FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

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Access to Abortion Coverage and Health Reform

The Patient Protection and Affordable Care Act (ACA) will make significant changes to health coverage for women, expanding their access to coverage and broadening the health benefits that many will receive. Coverage for abortion services, however, was addressed separately under health reform. As result, the extent of abortion coverage that women will receive once ACA is fully implemented in 2014 will depend largely on policies enacted at the state level as well as choices that plans and consumers will make in terms of coverage of abortion services. This brief summarizes the major insurance coverage provisions of the ACA that are relevant for women of reproductive age, reviews current federal and state policies on abortion coverage and how they may be modified under health reform, and discusses the potential impact of the federal legislation on women's access to abortion coverage.

How does the Patient Protection and Affordable Care Act affect overall coverage for women of reproductive age?

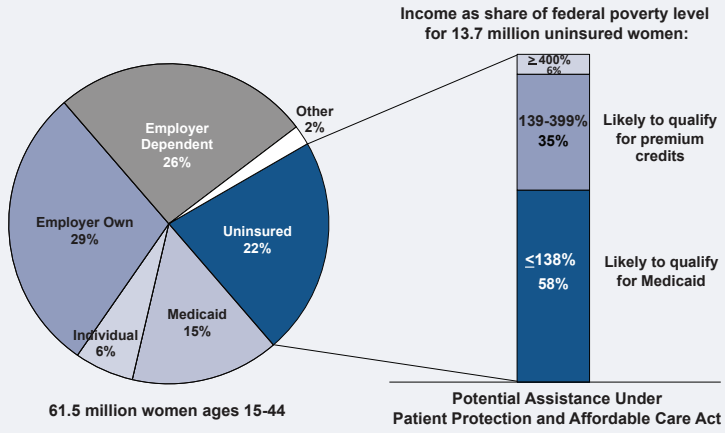
Signed into law on March 23, 2010, the ACA is a federal law aimed at ensuring that almost all U.S. citizens and legal residents have health insurance by requiring that most individuals obtain a minimum level of insurance coverage by 2014. This is to be achieved through a combination of public and private insurance expansions. By 2014, Medicaid will be available to cover many more of the nation's poorest uninsured, employers will be more likely to offer affordable coverage to their employees, and small businesses and other uninsured individuals will have access to state-based exchanges that will offer a variety of plans from which they can purchase insurance. The scope of benefits, including abortion, covered under these different avenues will vary.

The ACA will expand health care coverage to many of the nation's uninsured by extending Medicaid eligibility to all qualifying individuals with incomes up to 138% of the federal poverty level (FPL).[1] Uninsured individuals with incomes above 138% FPL will be able to purchase coverage in new state-based insurance exchanges that will act as marketplaces, open to all qualifying, uninsured individuals and small businesses with up to 100 employees. These state-based exchanges are to offer multiple insurance plans that uninsured individuals can choose from to purchase coverage. To help with the costs of insurance, the federal government will provide subsidies (in the form of premium credits) to eligible individuals and families with incomes from 139% to 399% FPL or if their share of premiums exceeds 9.5% of their income.[2]

It is estimated that 13.7 million women ages 15 to 44 are uninsured currently, 93% of whom would qualify for federal assistance under the health reform law, based on their income. The act would potentially extend Medicaid to 58% or 8 million women, and an estimated 4.8 million women (35%) would qualify for federal premium credits[3] to purchase coverage as shown in Figure 1.

Figure 1

Health Insurance Coverage and Poverty Levels of Uninsured Women Ages 15 to 44, 2009



Other includes programs such as Medicare and military-related coverage.
The federal poverty level for a family of four in 2009 was $22,050.
SOURCE: KFF/Urban Institute analysis of 2010 ASEC Supplement to the Current Population Survey, U.S. Census Bureau.

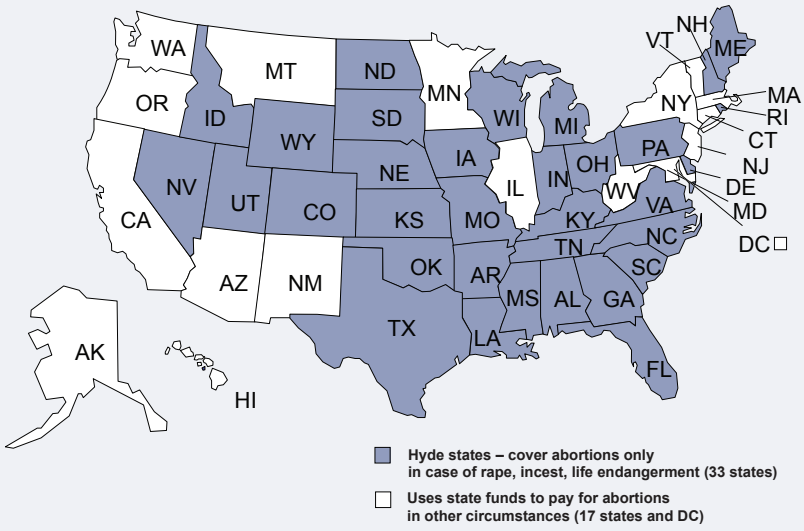
What are current federal and state laws regarding abortion coverage and financing?

Federal law bans the use of any federal funds for abortion, except when the pregnancy is a result of rape, incest, or if it is determined to endanger the woman's life. In effect since 1977, this rule known as the Hyde 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 Hyde Amendment initially affected only funding for abortions under Medicaid, but over the years, its reach broadened to limit federal funds for abortion for federal employees, women in the Indian Health Service, and in the military.

State level policies also have a large impact on abortion coverage, particularly since states are responsible for operation of Medicaid programs. The Medicaid program serves millions of low-income women and is a major payor of reproductive health services. It is estimated that two-thirds of adult women on Medicaid are in their reproductive years.[4] As discussed earlier, the federal Hyde Amendment restricts state Medicaid programs from using federal funds to cover abortions beyond the cases of life endangerment, rape, or incest. However, if a state chooses to, it can use its own funds to cover abortions in certain other circumstances, and states will continue to have this option under health reform. Currently, 17 states and the District of Columbia use state-only funds to cover abortions beyond the federal limitations for women on Medicaid.[5] In the other 33 states, Medicaid programs do not pay for any abortions beyond the Hyde restrictions (Figure 2). Currently, in these 33 states, an estimated 4.6 million women ages 15 to 44 are uninsured and have incomes less than 138% FPL, and would meet the income eligibility criteria to qualify for Medicaid under health reform (Table 2).[6]

Figure 2

Abortion Financing Under Medicaid, 2010



Source: Guttmacher Institute, State Policies in Brief, "State Funding of Abortion Under Medicaid," November 2010.

States also have authority over the scope of benefits for public employees. Currently, 13 states restrict abortion coverage in insurance plans for public employees. These restrictions range from states that provide coverage only under the Hyde limits to states that prohibit coverage for all abortions, regardless of circumstances.[7] States also regulate benefits covered by private insurance plans. Currently, at least four states (Idaho, Kentucky, Missouri, and North Dakota) 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 about their availability and no documentation of their cost or impact on access.

How will abortion coverage be handled by Medicaid and plans in the exchanges under health reform?

Medicaid: The ACA reinforces current federal restrictions, limiting federal funds to be spent on abortions only to cases when the pregnancy endangers the life of the woman or results from rape or incest. This will not change for Medicaid under health reform; state Medicaid programs will continue to have the option to cover other medically necessary abortions using only state funds and no federal funds. President Obama issued an executive order as part of health reform that restated the federal limits specifically for Medicaid and community health centers.[8]

Plans in the Exchange: Plans participating in state-based exchanges will be required to cover a minimum set of services, defined as "essential health benefits, and the ACA explicitly prohibits states from including abortion in any essential benefits package. Therefore, no state or insurer offering a plan in an exchange will be required to offer abortion coverage, and each exchange must include at least one plan that does not cover abortions beyond those permitted by current federal law. Furthermore, states can bar all plans participating in the state exchanges from covering abortions, which at least five states (Arizona, Louisiana, Mississippi, Missouri, and Tennessee) have already elected to do since the health reform law's passage.[9]

If the state does not bar coverage of abortions, private insurers can offer a plan that covers abortions beyond the federal limitations within an exchange. The ACA outlines a methodology for states to follow to ensure that no federal funds are used towards coverage for abortions beyond Hyde. Any plan that covers 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). This estimate cannot take into account any savings that might be achieved as a result of the abortions. Furthermore, plans that receive federal subsidies (it is believed that all plans in the exchanges will receive at least some federal subsidies) would have to collect two premium payments from all enrollees, including men and women of all ages. One payment would be for the value of the abortion benefit and the other payment would be for all other services. The funds would be deposited in separate allocation accounts, overseen and managed by state health insurance commissioners. Both the federal Office of Management and Budget and the Department of Health and Human Services are expected to publish guidelines in 2010 that states must follow to ensure that exchanges are adhering to these requirements.[10] The health reform law prohibits plans in the exchanges from discriminating against any provider because of "unwillingness" to provide abortions. It does not preempt other current state policies regarding abortion, such as parental notification and waiting period laws.

Currently, most (55%) women of reproductive age are covered through employer-sponsored plans from their own job or their husbands. Many of these plans do cover abortion currently and will be allowed to continue once health reform is fully implemented. Table 1 summarizes the ACA's major provisions on abortion coverage.

Table 1: Summary of Abortion Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148)

Benefit Design	Prohibits abortion coverage from being required as part of the federally established essential benefits package; States can prohibit coverage for any abortions by all plans in their state-based exchange; At least one plan within a state exchange must not cover abortions beyond those permitted by federal law (to save the life of the woman and in cases of rape and incest); Private Plans: Can provide a plan in the exchanges that covers abortions beyond those permitted by federal law as long as they comply with requirement to segregate federal funds; All states' Pre-existing Condition Insurance Plans cannot cover abortions beyond those permitted by federal law.
Financing	Prohibit federal subsidies (for premiums or cost sharing) from being used to purchase a health plan in the exchanges that includes coverage for abortions beyond those permitted by federal law; 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. Any exchange plan that covers abortions and includes enrollees that receive federal subsidies must collect two separate premium payments from all enrollees — one payment for value of abortion benefit and one payment for all other covered services.
State Role	Law will have no effect on state laws regarding coverage, funding or procedural requirements on abortions, such as parental notification/consent laws; States can use state-only funds to pay for "medically necessary" abortions beyond federal requirements under Medicaid or to pay for abortion coverage in plans offered in an exchange; States can prohibit plans in new exchanges from covering any abortions; State-level health insurance commissioners will monitor and oversee payment segregation requirements for the purchase of plans within their respective exchanges.
Discrimination/ Protection	Prohibit plans participating in the exchanges from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.

How much does an abortion cost?

The ACA's complex combination of restrictions means that under health reform, many currently uninsured women will obtain coverage either through Medicaid or an exchange; however, many of these women will not be covered for abortions and will have to pay out-of-pocket if they seek one. 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 or more.[11] Though the vast majority (~90%) of abortions are performed early in pregnancy, the costs could still be economically challenging for many low-income women.[12]

What is the impact of the federal abortion provisions on women in high-risk pools?

The new health insurance exchanges will become operational in 2014. Prior to that time, some uninsured individuals will be able to buy coverage in new state-based, federally subsidized high-risk pools. Separate from states' currently operating high-risk pools, these new federally funded, Pre-existing Condition Insurance Plans (PCIP) will be open to individuals who have been uninsured for at least six months with existing health conditions, and will provide temporary coverage until exchanges become fully operational in 2014. States can operate the PCIPs or request the federal government to operate them, but all are financed with federal funds.

In July 2010, the Department of Health and Human Services issued a federal directive prohibiting all of these new PCIPs from covering abortions, effectively extending the Hyde Amendment to these plans as well.[13] Women who enroll in these temporary high-risk pools will not be able to use their own private dollars to purchase abortion coverage. Since many women eligible for PCIPs have more health problems than average, they could be more likely to encounter medical complications should they become pregnant. It is estimated that an additional 200,000 to 400,000 individuals are expected to enroll in the temporary PCIPs.[14] This order does not preempt states' policies on abortion coverage in their existing high-risk pools, nor does it prohibit women from paying a provider directly should they seek an abortion.

* * * * *

As a result of health reform, many more women will gain health insurance coverage. The decisions that the federal government, states, insurance companies, and policymakers will make over the next few years will determine the extent of abortion coverage that will be available to women across the nation once health reform is fully implemented in 2014.

Table 2: State Level Estimates of Percent of Uninsured Women Ages 15-44 Likely to Qualify for Federal Assistance under the Patient Protection and Affordable Care Act

		Uninsured Women, 2008-2009		Percent of Currently Uninsured Women Ages 15-44 Potentially Eligible for Federal Assistance in 2014	
	Total Number of Women Ages 15-44 in State	Number	Percent of Total Women in State	Likely to Qualify for Medicaid **	Likely to Qualify for Premium Credits in the Exchanges ***
Alabama*	941,940	193,965	21%	63%	32%
Alaska	138,624	34,647	25%	49%	43%
Arizona	1,290,755	302,354	23%	58%	34%
Arkansas*	556,616	161,324	29%	57%	39%
California	7,712,611	1,909,644	25%	58%	36%
Colorado*	1,020,305	213,345	21%	57%	37%
Connecticut	683,718	91,238	13%	48%	41%
Delaware	174,875	28,325	16%	50%	40%
District of Columbia	149,583	17,640	12%	58%	32%
Florida*	3,439,595	1,000,591	29%	54%	38%
Georgia*	2,060,710	516,501	25%	64%	31%
Hawaii	243,668	25,898	11%	60%	28%
Idaho*	300,011	67,734	23%	59%	36%
Illinois	2,652,361	469,469	18%	54%	39%
Indiana*	1,263,857	253,215	20%	60%	36%
Iowa*	572,244	94,251	16%	52%	40%
Kansas*	546,268	97,788	18%	69%	26%
Kentucky*	859,623	208,348	24%	65%	32%
Louisiana*	923,220	232,129	25%	63%	31%
Maine*	244,584	29,488	12%	45%	44%
Maryland	1,172,744	196,542	17%	53%	41%
Massachusetts	1,353,253	90,192	7%	--	--
Michigan*	1,956,538	355,014	18%	58%	34%
Minnesota	1,030,700	125,338	12%	46%	47%
Mississippi*	593,878	138,132	23%	64%	31%
Missouri*	1,173,596	218,902	19%	53%	40%
Montana	181,434	38,227	21%	51%	39%
Nebraska*	351,675	52,110	15%	58%	38%
Nevada*	520,000	133,246	26%	50%	42%
New Hampshire*	256,892	37,572	15%	40%	48%
New Jersey	1,726,605	329,250	19%	53%	36%
New Mexico	396,222	122,328	31%	66%	28%
New York	4,035,744	708,705	18%	50%	40%
North Carolina*	1,893,856	425,668	22%	64%	31%
North Dakota*	124,975	16,977	14%	52%	46%
Ohio*	2,248,979	350,501	16%	58%	37%
Oklahoma*	722,740	167,708	23%	53%	42%
Oregon	751,120	160,498	21%	58%	36%
Pennsylvania*	2,393,581	327,877	14%	55%	37%
Rhode Island*	214,038	34,393	16%	59%	35%
South Carolina*	902,532	199,945	22%	60%	32%
South Dakota*	151,360	27,366	18%	59%	36%
Tennessee*	1,257,375	246,435	20%	56%	41%
Texas*	5,133,199	1,781,564	35%	58%	37%
Utah*	599,794	106,561	18%	53%	37%
Vermont	118,214	14,618	12%	39%	47%
Virginia*	1,593,387	273,285	17%	47%	45%
Washington	1,335,218	220,188	16%	53%	42%
West Virginia	342,321	80,517	24%	56%	37%
Wisconsin*	1,092,394	120,614	11%	56%	39%
Wyoming*	104,779	20,313	19%	45%	47%

Notes: The federal poverty level (FPL) for a family of four in 2009 was $22,050.
* State does not provide funds for abortions beyond restrictions in federal Hyde Amendment.
** Percent of women ages 15-44 who are currently uninsured with incomes <138% of the federal poverty level.
*** Percent of women ages 15-44 who are currently uninsured with incomes 139-399% of the federal poverty level.
-- Sample size insufficient to make reliable estimate.
Source: Kaiser Family Foundation/Urban Institute estimates of ASEC supplement to March 2009 and March 2010 Current Population Surveys, U.S. Census Bureau.

ENDNOTES

[1] Legislation extends Medicaid coverage to all individuals with incomes up to 133% of the poverty level (FPL) and includes a provision to disregard first 5% of income, effectively extending Medicaid to all individuals with incomes up to 138% FPL.

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

[3] Note that undocumented individuals will not have access to coverage through Medicaid or exchanges, regardless of ability to pay for coverage.

[4] Kaiser Family Foundation, *Medicaid's Role for Women*, 2007.

[5] Guttmacher Institute, State Policies in Brief, November 1, 2010.

[6] Kaiser Family Foundation/Urban Institute analysis of 2009, 2010 ASEC supplements to Current Population Survey, Bureau of the Census.

[7] Guttmacher Institute, *State Policies in Brief*, September 1, 2010.

[8] The White House Office of the Press Secretary, *Executive Order – Patient Protection and Affordable Care Act's Consistency with Longstanding Restrictions o the Use of Federal Funds for Abortion*, March 24, 2010. Available at www.whitehouse.gov/the-press-office/executive-order-patient-protection-and-affordable-care-acts-consistency-with-longst.

[9] Cohen, S. Insurance Coverage of Abortion: The Battle to Date and the Battle to Come, *Guttmacher Policy Review*, Fall 2010.

[10] Kaiser Health News, *Text: The President's Executive Order on Abortion Funding and The Health Bill*, Kaiser Family Foundation, March 25, 2010. Available at: www.kaiserhealthnews.org/Stories/2010/March/24/text-Obama-abortion-executive-order.aspx.

[11] Personal communication with Stephanie Poggi, National Network of Abortion Funds, November 13, 2009.

[12] Guttmacher Institute. *An Overview of Abortion in the United States*, January 2008.

[13] U.S. Health and Human Services, *Statement of HHS Spokeswoman Jenny Backus on the Pre-Existing Condition Insurance Plan Policy*, July 14, 2010.

[14] U.S. Health and Human Services, *HHS Secretary Sebelius Announces New Pre-Existing Condition Insurance Plan*, July 1, 2010. Available at: www.hhs.gov/news/press/2010pres/07/20100701a.html.

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