



# How the U.S. Health Insurance System Excludes Abortion

By Anusha Ravi June 27, 2018

Abortion access is a critical right for all people, regardless of their race and socio-economic status, that helps ensure long-term economic security for women and families across the nation. Access to reproductive health care can empower people to be able to continue their education, pursue a fulfilling and economically secure career path, and choose if and when to have children. In order to protect and expand access to this safe medical care, health insurance options must include abortion coverage.

Abortion coverage varies based on health insurance—whether a person has insurance through Medicaid, the Affordable Care Act (ACA) marketplaces, a private employer-sponsored plan, or another source. States also have a significant amount of control over how individual health insurance companies cover abortion. Insurance coverage of abortion, therefore, has become location- and coverage-specific, creating challenging circumstances for people seeking abortions, especially low-income people, many of whom are women of color.<sup>1</sup>

The political climate surrounding health insurance in America makes access to abortion care even more tenuous. Congressional Republicans' repeated threats to cut Medicaid; defund Planned Parenthood, which provides reproductive health services to nearly 2.5 million patients nationwide; and eliminate ACA protections for people with pre-existing conditions target women's health and abortion care as a policy priority.<sup>2</sup> Yet such actions would be disastrous for women across the nation. Moving forward, it is critical that abortion is treated similarly to all other types of health care, rather than being singled out due to political motives.

This issue brief outlines several health insurance categories and explains how each respective type of insurance generally covers abortion.

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## Medicaid

Medicaid is the federal-state program that provides health coverage to about 67 million people, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities.<sup>3</sup> Medicaid is funded jointly by states and the fed-

eral government and administered by states.<sup>4</sup> The ACA originally expanded Medicaid to a national standard that would cover adults with incomes below 138 percent of the federal poverty level, but the U.S. Supreme Court ruled in *National Federation of Independent Business v. Sebelius* to allow states latitude with regard to whether they expanded Medicaid.<sup>5</sup>

Since 1976, the Hyde Amendment has prohibited any federal funding from being used through the Medicaid program for abortion except in cases of rape, endangerment to the life of the woman, or incest.<sup>6</sup> Hyde has been approved yearly as part of the federal appropriations process and specifically targets low-income women who have health insurance coverage through Medicaid. Additionally, former President Barack Obama issued an executive order as part of the ACA that restated Hyde Amendment limitations for Medicaid coverage of abortion.<sup>7</sup>

The Hyde Amendment disproportionately affects the ability of women, particularly women of color and low-income women, to access abortion.<sup>8</sup> Historically, these groups have sought abortion care at higher rates because they are more likely to experience unintended pregnancies due to lack of access to contraception, comprehensive sexual education, and other forms of reproductive health care. These groups also experience other barriers to abortion services—such as geographic limitations, racism and sexism in the health care industry, and financial instability—that make limits on abortion care under Medicaid a double bind.<sup>9</sup> Language similar to the Hyde Amendment has been added to other federal programs that provide health insurance coverage—including the military TRICARE program, the Federal Employees Health Benefits Program, and the Peace Corps, among others.<sup>10</sup>

Some states have expanded their Medicaid programs to include abortion coverage using state funds. Seventeen states have a policy that directs Medicaid to pay for medically necessary\* abortions: Five states provide these funds voluntarily, while 12 states do so pursuant to a court order.<sup>11</sup> States such as California and New York have proactive policies in place to require coverage of abortion in all insurance plans, which is discussed in more detail below.

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## Employer-sponsored insurance

About 157 million people had employer-sponsored insurance in 2016.<sup>12</sup> Employers generally offer their employees and employees' families health insurance benefits in one of two ways. First, an employer may purchase insurance from an insurer on behalf of their employees. The employer pays a fixed premium to an insurance carrier that pays for the medical claims. If the claims exceed the total premiums paid, the insurer is at risk. These plans are called “fully funded,” “fully insured,” or “state-regulated” plans.<sup>13</sup>

Second, an employer may choose to self-insure—meaning that the employer functions as the insurer and bears the risk of employees’ health care costs—as an alternative to purchasing health insurance coverage from insurance companies for employees. These plans are called “self-insured” or “self-funded” plans.<sup>14</sup>

The distinction between fully insured and self-insured plans matters because federal and state laws treat them very differently. This is due to the Employee Retirement Income Security Act of 1974 (ERISA) and how the Supreme Court has interpreted this federal law. Under this law, fully insured plans are subject to both state insurance law and federal law, while self-insured plans are subject only to federal law.<sup>15</sup> ERISA does not explicitly restrict coverage of abortion, so self-funded plans are not generally subject to state-based abortion restrictions.

As a result, states can only regulate how fully insured plans in their state cover abortion services. Eleven states prohibit abortion coverage in private plans.<sup>16</sup> Twenty-two states take the additional step of restricting abortion coverage in all insurance plans for public employees.<sup>17</sup>

## State policies to increase abortion access

Some states have made efforts to expand access to abortion to make up for gaps in health insurance coverage. California, New York, Oregon, and Washington state require nearly all fully funded health insurance plans to cover abortion care. These models have proven to be a relatively comprehensive solution: California’s system likens abortion coverage to maternity care in terms of coverage requirements.<sup>18</sup> New York’s system requires all insurance policies to cover medically necessary abortion care<sup>19</sup>—broadly defined as “necessary to prevent, diagnose, correct, or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with a person’s capacity for normal activity, or threaten some significant handicap.”<sup>20</sup> The Reproductive Health Equity Act in Oregon requires fully funded health plans to cover abortion without cost sharing.<sup>21</sup> Washington state recently passed a law, S.B. 6219, which requires fully funded health insurance plans that offer maternity care to also cover abortion care and contraception.<sup>22</sup>

These proactive measures have increased access to abortion for people who have private insurance plans as well as those with public insurance programs, as these states use state funds to finance abortion care. In such states, however, health insurance plans that provide abortions have to comply with special accounting rules.<sup>23</sup> The issuer must establish two accounts for enrollees’ premium payments: one for abortion claims and one for all other claims. This ensures that abortion coverage will only be paid for using private, nonfederal dollars.

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## Other private insurance

Almost half of all Americans have employer-sponsored private health insurance coverage.<sup>24</sup> Individuals without access to employer-sponsored insurance and who are not eligible for Medicare, Medicaid, or other coverage can purchase health insurance in the individual market—either through the ACA marketplace or directly from a carrier or through an agent or broker in an “off-exchange plan.” In July 2017, about 5.4 million people were in off-exchange plans.<sup>25</sup>

## The Affordable Care Act

The ACA was a comprehensive health care reform law enacted in March 2010 that created stronger consumer protections, especially in individual market plans; expanded insurance coverage to millions of people; and increased access to women’s health care benefits, among other things.<sup>26</sup> Almost 20 million people have gained health insurance under the ACA since it was signed into law.<sup>27</sup> At the end of the open enrollment period in December 2017, 8.8 million customers had selected an ACA marketplace plan for 2018.<sup>28</sup>

The ACA created an online health insurance marketplace where individuals can purchase insurance coverage through HealthCare.gov or a state marketplace and receive financial help in the form of premium assistance and cost-sharing reductions, if they qualify. Abortion coverage remains limited through this marketplace. During ACA negotiations, abortion coverage was a contentious topic.<sup>29</sup> Pro-choice members of Congress were intent on ensuring that the ACA did not alter existing private health insurance coverage of abortion, while anti-choice members attempted to add provisions that would ban federal premium subsidies for private health insurance plans that offered abortion. Ultimately, there was a compromise that explicitly allowed states to prohibit plans in the ACA’s insurance marketplaces from covering abortion. President Obama then reinforced this provision in an executive order that ensured no federal funds would be used for abortion.<sup>30</sup>

The ACA triggered state action that banned coverage of abortion in health insurance plans offered through the insurance exchanges. Twenty-six states have restricted abortion coverage in plans offered through the marketplace, though some allow individuals to purchase riders for abortion care.<sup>31</sup> Riders, defined as “a limited scope supplemental benefit policy that covers certain services,” are available for individuals to use as supplements to their health insurance plan, providing a specific coverage area that they predict they will require in the future.<sup>32</sup> However, using riders for abortion is not a practical option: It is difficult to foresee the need for abortion, and there is limited availability of approved riders. The Kaiser Family Foundation reported that in a study conducted for plan years 2017 and 2018, researchers were unable to find

any insurers offering abortion riders in the nine states that ban abortion coverage but allow riders.<sup>33</sup> Therefore, laws that prohibit health insurance coverage of abortion but permit riders are essentially bans on abortion coverage.

Additionally, cost-sharing reduction (CSR) payments—which lower deductibles, copayments, and coinsurance for enrollees with incomes up to 250 percent of the federal poverty level—cannot be used for abortion costs.<sup>34</sup> CSR payments can greatly assist lower-income individuals and families in decreasing their out-of-pocket health care costs, but federal reimbursements to insurers that receive CSR payments are restricted to claims for essential health benefits (EHBs), a category of which abortion is not considered to be a part.<sup>35</sup>

Marketplace plans that cover abortion and include enrollees who qualify for federal premium subsidies have to abide by special accounting mechanisms in order to ensure that federal subsidies are not being used for abortion coverage beyond cases of rape, incest, or life endangerment. These plans must collect two separate premium payments from enrollees to segregate funds used for the abortion benefit from those that contribute to the value of all other covered services.<sup>36</sup> The Centers for Medicare & Medicaid Services has stated that insurers do not have to require the consumer to make two separate payments but can instead provide an itemized monthly invoice that shows a premium charge for covered abortion services that go beyond the restrictions of the Hyde Amendment.<sup>37</sup>

During the first year of ACA implementation, the Guttmacher Institute reported that individuals shopping for health insurance in the marketplace were unsure whether plans covered abortion.<sup>38</sup> According to Guttmacher’s analysis, this ambiguity has become an ongoing problem for consumers. Additionally, there is a misconception touted by anti-abortion legislators that enrollees are paying higher premiums in order for plans to cover abortion; these premiums are disingenuously called “abortion surcharges.” In actuality, plans that do cover abortion care are required to abide by special accounting mechanisms that ensure no federal funds or premium dollars from other claims are used to cover abortion care.<sup>39</sup>

Anti-abortion legislators are capitalizing on the gap in information by supporting legislation that actually discourages coverage of abortion care entirely.<sup>40</sup> In 2017, for example, the U.S. House of Representatives passed the No Taxpayer Funding for Abortion and Abortion Insurance Full Disclosure Act.<sup>41</sup> The act would make permanent the restrictions on federal funding being used for abortion care and would prevent enrollees on health insurance plans that provide abortions from obtaining a federal premium assistance credit.<sup>42</sup>

### *Threats to the ACA target abortion coverage*

While enactment of the ACA did not support universal coverage of abortion, it did significantly increase access to women's health care in general, such as through guaranteed maternity care and Medicaid expansion.<sup>43</sup> These changes have been particularly noteworthy in the 33 states—and the District of Columbia—that have expanded Medicaid. Throughout 2016, President Donald Trump and his allies in Congress made several attempts to repeal the ACA and replace it with a law that would offer less robust coverage and leave millions of people uninsured. Each repeal attempt included unique threats to abortion care. For instance, the American Health Care Act (AHCA), passed by the House in May but ultimately not put into law, would have banned abortion coverage in all marketplace and nonmarketplace plans, as well as disqualified employers from receiving tax credits if they offered their employees plans that covered abortion.<sup>44</sup> The Senate's Better Care Reconciliation Act included the same anti-choice provisions as the AHCA, and specifically excluded health insurance plans that cover abortion from receiving funding from a state support program created by the bill, the State Stability and Innovation Program.<sup>45</sup> The most recent attempt to repeal and replace the ACA, Graham-Cassidy 2.0, was built upon the original Graham-Cassidy bill from 2017 that would have prohibited using the ACA's tax credits to pay for plans that cover abortion. The 2018 bill proposes expanding the restrictions on federal funding being used for abortion through the Hyde Amendment.<sup>46</sup>

Health insurance costs will continue to rise due to efforts to destabilize and sabotage the ACA. The repeal of the individual mandate and the decision to cease CSR payments to insurers are predicted to increase premiums for marketplace health insurance plans.<sup>47</sup> Because women are more likely than men to live in poverty,<sup>48</sup> serve as unpaid caregivers,<sup>49</sup> and report a delay in accessing health care due to costs,<sup>50</sup> rising costs will disproportionately affect low- and middle-income women's ability to lead healthy lives and afford health insurance and services, including reproductive health care and abortion.

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### Policy recommendations

Ongoing attempts to exclude and restrict abortion care are detrimental to women's health and will particularly affect low-income women and women of color. Congress must prioritize women's health by repealing the Hyde Amendment and passing legislation such as the Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act of 2017.<sup>51</sup> This bill requires the federal government, as a health insurance provider, to ensure coverage for abortion care in public health insurance programs such as Medicaid. The bill also requires the federal government, as an employer or health plan sponsor, to ensure coverage for abortion care for participants in and beneficiaries of programs such as the Federal Employees Health Benefits Plan and TRICARE.

Bans on abortion funding affect approximately 29 million women of reproductive age, for whom the EACH Woman Act would help increase access to abortion care.<sup>52</sup> Many of these individuals are low-income women and women of color, given that Medicaid serves those living below the federal poverty level, and the majority of enrollees are women and people of color.<sup>53</sup> For these groups, the financial barriers to accessing abortion care can be insurmountable, and the Hyde Amendment prevents them from accessing the health care that they need. The EACH Woman Act will help protect against political interference in women’s personal decision-making about their health care—a necessary step for women across the country to be able to access abortion care and lead economically secure lives.

In addition to federal legislation, states should take initiative to better integrate abortion care into the broader health care system. They can do this by expanding Medicaid to cover abortion using state funds and/or passing legislation that requires all state health insurance plans to cover abortion. The aforementioned examples of California, New York, Washington state, and Oregon are productive models for states to emanate in terms of incorporating abortion coverage into a state health insurance system.

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## Conclusion

Currently, abortion is segregated from the health insurance system and treated as a separate service that states may regulate differently from other types of care. Abortion coverage varies vastly depending on the type of insurance a person holds and the state in which they live. This lack of uniformity can exacerbate existing inequalities in access to reproductive health care and leave women at the whims of their legislators for lifesaving, critical care. In order to support women’s economic security and bodily autonomy, it is vital that abortion be comprehensively integrated into the U.S. health insurance system.

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*\* Author’s note: The term “medically necessary” in regard to abortion differs in meaning on a state-by-state basis. There is no formal definition of “medically necessary abortion” on a federal level, so states are allowed significant leeway to interpret what qualifies as a “medically necessary” abortion.*

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