Guttmacher Policy Review
Fall 2010 | Volume 13 | Number 4

Erratum: In the original posted and print versions of this article, in the table on page 5, Massachusetts was incorrectly listed as banning abortion coverage for public employees. The table and the accompanying text has been corrected.

Insurance Coverage of Abortion: The Battle to Date and the Battle to Come

By Susan A. Cohen

After months of stalemate, charges, countercharges and finally a resolution that failed to satisfy partisans on either side of the abortion debate, the fight in Congress over whether and to what extent abortion coverage would be allowed under the new health care reform law appeared to end with the president's signing of the bill on March 23. Almost as soon as the ink had dried, however, abortion foes started agitating to revive the debate—and to broaden it.

Antiabortion leaders insist that under the Patient Protection and Affordable Care Act, the final compromise language—a meticulously designed set of rules to segregate premium payments so that no federal funds will go toward paying claims for abortion—is still tantamount to federal funding of abortion. Based on the premise that even the remotest government connection to abortion is the same as supporting it, they have thrown down the gauntlet, unveiling a radical agenda that would ban abortion coverage in any health insurance plan that receives any government subsidy, whether direct or indirect. The targets run the gamut from Medicaid to typical employment-based insurance plans that are treated preferentially under the U.S. tax code.

Meanwhile, the battle in the states over insurance coverage of abortion has only just begun. Since March, five states have moved to preemptively ban coverage in the health insurance exchanges created under the federal law that are slated to become operational in 2014. In states where abortion coverage in exchange health plans will still be legal, it remains an open question as to whether or not insurers will still offer it—for both practical and political reasons.

What Congress Wrought

From the beginning, the administration argued that health care reform should not be the vehicle for advancing or contracting abortion rights. For reproductive health advocates, that already represented a defeat, because the whole purpose of health care reform was to expand coverage of basic health services, which logically should include the full range of reproductive health services, including abortion. Preserving the status quo also meant that revisiting the injustice of the Hyde amendment—which bans abortions under Medicaid, except those necessary to save the woman's life or in cases of rape or incest—was taken off the table at the outset, leaving the nation's poorest women still having to come up with their own money to terminate an unintended pregnancy.

Even so, abortion rights leaders from House Speaker Nancy Pelosi (CA) to Sen. Barbara Boxer (D-CA) adopted, early on, President Obama's explicit mantra that "this is a health care bill, not an abortion bill." They defended the status quo in terms of federal funding for abortion, contrary to their own positions, in hopes of quelling the mounting insurrection over health care reform generally among conservative Democrats—many also antiabortion—whose support they needed for passage of the bill.

Inevitably, the fight devolved into what constituted the status quo in the context of health care reform. Abortion rights advocates took abortion

opponents at their word that the compromise they could live with meant ensuring that no federal funds could be used for abortion, which would imply modeling the health care bill after the restrictions in the joint federal-state Medicaid program. Under the Hyde amendment, federal funds may not be used to subsidize abortions, except in the most extreme cases, but states have the option to use their own funds to pay for abortions for their Medicaid recipients. Accordingly, advocates argued that plans on the exchanges should at the least be allowed to include abortion coverage, so long as the cost of any abortion was paid for exclusively by an enrollee's own premium contributions and not by federal funds that might provide a partial subsidy of an enrollee's premium. Abortion opponents rejected that analysis, pointing instead to longtime law governing the Federal Employees Health Benefits Program (FEHBP) that goes beyond Hyde, prohibiting any participating plan from offering abortion coverage despite the fact that employees pay part of the premiums. For its part, the U.S. Conference of Catholic Bishops made its priorities eminently clear to congressional leadership: Legislate the FEHBP approach, or the bishops—notwithstanding their many years of support for health care reform—would work to defeat expanding health insurance coverage to 32 million people.

When the House of Representatives took up the health reform bill in November 2009, the antiabortion faction won the first round, as antiabortion Democrats joined all House Republicans to pass the extreme antiabortion amendment touted by the bishops and offered by Rep. Bart Stupak (D-MI). Technically, under the Stupak amendment, an exchange plan could offer insurance that covers abortion, except that no person receiving any federal premium subsidies could enroll in such plans. And given that the exchanges are designed primarily for people in need of assistance to afford insurance, there would almost certainly be too few eligible people in the pool to make it economically practical for a company to offer one. Thus, the gap between a flat ban and the Stupak restriction amounted to a distinction without a difference.

The Senate took up health reform the following month, and there the Stupak amendment was defeated. Instead, the Senate endorsed a convoluted new approach drafted essentially by antiabortion Sen. Ben Nelson (D-NE), who bartered with Majority Leader Harry Reid (NV) over abortion and other issues in exchange for his critical support for the health reform bill on final passage. After months of extended debate, and to expedite getting the bill to the president, congressional leaders agreed that the House would take an up-or-down vote on the Senate-passed bill, in its entirety and without an opportunity to vote on the abortion issue. Thus, the Nelson provision rode that wave into law.

The Nelson amendment establishes numerous requirements and some potentially high hurdles both for individuals and especially for insurance companies utilizing the exchanges. In theory at least, plans may include abortion coverage, so long as the portion of any premium that pays for such coverage and any claims for an actual abortion are paid for with private funds. To ensure that no subsidy dollars go toward these purposes, consumers purchasing insurance covering abortion (whether that is their specific goal or not) will be required to make two premium payments—one to cover abortion services and one to cover everything else. At the same time, insurers wishing to include abortion coverage will have to estimate the actuarial cost of covering it and then establish a financial segregation system ensuring that premiums to cover abortion and claims for abortion never mix with any federal funds.

Abortion rights advocates view the Nelson formulation as far exceeding what was necessary to ensure that no federal funds subsidize abortion care. Moreover, they are concerned that the new requirements may pose enough obstacles to cause insurers—many of which currently cover abortion under most plans—to discontinue abortion coverage. By contrast, antiabortion groups, including the bishops, allege that by allowing the possibility of abortion coverage on the health exchanges, the Nelson amendment amounts to government entanglement with abortion that is equivalent to government funding of abortion. Additionally, they allege that the Nelson require-

ments are little more than a shell game; because money is fungible, the federal subsidies still will end up supporting abortion.

On September 20, pursuant to an executive order President Obama issued in March as part of the delicate negotiations to win over the last few votes for the health care bill from antiabortion Democrats, the administration issued guidelines for how plans and state insurance commissioners should begin thinking about implementation of the Nelson amendment. The guidelines are designed more to solicit input than to offer direction, laying the groundwork for regulations with the force of law that are expected in the next year or so, but well before 2014 when the exchanges will be up and running.

The extent to which abortion coverage actually will be available to people will largely depend on what insurance companies perceive to be practical, efficient and in their business interests.

According to the guidelines, any exchange plan offering abortion coverage beyond cases involving life endangerment, rape or incest must submit a plan to the state insurance commissioner explaining the accounting system it will use to ensure the segregation of federal funds—for premiums and for claims—from abortion. All exchange plans, regardless of whether they cover abortion, will have to provide an annual statement to the state insurance commissioner that they are in compliance with the Nelson requirements. Finally, state insurance commissioners will have to conduct periodic audits to ensure that plans are in compliance. The Obama administration notes that it anticipates "that both public input from the accounting community, insurance industry, and interested parties…along with details about the operational and business features of the Exchanges as they are developed, will inform clarifications and enhancements to the guidelines."

The Next Front: States and Insurers

Clearly, the extent to which abortion coverage actually will be available to people will largely depend on what insurance companies perceive to be practical, efficient and in their business interests. On the basis of the federal law's plain language and its implications for running a business, Timothy Jost, professor of law at Washington and Lee University, has said "it is likely that few plans will offer abortion coverage at all." Sara Rosenbaum, professor of health law and policy at George Washington University, agrees: The "logical" response for private insurers marketing plans within the exchanges and eventually in the broader market as well "would be not to sell products that cover abortion services." And neither Jost nor Rosenbaum even factored in the political pressures and campaigns targeting insurance companies that may be expected on this issue in the coming years.

Although much remains murky about how the abortion provision in the federal law will be implemented and how insurance companies will respond, the new law is explicit that states remain free to completely prohibit abortion coverage in private plans or, alternatively, to encourage it—at least up to a point. During the 2010 state legislative session alone, bills to ban abortion coverage in the state-level health care exchanges were introduced in 12 states; five states—Arizona, Louisiana, Mississippi, Missouri and Tennessee—enacted them. The legislatures in Florida and Oklahoma also passed bans, but in each case, the bill was vetoed by the governor.

The five new state laws specifically ban abortion coverage in the exchanges for everyone, except if the woman's life is endangered or perhaps in cases of rape or incest. The prohibition applies regardless of whether the individual subscriber receives any premium subsidy from the federal government. Long-standing Missouri law already prohibits abortion coverage in all private plans written in the state, which would include plans offered in the exchanges. Four other states have similar laws. In addition, 12 states have existing bans on abortion coverage in plans available to public employees in the state (see chart).

Attention to the issue of abortion coverage on the health care exchanges and in the private market more generally also raises the issue of abortion coverage for women relying on public insurance (e.g., Medicaid). Currently, 17 states and the District of Columbia use their own dollars to pay for abortion for women on Medicaid. No doubt, antiabortion activists may try to reopen debates to restrict Medicaid coverage of abortion, especially in the five jurisdictions that fund abortions voluntarily (as opposed to by court order). Conversely, abortion rights advocates in the states that subsidize abortions for poor women may be able to use this opportunity to argue that, at a minimum, equity would require that abortion coverage remain permissible on the health care exchanges. Or, going even further, some may consider efforts to enact broad guarantees of abortion coverage under both public and private insurance plans issued in their state.

In those states that still ban abortion coverage under Medicaid, abortion foes may exploit this moment to justify similar bans affecting the exchanges. Conversely, abortion rights proponents may view the new debates over whether abortion will be considered health care for the purpose of coverage on the exchanges as opportunities to return lawmakers' attention to the cruelty and inequity of their state Medicaid abortion policy. With the large expansion of Medicaid accompanying the rollout of health care reform, more women than ever will be affected by the states' decisions about whether abortion will be available to them as a legitimate, covered medical service.

A New Radicalism

Only four months after making great gains on federal abortion policy in health reform, antiabortion activists laid out their comprehensive forward agenda to further isolate and separate abortion from any associations with mainstream health care. In late July, Rep. Chris Smith (R-NJ) and some 165 cosponsors introduced the No Taxpayer Funding for Abortion Act. Smith argued that the debate over health care reform and its outcome made clear that "it is time for a single, government-wide permanent protection against taxpayer funding for elective abortion."

STATES THAT PROHIBIT COVERAGE

Several states first banned abortion coverage for public employees—and even in all private plans written within their borders—more than two decades ago. Now, some are moving to ban abortion coverage in health exchange plans, which will begin operating in 2014.

Specifically ban abortion coverage in health exchange plans	Ban coverage for public employees
Arizona	Arizona
Louisiana	Colorado
Mississippi	Illinois
Missouri	Kentucky
Tennessee	Mississippi
Ban coverage in *all* private plans	Nebraska
Idaho	North Dakota
Kentucky	Ohio
Missouri	Pennsylvania
North Dakota	Rhode Island
Oklahoma	South Carolina
	Virginia

His solution includes refighting the fight over health care to enact the Stupak amendment to essentially ban abortion coverage in exchange plans. He would further solidify the Hyde amendment and its progeny (affecting all women dependent on the federal government for their health care or insurance), by writing the prohibitions into permanent law, instead of their current form in which they must be—and are—renewed annually on the various relevant appropriations bills. The original Hyde amendment has been enacted annually since 1978; most of the other abortion funding restrictions spanning the federal government were enacted starting in the early 1980s.

The Smith bill would go even further, however, into uncharted territory. It would carry the argument against funding abortion to an extreme by preventing employers from taking a tax deduction for insurance plans that include abortion coverage. Moreover, individuals' premiums for plans that cover abortion could not be paid with pretax dollars. In addition, any costs incurred by an individual for an abortion would be disallowed under a flexible health spending account or for the purposes of a potential medical care deduction from federal taxes.

The idea of going after tax credits and deductions as if they were the same as direct government funding of abortion loomed during the health care debate, but abortion foes never pushed the issue, presumably because they recognized it for the strained view of "funding" that it is. But with the Democratic Party on the run leading up to the midterm elections and the disinformation campaign against the health care law being used as a rallying tool on the right, it is not surprising that antiabortion activists feel emboldened. They see "abortion funding" as a wedge issue that they can exploit on its own and, failing that, at least use to further confuse people and fan opposition to the health care law. Accordingly, the sweeping Smith bill can be used as a whole to demagogue against abortion and its individual provisions deployed when specific legislative openings present themselves. As such, it represents a clear political, communications and legal roadmap for the future direction of the antiabortion movement.

The Smith bill would carry the argument to an extreme by preventing employers from taking a tax deduction for insurance plans that include abortion coverage.

Meanwhile, the legislative maneuverings during health care reform forced abortion rights advocates into a corner. Having early on lost the opportunity to begin raising public awareness once again about the harsh antiabortion policy that the country's poorest women have lived with for a generation, they also now have lost real ground in terms of the public debate around abortion generally and very likely in terms of the extent of actual insurance coverage. As abortion rights advocates regroup and begin formulating an active strategy of their own, at least a couple of issues seem salient.

First, health insurance coverage of abortion, as is the case with many other basic health care services, often has less to do with actual access to care than it does with being able to pay for needed health services without having to worry so much and sacrifice other necessities. A main argument that abortion foes insist on making, especially now at the state level—that banning abortion coverage from insurance is necessary to prevent abortion rates from skyrocketing—is simply without foundation (related article, page 7). Second, the idea that abortion is not health care is simply and patently false, however much some people may object to the fact that women choose it. Moreover, the notion that any government involvement with health insurance, public or private, that allows for abortion coverage violates the rights of individual taxpayers who conscientiously object is nonresponsive to the fact that abortion remains a legal, constitutionally protected health care service. As such, its claim to be deserving of insurance coverage is at least as great as any other medical service.

Insurance companies have barely begun thinking about whether and how to offer abortion coverage in the health exchanges, since they have until 2014 to figure this out. Their hands are being tied for them in certain states, so far all in a negative direction. And they will be buffeted by the political pressures coming from both sides. Unless the federal government does step in and re-legislate in this area, insurers—as analysts have suggested—will decide what to do about abortion coverage based on what they perceive is in their business interest. Meanwhile, as these contingencies play out, if current trends continue, three million U.S. women will experience an unintended pregnancy each year—almost half of whom will have an abortion. One in three U.S. women will have an abortion by age 45: Health care by any other name. www.guttmacher.org