



Access to Abortion Coverage and Health Reform

Women's issues have emerged as central to the debate on health care reform. Access to abortion services has become one of the most highly charged elements of the debate. This issue has been handled differently in both the bill that was approved by the House of Representatives, H.R. 3962, the Affordable Health Care for America Act, and the bill put forth by the Senate leadership, the Patient Protection and Affordable Care Act, H.R. 3590. The way that Congress addresses abortion coverage under health reform has the potential to affect many women, as abortion is one of the most common surgical procedures performed on women. In 2005, there were more than 1.2 million abortions in the United States. It is estimated that at current rates, about a third of women will have had an abortion by age 45.¹ This brief discusses current law regarding federal and state policies that address abortion coverage, lays out key issues being debated regarding abortion coverage under health reform, and raises questions about the possible impact of the House and Senate legislation on women's coverage for abortion services.

What are current federal and state laws regarding insurance coverage for abortion?

Current federal law bans the use of any federal funds for abortion, except in the event of rape, incest, or the woman's life endangerment, as specified in the federal Hyde Amendment, which has been in effect since 1977. This amendment is not a permanent law; rather it has been attached annually to Congressional appropriations bills, and has been approved every year by the Congress. The broadest reach of the Hyde Amendment is on the Medicaid program, basically limiting federal Medicaid funding for abortions to life endangerment, rape, or incest cases in most states. States can choose to broaden the circumstances to cover other "medically necessary" abortions for women on Medicaid with their own funds and 17 states do, but in the majority of states women on Medicaid only have coverage in cases of rape, incest, or when the pregnancy is documented by a physician to be a threat to the life of the woman. Over the years, the Hyde Amendment has been broadened to limit federal funds for abortion for federal employees, in the Indian Health Service, and women in the military.

State level policies can also affect abortion coverage. States have the authority to regulate benefits covered by private insurance plans. Currently, five states (Idaho, Kentucky, Missouri, North Dakota, Oklahoma) prohibit private insurance coverage for abortions except in the case of rape, incest, or to save the woman's life. These states allow insurers to sell riders for abortion coverage, but there is little evidence that riders are actually available in these states and there is no documentation of their cost or impact on access.

How do the House and Senate bills address coverage of abortion?

While both the House and Senate bills specify that abortion coverage shall not be included in any essential benefits package, the House bill, H.R. 3962 and Senate bill, H.R. 3590 differ considerably regarding the limitations on abortion coverage (Table 1). Both bills expand coverage to many of the nation's uninsured by extending Medicaid eligibility to all qualifying individuals (with incomes up to 150% of the federal poverty level in the House and up to 133% of poverty in the Senate). The House bill establishes a national health insurance exchange that would essentially be a marketplace where individuals with incomes above 150% of poverty can purchase insurance coverage. Initially, the Exchange would be open to all qualifying people who are uninsured and employees of some small businesses, with the possibility of opening to more people over time. The Exchange would offer multiple insurance plans that individuals can choose from, including at least one publicly-financed plan as well as several privately-operated plans. To help individuals purchase insurance, the federal government will provide subsidies (in the form of premium credits) to eligible individuals and families with incomes between 150% and 400% FPL. The House bill also extends premium credits to individuals with employer-sponsored insurance if their share of premiums exceeds 12% of their income, which could make an additional 1 million people eligible for purchasing coverage in the Exchange.² In total, it is estimated that 86% of participants in the Exchange would receive subsidies.³

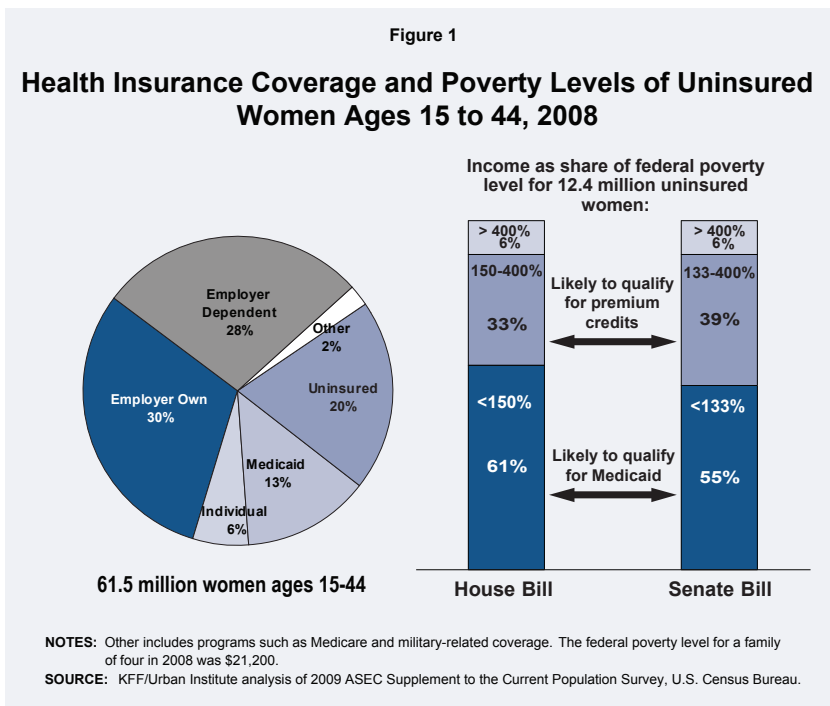
The Senate leadership bill expands Medicaid to 133% FPL and creates state-based health insurance exchanges through which individuals and certain small employers can purchase coverage. The exchanges could include an optional public plan (“community health insurance option”). Similar to the House, the Senate bill would provide subsidies for premiums and cost sharing to assist lower-income uninsured individuals, as well as to those with employer-sponsored coverage if their share of premiums exceeds 9.8% of their income, purchase coverage in the exchanges.

Both bills place restrictions on federal coverage of abortion, but the restrictions in the House bill are much farther reaching. The most direct impact of both bills are on the plans that will be offered in the new health insurance exchanges. According to the House legislation, the public plan within the Exchange would be prohibited from providing coverage for abortions beyond those permitted by current federal law (to save the life of the woman or in cases of rape or incest). The House bill also prohibits federal premium credits that low-income individuals will receive from the federal government from being used to purchase a health plan in the Exchange that includes coverage for all but federally permitted abortions. Although it is not required, private insurers may opt to offer a plan in the Exchange that covers abortions beyond those permitted by federal law. These insurers, however, will be required to also offer an identical plan that does not cover abortions for which federal funding is prohibited.

Private plans participating in the Exchange may choose to offer supplemental coverage for abortions in the form of riders that are totally separate from other benefits, but that coverage must be paid for entirely with non-federal funds. Furthermore, the plans must be separately operated to assure that federal funds are not used to administer or operate plans that cover abortions.

The Senate leadership bill reiterates current law under the Hyde Amendment by specifying that federal subsidy dollars can only be used for abortions in cases where the pregnancy endangers the life of the woman or results from rape or incest. Coverage for other abortions would have to be paid for with private, state or local funds. The Senate bill allows the “community option” plans to cover abortions beyond the federal limits if the state chooses to do, as long as federal funds are not used to pay for the coverage. In order to ensure that federal funds are not used for abortion coverage, plans that do cover abortions beyond Hyde limitations must estimate the actuarial value of such coverage by taking into account the cost of the abortion benefit (valued at least \$1 per enrollee per month) and cannot take into account any savings that might be achieved as a result of the abortions. The Senate bill also requires that any exchange offer at least one plan that offers coverage for abortions beyond those for which federal funds are permitted as well as at least one plan that does not go beyond the federal limits.

It is estimated that 12.4 million women ages 15 to 44 are uninsured, 94% of whom would qualify for federal assistance under the House and Senate bills. The House bill would extend Medicaid coverage to 61% of this group through Medicaid — 7.5 million women, while the Senate bill would extend Medicaid to 55% or 6.7 million women. Under the House proposal, 4.1 million women (33%) would qualify for federal premium credits to purchase coverage, and under the Senate 4.8 million women (39%) would fall into this group, as shown in Figure 1.



The Senate bill prohibits plans in the exchanges from discriminating against any provider because of a “willingness” or “unwillingness” to provide abortions, while the House bill only explicitly prohibits discrimination against providers because of their “unwillingness” to provide abortions.

The new House bill is a significant departure from current law as well as the Senate bill and goes much further in terms of limiting coverage. Additionally, it is important to note that any final health reform legislation would codify into federal law the abortion provisions so that they would not require annual approval, unlike the current Hyde Amendment. As the health reform process goes forward, differences between the House bill and a bill that ultimately gets approved in the Senate will need to be reconciled in the House-Senate Conference Committee.

Table 1: Side-by-Side Comparison of Abortion Provisions in House and Senate Health Reform Bills

	House Bill (HR 3962)	Senate Bill (HR 3590)
Benefit Design	<p>Prohibit abortion coverage from being required as part of the essential benefits package;</p> <p>Public Plan: Prohibited from providing coverage for abortions beyond those permitted by federal law (to save the life of the woman and in cases of rape and incest);</p> <p>Private Plans: Can only provide a plan in the Exchange that covers abortions beyond those permitted by federal law (to save the life of the woman and in cases of rape and incest) if they also offer an identical and separately operated plan that does not cover abortions for which federal funding is prohibited;</p> <p>Private plans participating in the Exchange may, but are not required to, offer separate supplemental coverage (riders) for abortions.</p>	<p>Prohibit abortion coverage from being required as part of the minimum benefits package;</p> <p>Public Plan: Optional Community Health Insurance plan offered by a state exchange may provide coverage for abortions beyond those permitted by federal law (to save the life of the woman and in cases of rape and incest) if state chooses to do so, but coverage for the abortion benefit cannot be paid for with any federal funds;</p> <p>Private Plans: May choose to cover abortions beyond Hyde restrictions (see financing below);</p> <p>Require that at least one plan in each exchange provide coverage for abortions beyond those for which federal funds are permitted and require that at least one plan in the exchange limit abortion coverage to circumstances only in which federal funds are permitted (in cases of rape or incest or to save the life of the woman).</p>
Financing	<p>Prohibit federal premium subsidies from being used to purchase a health plan in the Exchange that includes coverage for abortions except to save the life of the woman or in cases of rape or incest;</p> <p>Individuals receiving federal subsidies may purchase supplemental coverage for abortions but that coverage must be paid for entirely with non-federal (e.g. state, local, and private) funds.</p>	<p>Prohibit federal subsidy funds (for premiums or cost sharing) from being used to pay for abortion coverage in plans that opt to offer such coverage;</p> <p>Plans choosing to cover abortions, must take all necessary steps to ensure segregation of federal subsidies for premiums or cost sharing from private premium payments or state funds for plans that choose to cover abortion services beyond Hyde—which only allows coverage for abortion services to save the life of the woman and in cases of rape or incest;</p> <p>In order to segregate funds, plans that choose to offer coverage for abortions beyond Hyde limitations must estimate the actuarial value of covering abortions by taking into account the cost of the abortion benefit (valued at least \$1 per enrollee per month) and cannot take into account any savings that might be reaped as a result of the abortions.</p>
State Role	<p>Law will have no effect on state laws regarding coverage, funding or procedural requirements on abortions, such as parental notification/ consent laws;</p> <p>States may use state-only funds to pay for “medically necessary” abortions beyond federal requirements under Medicaid or to pay for supplemental coverage/riders for abortions offered by plans.</p>	<p>Law will have no effect on state laws regarding coverage, funding or procedural requirements on abortions, such as parental notification/consent laws;</p> <p>States have authority to specify whether community option plan will cover abortions beyond federal requirements;</p> <p>States may use state-only funds to pay for “medically necessary” abortions in Medicaid or to pay for abortion coverage in plans offered in an exchange.</p>
Discrimination/ Protection	<p>Prohibit plans participating in the Exchange from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.</p>	<p>Prohibit plans participating in the exchanges from discriminating against any provider because of either a willingness or unwillingness to provide, pay for, provide coverage of, or refer for abortions.</p>

What would be the impact of the abortion provisions in the House and Senate proposals on women with private insurance?

These provisions would have direct effects on women seeking coverage in an exchange as well as on plans that offer coverage in an exchange. In the House bill, women who choose the public option would not have abortion coverage nor would they have access to a rider. Women who receive any level of federal subsidy cannot purchase coverage from a plan that offers abortion coverage, but they do have the option of purchasing a separate rider for abortion coverage alone, if offered by the plan. Women who do not receive federal subsidies and seek coverage in the Exchange could be able to buy coverage from a plan that offers an abortion benefit, if such a plan is available. However, it is unclear whether a woman would necessarily seek or know to buy a service-specific rider for abortion when she is choosing her insurance plan, or whether women without subsidies would necessarily know whether they are buying coverage from a plan that covers abortion or not. It is also unknown what the price differential would be between the two plans and how much the rider would cost, if offered. In the Senate bill, if a woman is in a state exchange that offers a public plan, that plan may cover abortions, depending on whether the state decides to offer it, and as long as all steps are taken to ensure that federal funds are not used for the purchase of the abortion benefit.

The House bill goes beyond the Senate bill by requiring the sale of a distinct insurance product that is designed specifically for those receiving subsidized coverage. For insurers, the law sets a number of restrictions, particularly the requirement to isolate federal dollars from private funds because a plan that receives any federal funds cannot provide abortion coverage. Although it is hard to predict the response of insurance plans to this type of law, some legal scholars contend that given the size of the potential pool of women and their families that will be eligible for federal subsidies under the exchange and other complexities, this might limit the development of insurance plans that offer either abortion coverage or a rider, and ultimately carry over to products offered in the employer market.⁴ It is estimated that in 2003, 46% of workers with employer insurance were in plans that offer abortion coverage, and a study conducted in 2002 found that 87% of plans offered abortion as a covered benefit.⁵

This complex combination of restrictions means that, under both the House and Senate bills many women who will obtain coverage under health reform either through Medicaid or an exchange would have to pay for an abortion out-of-pocket, particularly under the House bill. The cost of an abortion varies depending on factors such as location, facility, timing, and type of procedure. A clinic-based abortion at 10 weeks' gestation is estimated to cost between \$400 and \$550, whereas an abortion at 20-21 weeks' gestation is estimated to cost \$1,250-\$1,800.⁶ The vast majority of abortions are performed early in pregnancy. In 2004, 89% were in the first twelve weeks of pregnancy and only 1% were at 21 weeks or later.⁷ In general, abortions performed in hospitals are more expensive than those performed at clinics.

What is the impact on low-income women covered by Medicaid?

Both the House and Senate bills include major expansion of the Medicaid program, extending coverage to qualifying uninsured individuals with incomes below 150% of the federal poverty line under the House version and up to 133% of poverty in the Senate. The Medicaid program already serves millions of low-income women, and is a major financier of reproductive health services. It is estimated that two-thirds of adult women on Medicaid are in their reproductive years.⁸ The federal Hyde Amendment applies to the Medicaid program currently, restricting state Medicaid programs from using federal funds to cover abortions beyond the cases of life endangerment, rape, or incest. However, under both the House and Senate bills, states can use their own funds to cover other "medically necessary" abortions, which 17 states do now.⁹ In the other 33 states and DC, state Medicaid programs do not pay for any abortions beyond the situations of life endangerment, rape, or incest (Table 2). In these states, an estimated 4.1 million women ages 15-44 are currently uninsured and also have incomes less than 133% of the federal poverty level (Senate proposal), rising to 4.5 million women with incomes less than 150% of poverty (House proposal). Many of these women would likely qualify for Medicaid under either of the bills.¹⁰

Table 2: State Level Estimates of Percent of Uninsured Women Ages 15-44 Likely to Qualify for Federal Assistance Under House and Senate Health Reform Bills

	PERCENT OF UNINSURED WOMEN ELIGIBLE FOR FEDERAL ASSISTANCE						
	Total Number of Women Ages 15-44	UNINSURED WOMEN		House Bill (HR 3962)		Senate Bill (HR 3590)	
		Total Number	Percent of Total Women in State	Likely to Qualify for Medicaid**	Likely to Qualify for Premium Credits in the Exchange***	Likely to Qualify for Medicaid#	Likely to Qualify for Premium Credits in the Exchange##
Alabama*	940,728	163,027	17%	70%	27%	66%	32%
Alaska	138,466	35,278	25%	40%	47%	39%	48%
Arizona	1,291,329	314,872	24%	61%	34%	56%	39%
Arkansas*	558,667	143,444	26%	63%	32%	54%	42%
California	7,751,730	1,769,041	23%	62%	32%	55%	39%
Colorado*	1,009,555	212,514	21%	59%	34%	52%	42%
Connecticut	687,728	80,627	12%	55%	36%	49%	42%
Delaware*	176,726	26,910	15%	57%	35%	50%	42%
District of Columbia*	146,428	14,487	10%	60%	28%	55%	33%
Florida*	3,462,675	930,106	27%	53%	37%	48%	42%
Georgia*	2,060,476	472,038	23%	68%	25%	61%	32%
Hawaii	245,232	23,034	9%	54%	34%	49%	39%
Idaho*	301,876	63,485	21%	62%	32%	57%	37%
Illinois	2,673,186	455,087	17%	58%	34%	52%	41%
Indiana*	1,270,832	218,998	17%	63%	31%	56%	38%
Iowa*	577,375	84,050	15%	57%	33%	50%	40%
Kansas*	542,896	95,091	18%	66%	28%	60%	34%
Kentucky*	861,081	195,025	23%	67%	29%	64%	32%
Louisiana*	907,422	218,645	24%	67%	27%	60%	34%
Maine*	248,739	28,277	11%	48%	39%	45%	42%
Maryland	1,174,973	208,416	18%	58%	35%	50%	43%
Massachusetts	1,341,671	96,535	7%	--	--	--	--
Michigan*	1,991,068	318,012	16%	57%	31%	50%	37%
Minnesota	1,038,556	123,394	12%	57%	38%	48%	47%
Mississippi*	598,491	148,187	25%	71%	22%	66%	27%
Missouri*	1,180,972	201,606	17%	60%	34%	53%	41%
Montana	180,694	37,879	21%	59%	35%	55%	39%
Nebraska*	352,270	56,031	16%	56%	39%	50%	45%
Nevada*	520,802	118,622	23%	54%	39%	48%	45%
New Hampshire*	260,125	35,321	14%	46%	43%	40%	49%
New Jersey	1,733,597	337,318	19%	54%	36%	46%	44%
New Mexico	403,703	126,496	31%	60%	33%	55%	38%
New York	4,056,783	694,524	17%	59%	34%	54%	39%
North Carolina*	1,881,734	403,274	21%	62%	34%	58%	38%
North Dakota*	124,614	16,403	13%	63%	33%	53%	43%
Ohio*	2,277,933	344,107	15%	61%	34%	55%	41%
Oklahoma*	720,611	157,584	22%	60%	34%	56%	37%
Oregon	747,701	144,438	19%	56%	36%	51%	42%
Pennsylvania*	2,400,877	274,308	11%	59%	33%	54%	38%
Rhode Island*	216,579	31,367	14%	58%	34%	51%	41%
South Carolina*	895,722	186,183	21%	60%	35%	54%	41%
South Dakota*	153,114	24,357	16%	56%	36%	52%	40%
Tennessee*	1,249,525	229,256	18%	59%	35%	50%	44%
Texas*	5,094,986	1,648,911	32%	60%	35%	54%	41%
Utah*	592,539	92,015	16%	54%	38%	50%	42%
Vermont	119,776	16,603	14%	46%	44%	34%	56%
Virginia*	1,585,309	286,413	18%	51%	37%	47%	42%
Washington	1,330,923	202,893	15%	56%	39%	49%	46%
West Virginia	344,608	76,896	22%	61%	32%	53%	40%
Wisconsin*	1,101,746	120,859	11%	59%	31%	53%	37%
Wyoming*	103,513	20,538	20%	51%	43%	46%	47%

Notes: The federal poverty level (FPL) for a family of four in 2008 was \$21,200.

* State does not provide funds for abortions beyond restrictions in federal Hyde Amendment.

** Includes women ages 15-44 who are currently uninsured with incomes <150% of the federal poverty level.

*** Includes women ages 15-44 who are currently uninsured with incomes 150-400% of the federal poverty level.

-- Sample size insufficient to make reliable estimate.

Includes women ages 15-44 who are currently uninsured with incomes <133% of the federal poverty level.

Includes women ages 15-44 who are currently uninsured with incomes 133-400% of the federal poverty level.

Source: Kaiser Family Foundation/Urban Institute estimates of ASEC supplement to March 2008, 2009 Current Population Surveys, U.S. Census Bureau.

How do the federal exceptions (rape, incest, and life endangerment) affect women's access to abortion services?

The House and Senate bills only allow federal funds to be used for abortions in the cases of rape, incest, or to protect the life of the woman. These narrow exemptions have raised many questions such as how a woman proves that the pregnancy is the result of rape or incest. These are not new issues, since current law includes the same provision. Regarding life endangerment, the House bill requires certification by a physician that the woman may die if she continues the pregnancy. However, this could present challenges depending on the circumstances a pregnant woman faces. For example, an ultrasound may identify a fetal anomaly at 20 weeks of gestation which indicates that the fetus will not survive. While the situation may not be immediately life threatening to the woman, under the House bill restrictions, she may have to pay for an abortion out of pocket, and at this advanced stage or given a medical complication, it would likely be conducted in a hospital, significantly more expensive than a clinic-based procedure. This situation could apply to women in a multitude of circumstances, including those with underlying chronic conditions, those who develop other acute conditions during pregnancy, or those who have incomplete miscarriages that require subsequent intervention, such as a dilation and curettage (D&C).

Women have much at stake in the ongoing national debate on health reform. Comprehensive coverage and the scope of benefits are at the heart of making health care accessible to women. The decisions that policy makers enact regarding access and coverage of abortion are sure to be the subject of tremendous discussion and debate, and could affect care for millions of women today and in the future.

¹ Guttmacher Institute, *Facts on Induced Abortion in the United States*, July 2008.

² Congressional Budget Office, Letter to Congressman John Dingell Regarding H.R. 3962, November 6, 2009.

³ Kaiser Family Foundation estimate based on Congressional Budget Office, Letter to Congressman John Dingell Regarding H.R. 3962, November 6, 2009, Table 3.

⁴ Rosenbaum et al. *An Analysis of the Implications of the Stupak/Pitts Amendment on Medically Indicated Abortions*. http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_FED314C4-5056-9D20-3DBE77EF6ABF0FED.pdf, Accessed November 17, 2009.

⁵ Kaiser/HRET, Employer Health Benefits Survey, 2002; Sonfield, A., et al., U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Coverage Mandates, 2002, *Perspectives on Sexual and Reproductive Health*, 36(2), 2004.

⁶ Personal communication with Stephanie Poggi, National Network of Abortion Funds, November 13, 2009.

⁷ Guttmacher Institute. Henshaw SK Adjustments to Strauss LT et al. Abortion Surveillance – United States, 2004. *MMWR*, 56 (SS-9), 2007.

⁸ Kaiser Family Foundation, *Medicaid's Role for Women*, 2007.

⁹ Guttmacher Institute, *State Policies in Brief*, November 1, 2009.

¹⁰ Kaiser Family Foundation/Urban Institute analysis of 2008, 2009 ASEC supplements to Current Population Survey, Bureau of the Census.

This publication (#8021) is available on the Kaiser Family Foundation's website at www.kff.org.