model, the exchange functions as a simple clearinghouse for consumers to shop for plans. Alternatively, states can design their exchange boards as active purchasers of health insurance plans, with the flexibility and authority to set and enforce terms of participation in the exchange (Hacker and Archer 2012). A board could choose to require or incentivize features such as coordination of care, access to specific services, or quality measures that it considers important for its state population.

As of May 2012, fourteen states plus the District of Columbia had created health insurance exchanges. Of these, seven states created their exchange boards as active purchasers, and an additional five have not ruled out this approach (Kaiser Family Foundation 2012b). The opportunities to use exchange-based contracting as a mechanism for health care improvement are robust and could result in significant population health benefits across the United States.

For Medicaid-eligible adults, the PPACA encourages expanded attention to quality of care. It requires DHHS to establish quality measures for this population and to create procedures that will encourage voluntary quality reporting by state Medicaid programs.

In summary, as states create exchanges to comply with the PPACA and some expand their Medicaid programs, the extent to which input-based assessment is an effective tool for quality improvement depends on how well compliance is measured. Similarly, the extent to which output-based accountability incentivizes access to high-quality services depends on consumers having adequate information on which to base purchasing decisions. Thus for states to hold plans accountable for quality, they will need to require that health plans collect and report relevant health care data. I now turn to a discussion of what data plans might be asked to report in order to improve reproductive health services, who might use these data, and how their use can improve care and outcomes.

Using Health Care Data to Improve Care

Data generated from health care encounters offer the opportunity for policy makers, researchers, health plans, and providers to study large populations and gain insights that can improve care.

What data can health plans collect? When individuals enroll in health plans and receive health services, information about their demographic characteristics, health conditions, and treatment is generated and held by health plans and providers. Overview information that providers generally send to payers for billing—such as dates of service, diagnosis and procedure codes from the International Classification of Diseases (ICD) or a similar system, and basic patient and provider characteristics—is described as *administrative* health care data. Information of a more *clinical* nature—such as medical history and physical exam test results—is collected in medical records but not routinely sent to payers or other parties. As electronic medical records (EMRs) become widely adopted, collection and analysis of aggregate clinical data is expected to become a powerful tool for quality improvement (Jha

2011). Quality is assessed through both *outcome* and *process* measures, which can rely on administrative or clinical data or a combination of the two. Outcome measures include rates of specific diagnoses (such as infections) or events (such as hospitalizations), whereas process measures assess whether providers followed guidelines and provided appropriate tests (such as cancer screening) and treatments (such as medications). Table 1 summarizes types of health care data and uses Pap smears for cervical cancer (or precancerous dysplasia) screening as an example of how each data type might be used to assess reproductive health care and outcomes. These measures, along with *patient satisfaction* data collected through surveys, are designed to assess and track quality of care.

One group of quality measures commonly used to assess health plans is the Healthcare Effectiveness Data and Information Set (HEDIS), established and maintained by the National Committee for Quality Assurance (NCQA), a private nonprofit organization. HEDIS primarily relies on process measures (such as health care visits, tests performed, and medications prescribed) collected through administrative data; patient satisfaction and some care processes are also assessed through surveys. NCQA reports that more than 90 percent of US health plans use HEDIS to measure and track quality, and they are used in NCQA's Health Plan Report Card and voluntary plan accreditation program. In the realm of reproductive health, HEDIS is somewhat limited. It includes measures on the timeliness of prenatal and postpartum care, appropriate use of prenatal testing, screening tests for cervical and breast cancer, and chlamydia screening for women. Many other areas of women's and reproductive health care that are endorsed by DHHS have no HEDIS measures to assess their quality, including breastfeeding support, domestic violence screening and counseling, and contraception.

Current reporting and use of data

The Center for Medicare and Medicaid Services (CMS) currently collects large volumes of administrative data about Medicare and Medicaid beneficiaries and the health care they receive, as well as quality data from providers who receive CMS funds. CMS requires managed care organizations participating in the Medicare Advantage program to report HEDIS measures, and states have the option of using HEDIS to report CMS-required information on their Medicaid managed care plans. States are required to report data from Medicaid claims (but not quality measures) to CMS. Under traditional (fee-for-service) Medicare, providers are assessed using quality measures that CMS establishes and maintains.

Data collected by CMS are accessed by diverse users for a variety of purposes. CMS itself uses quality data to determine payments to providers under specific pay-for-performance programs (Kahn et al. 2006). It also makes quality data available to the public—for example, through the DHHS website Hospital Compare (www.hospitalcompare.hhs.gov). These uses of data are intended to incentivize providers to improve the care they give. Health care researchers from academic and nonprofit organizations can also access data about Medicare and Medicaid beneficiaries and their health service utilization. CMS reviews data requests and can issue data user agreements for specific data files. These generally include administrative information such as beneficiary demographics, reasons for Medicare or Medicaid eligibility, dates of services, types of services provided, and diagnoses.

Private health insurance plans similarly collect and report data from providers. Organizations such as NCQA encourage consumers to ask for quality information from their health plans to motivate plans to publicly report this data. Researchers can also purchase administrative data sets from commercial vendors based on private insurance claims.

Benefits of population health data for research

Many research methods designed to improve health care rely on data collection outside health care settings or from a small subset of patients. For example, surveys are cumbersome to complete and often reach too small a sample to collect meaningful information on rare outcomes. Clinical trials similarly enroll relatively small numbers of patients with specific diseases and aim to study the efficacy of single interventions. In comparison, large population health databases derived from everyday clinical encounters provide information on all covered individuals and all treatments they receive, allowing unique opportunities to study outcomes that are otherwise difficult research targets. For example, Denmark provides universal government-sponsored health care to its population and thereby collects comprehensive health utilization data. A 2010 Danish study using pharmacy and birth registries revealed that some common antidepressants increase the risk of rare congenital heart problems in infants exposed in utero (Kornerup et al. 2010). In the United States a recent study using Medicare data identified which chemotherapy regimens for breast and ovarian cancer patients were most commonly associated with side effects from bone marrow suppression (Nurgalieva, Liu, and Du 2011). These studies, and many like them, would be difficult to conduct using traditional health care surveys or clinical trials. Large population health databases provide a valuable source for research to improve health outcomes, especially for conditions such as rare pregnancy complications (Kieler 2010).

Who Should Be Able to Use Health Care Data, and How

I envision five groups of data users accomplishing three broad purposes with health data under the PPACA. Users include (1) health care consumers, including patients, potential patients, and their family members; (2) payers, such as state and federal governments and employers; (3) providers, such as hospitals and clinics; (4) plans, for example, insurers who contract with states or employers to enroll individuals; and (5) researchers working to improve population health and health care. Each of these user groups would use data to select or change plans or providers, hold plans and providers accountable, and/or improve health care and policy.⁴

Consumers would take advantage of information to select the health plan and specific provider that best fit their individual needs. Currently most health consumers receive at best a limited overview of services provided by different health plans they can select. With better data collection and dissemination, consumers could choose plans based on quality of care in the areas that matter most to them. For example, women could review measures related to Pap smear screening and pregnancy care. Patients not satisfied with their care would be able to access this same information to change providers, which would incentivize high-quality care at multiple levels of the delivery system.

Payers would use data to hold health plans accountable for the quality and efficiency of the care they provide: states could require plans to meet the quality criteria for NCQA accreditation, excluding future contracts with plans that do not meet the standards and giving bonus payments to those that significantly exceed them. Data would also allow states to determine whether their standards are fair and effective and to shape future policy based on past achievements and challenges. For example, if a state learns that many health plans have failed to meet the standard it set for Pap smear rates, it can investigate common barriers and propose changes to help plans and their providers improve care for patients.

⁴See Lawlor 2003 for an analogous conceptualization of how accountability and benefits work under Medicare contracting arrangements.

Providers could benefit from data to compete for patients and improve the care they provide. A hospital seeking to reach out to new patients may review data from other providers in its region and discover gaps in specific services. A clinic may learn that it is losing potential patients because its quality indicators for prenatal care are lower than those of its competitors, causing women to enroll elsewhere during their pregnancies.

Health plans would use data to select providers and foster high-quality care: patients would want providers with effective prenatal care programs, and plans would therefore want to include those providers in their contracts. Plans could highlight these practices to encourage even more patients to take advantage of them, thereby improving outcomes. Other providers would then emulate those services in order to compete.

Finally, researchers would have access to data to identify new health problems and learn what policies and interventions are effective. Health services researchers from academic and nonprofit spheres have been important actors in health policy by shedding light on numerous health disparities and lapses in quality of care. Yet many problems remain entrenched. Despite the existence of highly effective contraceptive methods, rates of teen and unintended pregnancy have remained high in the United States. What programs and interventions would truly help address this challenge? Beyond the current HEDIS measures, what quality measures should we adopt to assess and improve reproductive care? With enhanced access to data, researchers would have the potential to learn how delivery of care could best meet the needs of patients and the population.

The two parts of figure 1 illustrate how these five groups accessing health data can hold plans and providers accountable for the benefit of patients and the state as payer.

Conclusion

In the United States, young adults who lack health insurance generally either forgo preventive health care services such as contraception and cancer screening or get them through a variety of piecemeal programs and out-of-pocket spending (Callahan and Cooper 2005). This not only threatens the quality of care they receive but also limits the ability of health care regulators, researchers, and consumers themselves to learn from the care they and others receive.

Under the PPACA, many of these previously uninsured people and services will be covered under Medicaid or a plan offered through a state health exchange. States are empowered to contractually require health plans to collect and report health care data and to meet minimum quality standards. If they do, these plans—and the people and services they cover—will provide an important source of data to learn about and improve care. In implementing the new exchanges, states can take advantage of the existing Medicaid infrastructure to integrate patient care and data collection for beneficiaries across a wide spectrum of incomes.

The PPACA thus has great potential to improve the reproductive health of the US population. Expanded coverage of young adults and the reproductive health services they seek will not only benefit current patients but will allow us to learn and improve care for the benefit of future users. In order for this potential to be realized, data collection, reporting, and quality must be a required part of PPACA implementation. Providers and health plans should be required to report both administrative and EMR-derived clinical data to state and federal authorities while respecting individual patient privacy. State-administered health insurance exchanges, as well as expanded Medicaid programs, must write data reporting requirements into their contracts with plans. While women with employer-based insurance will not immediately be affected by new data reporting requirements, over time more

employers may drop coverage and state-based plans may represent a growing share of the total insurance market. Furthermore, employers or states may adopt broader requirements for plans to collect and publicly report health data from employer-based insurance.

Going forward, it will be important for future research to track the availability and use of data under the PPACA. If data are shared with the public, are they used by consumers across spectrums of age, culture, and geography? If so, for what purposes? How do consumers, states, and other stakeholders benefit from the data, and are there any unanticipated effects of data reporting? How can data quality and transparency be improved?

It is my hope that by providing high-quality, usable data to health consumers, payers, plans, providers, and researchers, the PPACA can bring about an expanded, holistic vision of reproductive health care that addresses individuals' needs across the life span.

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References

- Agenor, M., et al. Young Adults and the Coverage of Contraceptive Services in the Wake of Health Reform: Results from an Assessment of Young Adult-Targeted Health Plans in the Commonwealth of Massachusetts. Cambridge, MA: Ibis Reproductive Health; 2009.
- Alexander GR, Kogan MD, Nabukera S. Racial Differences in Prenatal Care Use in the United States: Are Disparities Decreasing? *American Journal of Public Health*. 2002; 92(12):1970–75. [PubMed: 12453818]
- Annas GJ. The Real Pro-Life Stance—Health Care Reform and Abortion Funding. *New England Journal of Medicine*. 2010; 362(16):e56. [PubMed: 20375398]
- Arnould, RJ.; Rich, RF.; White, WD. *Competitive Approaches to Health Care Reform*. Washington, DC: Urban Institute Press; 1993.
- Berg CJ, et al. Preventability of Pregnancy-Related Deaths: Results of a State-Wide Review. *Obstetrics and Gynecology*. 2005; 106(6):1228–34. [PubMed: 16319245]
- Berg CJ, et al. Pregnancy-Related Mortality in the United States, 1998 to 2005. *Obstetrics and Gynecology*. 2010; 116:1302–9. [PubMed: 21099595]
- Brennan, TA.; Berwick, DM. *New Rules: Regulation, Markets, and the Quality of American Health Care*. San Francisco: Jossey-Bass; 1996.
- Callahan ST, Cooper WO. Uninsurance and Health Care Access among Young Adults in the United States. *Pediatrics*. 2005; 116(1):88–95. [PubMed: 15995037]
- Centers for Disease Control and Prevention (CDC). HIV among African Americans. 2011a Nov. www.cdc.gov/hiv/topics/aa/PDF/aa.pdf
- Centers for Disease Control and Prevention (CDC). Sexually Transmitted Disease Surveillance 2010. Atlanta: Department of Health and Human Services; 2011b. www.cdc.gov/std/stats10/surv2010.pdf
- Centers for Disease Control and Prevention (CDC). [accessed June 1, 2012] Preterm Birth. 2012. www.cdc.gov/reproductivehealth/maternalinfanthealth/PretermBirth.htm
- Davidson, SM.; Somers, SA. *Remaking Medicaid: Managed Care for the Public Good*. San Francisco: Jossey-Bass; 1998.
- Dehlendorf C, et al. Disparities in Family Planning. *American Journal of Obstetrics and Gynecology*. 2010; 202(3):214–20. [PubMed: 20207237]
- Donahue, JD. *The Privatization Decision: Public Ends, Private Means*. New York: Basic Books; 1989.
- Finer LB, Zolna MR. Unintended Pregnancy in the United States: Incidence and Disparities, 2006. *Contraception*. 2011; 84(5):478–85. [PubMed: 22018121]

- Freund, D. Outcomes Assessment: Market Incentives or Regulatory Fiat. In: Arnould, RJ.; Rich, RF.; White, WD., editors. *Competitive Approaches to Health Care Reform*. Washington, DC: Urban Institute Press; 1993. p. 49-66.
- Hacker, J.; Archer, D. *Flexible Authority: Ensuring Health Insurance Exchanges Shape the Rules of the Game*. Washington, DC: Health Care for America Now; 2012.
- Handler, JF. *Down from Bureaucracy: The Ambiguity of Privatization and Empowerment*. Princeton, NJ: Princeton University Press; 1996.
- Jha AK. The Promise of Electronic Records: Around the Corner or Down the Road? *Journal of the American Medical Association*. 2011; 306(8):880–81. [PubMed: 21862751]
- Kahn CN III, et al. Snapshot of Hospital Quality Reporting and Pay-for- Performance under Medicare. *Health Affairs*. 2006; 25(1):148–62. [PubMed: 17533665]
- Kaiser Family Foundation. Women's Health Insurance Coverage. Fact Sheet: Women's Health Policy Facts. 2011 Dec. www.kff.org/womenshealth/upload/6000-091.pdf
- Kaiser Family Foundation. Kaiser Health Tracking Poll—May 2012. 2012a. www.kff.org/kaiserpolls/8315.cfm
- Kaiser Family Foundation. State Action toward Creating Health Insurance Exchanges, as of May 17, 2012. 2012b. www.statehealthfacts.org/comparemaptable.jsp?ind=962&cat=17
- Kieler H. The Nordic Health Registers—an Important Source when Evaluating the Safety of Antidepressants during Pregnancy. *Clinical Epidemiology*. 2010; 2:205–7. [PubMed: 21042552]
- Kornum JB, et al. Use of Selective Serotonin-Reuptake Inhibitors during Early Pregnancy and Risk of Congenital Malformations: Updated Analysis. *Clinical Epidemiology*. 2010; 2:29–36. [PubMed: 20865100]
- Lawlor, Edward F. *Redesigning the Medicare Contract: Politics, Markets, and Agency*. Chicago: University of Chicago Press; 2003.
- Long SK, Yemane A, Stockley K. Disentangling the Effects of Health Reform in Massachusetts: How Important Are the Special Provisions for Young Adults? *American Economic Review*. 2010; 100(2):297–302.
- March of Dimes et al. *Born Too Soon: The Global Action Report on Preterm Birth*. Geneva: World Health Organization; 2012. reliefweb.int/sites/reliefweb.int/files/resources/201204_borntoosoon-report.pdf
- Nurgalieva Z, Liu CC, Du XL. Chemotherapy Use and Risk of Bone Marrow Suppression in a Large Population-Based Cohort of Older Women with Breast and Ovarian Cancer. *Medical Oncology*. 2011; 28(3):716–25. [PubMed: 20361359]
- Prejean J, et al. Estimated HIV Incidence in the United States, 2006–2009. *PLoS ONE*. 2011; 6(8):e17502. [PubMed: 21826193]
- Public Religion Research Institute. February PRRI Religion and Politics Tracking Poll. 2012 Feb 7. publicreligion.org/research/2012/02/january-tracking-poll-2012
- Rosenbaum, S.; Johnson, KA. *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*. 2. Washington, DC: George Washington University Medical Center; 1998.
- Smith-Bindman R, et al. Does Utilization of Screening Mammography Explain Racial and Ethnic Differences in Breast Cancer? *Annals of Internal Medicine*. 2006; 144(8):541–53. [PubMed: 16618951]
- US House of Representatives. H.Res. 1022 (110th): Reducing Maternal Mortality Both at Home and Abroad. 110th Congress, 2007–2009; textas. May 21, 2008; 2008. www.govtrack.us/congress/bills/110/hres1022/text
- US National Program of Cancer Registries. *United States Cancer Statistics: 1999–2008 Cancer Incidence and Mortality Data*. Atlanta: Centers for Disease Control and Prevention; 2012. apps.ncccd.cdc.gov/uscs
- World Health Organization (WHO). *Maternal Health: Maternal Mortality Ratio (per 100,000 Live Births)*. 2010. 2012a. gamapserver.who.int/gho/interactive_charts/mdg5_mm/atlas.html
- World Health Organization (WHO) et al. *Trends in Maternal Mortality, 1990–2010: WHO, UNICEF, UNFPA and the World Bank Estimates*. Geneva, Switzerland: WHO; 2012b.

Figure 1a. Pathways of Accountability

Figure 1b. Pathways of Benefit

Figure 1.
 Figure 1a. Pathways of Accountability
 Figure 1b. Pathways of Benefit

Table 1

Types of Health Care Data Used to Assess Quality of Cervical Cancer Screening

	Administrative Data	Clinical Data
Process measures	ICD procedure code for Pap smear	Physician note in chart stating Pap smear was done
Outcome measures	ICD diagnosis code for cervical dysplasia	Laboratory result of Pap smear indicating cervical dysplasia