

**ABORTION COVERAGE AND HEALTH REFORM:
RESTRICTIONS AND OPTIONS FOR EXCHANGE-BASED INSURANCE MARKETS**

MAGDA SCHALER-HAYNES, ARINA CHESNOKOVA, CYNTHIA COX, MARLA FEINSTEIN,
AMANDA SUSSEX AND JULIA HARRIS*

INTRODUCTION	324
I. BACKGROUND: ABORTION FREQUENCY AND FINANCING.....	327
A. Frequency and Types of Abortion.....	330
B. The Approximate Price of an Abortion.....	330
C. Health Insurance Coverage Patterns in the United States	331
1. Private Health Insurance.....	331
2. Insured Women Often Forgo Coverage for Abortion Services.....	333
3. Public Health Insurance	334
D. Provider Subsidies and Private Donations	336
E. Abortions Funded Through Borrowed Money	337
F. Forgone Abortion Due to Inability to Pay.....	337
II. THE HYDE AMENDMENT.....	337
III. DIVERGENT ABORTION COVERAGE RESTRICTION PROPOSALS CONSIDERED IN THE HEALTH REFORM DEBATE.....	339
A. The Capps Amendment.....	341
B. The Stupak-Pitts Amendment	342
IV. SOURCES OF ABORTION COVERAGE RESTRICTIONS IN HEALTH REFORM: THE ACA, THE EXECUTIVE ORDER AND THE REGULATIONS	344
A. The ACA Abortion Coverage Restrictions	346
1. Segregated Premium Collection	348
2. Separate Accounts	349
3. Abortion Benefit Pricing.....	350
4. Coverage Information for Enrollees	351
5. Non-discrimination Protection for Refusal to Provide Abortion Services.....	352
6. Preemption.....	352
7. Emergency Services and Federal Civil Rights Laws	353
8. Multi-State Plans	353
9. One-sided Protections.....	353
B. The Executive Order	353
C. The Pre-Regulatory Model Guidelines	356
1. Accounting Guidelines for Insurance Carriers.....	356
2. State Obligations: Compliance and Enforcement	357
D. The HHS Final Rule Regarding Establishment of Exchanges and Qualified Health Plans Issued March 2012.....	358
V. POST HEALTH REFORM LEGISLATION: FURTHER RESTRICTIONS ON ABORTION COVERAGE	358

A.	Snapshot of the States: New and Old Laws Restrict Exchange-Based Abortion Coverage	359
1.	Limited Exceptions to State-Based Coverage Bans	359
Utah: The First Exchange-Based Abortion Coverage Ban in Effect.....	360	
Rhode Island: A Permanently Enjoined Ban	361	
The State of Washington: The Only Abortion Coverage Mandate Proposed to Date	362	
Riders: Often Mentioned but Hardly Offered	362	
Kansas: A Court Challenge to the Kansas Law	364	
Model Legislation for States from Americans United for Life	365	
B.	Federal Abortion Coverage Legislation Introduced After Health Reform	366
VI.	ABORTION COVERAGE AND THE ESSENTIAL HEALTH BENEFIT PACKAGE.....	368
A.	Mandatory Benefits under the ACA.....	370
B.	Women’s Health and the Essential Health Benefits Package.....	370
C.	Benefits Beyond Those Required in the EHB.....	371
VII.	STATE OPTIONS TO SUPPORT EXCHANGE-BASED ABORTION COVERAGE.....	372
A.	Maintain Individual and Small Group Health Insurance Markets Outside State-Based Exchanges.....	373
B.	Streamline Payment Instruments.....	373
1.	Payment Mechanisms	374
C.	Ensure Confidentiality Protection for Coverage and Care Decisions	375
D.	Consider State Level Abortion Rights and Equal Protection Laws in the Context of the New Federal Restrictions	376
E.	Provide Support and Guidance to Industry	376
F.	Consider the Need For and Viability of an Abortion Coverage Mandate	377
1.	The Mechanics of Benefit Mandates Post-ACA.....	378
G.	Structure the Exchange to Segregate Funds	381
H.	Exempt Abortion Coverage from Requirements that Multi-State Plans Offer Uniform Benefit Packages	382
I.	Finance Exchange-Based Abortion Coverage.....	382
J.	Setting the Premium for Abortion Coverage: an Estimate for New York State.....	382
VIII.	CONCLUSION.....	386

INTRODUCTION

On March 23, 2010, President Obama signed the Affordable Care Act (ACA) into law.¹

* Magda Schaler-Haynes, health policy consultant; Lecturer of Health Policy and Management, Mailman School of Public Health, Columbia University. JD, Columbia University School of Public Health; MPH, Columbia University School of Law.

Arina Chesnokova, Research Associate, PolicyLab, The Children’s Hospital of Philadelphia. MPH, Mailman School of

This health reform legislation was a signature presidential initiative designed to expand access to health insurance for some 52,000,000 uninsured and 29,000,000 underinsured Americans.² In addition to broad coverage expansions, the ACA institutes restrictions poised to disrupt longstanding coverage for abortion services in private health insurance markets across the United States.³ This article addresses abortion coverage restrictions introduced in health reform, and explores the impact of those restrictions on markets inside and outside newly created health exchanges.

Under the ACA, federal subsidies to purchase health insurance will be made available to people with incomes above Medicaid eligibility and up to 400 percent of the federal poverty level (FPL). These individuals will use subsidies to purchase private health insurance through health insurance exchanges established by the ACA. The ACA simultaneously expands and restricts coverage—new subsidies will facilitate the purchase of health insurance, yet no subsidy may be used to purchase insurance coverage for most abortion services.

Although some experts maintain that access to safe, legal abortion is essential to the continuum of comprehensive health care,⁴ abortion remains at the center of political controversy. The right to abortion has been challenged but upheld by the United States Supreme Court since 1973.⁵ While highly regulated, abortion may not be unduly burdened by government action.

Health insurance is one method by which women seeking abortion pay for the service. An estimated eighty-seven percent of private health insurance plans in the United States cover abortion services.⁶ Consumer surveys indicate a preference for coverage to be included in health

Public Health, Columbia University.

Cynthia Cox, MPH, Mailman School of Public Health, Columbia University.

Marla Feinstein, MPH, Mailman School of Public Health, Columbia University.

Amanda Sussex, MPH, Mailman School of Public Health, Columbia University.

Julia Harris, MPH, Mailman School of Public Health, Columbia University; MIA, Columbia University School of International and Public Affairs.

The authors gratefully acknowledge the comments and contributions of Professor Miriam Laugesen of the Department of Health Policy and Management at Columbia University, as well as the policymakers, providers, actuaries, advocates and insurers who spoke “off the record.” In addition, the authors thank the editors of the *Journal of Law and Social Change*, in particular, Joline Price, Mamina Cherkin and Erin Staab.

¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

² *Uninsured and Underinsured Adults*, THE COMMONWEALTH FUND, <http://www.commonwealthfund.org/Charts/Report/Why-Not-the-Best-Results-from-the-National-Scorecard-on-US-Health-System-Performance2011/U/Uninsured-and-Underinsured-Adults.aspx> (last visited Feb. 29, 2012).

³ SARA ROSENBAUM ET AL., DEP’T OF HEALTH POL’Y, GEORGE WASHINGTON UNIV. SCH. OF PUB. HEALTH, AN ANALYSIS OF THE IMPLICATIONS OF THE STUPAK/PITTS AMENDMENT FOR COVERAGE OF MEDICALLY INDICATED ABORTIONS I (2009), available at http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/index.cfm?mdl=pubSearch&evt=view&PublicationID=FED314C4-5056-9D20-3DBE77EF6ABF0FED.

⁴ See WENDY CHAVKIN & SARA ROSENBAUM, WOMEN’S HEALTH AND HEALTH CARE REFORM: THE KEY ROLE OF COMPREHENSIVE REPRODUCTIVE HEALTH CARE, available at <http://www.mailmanschool.org/facultypubs/womenshealthcarereform.pdf> (arguing that access to reproductive health care is essential to women’s health).

⁵ See, e.g., *Roe v. Wade*, 410 U.S. 113 (1973) (holding that the right to privacy includes the right to abortion decisions); *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 846 (1992) (reaffirming the central holdings of *Roe v. Wade*); *Gonzales v. Carhart*, 550 U.S. 124, 146 (2007) (“Before viability, a State ‘may not prohibit any woman from making the ultimate decision to terminate her pregnancy.’”).

⁶ Adam Sonfield et al., *U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive*

benefit packages.⁷ Without legislative interference, health insurers typically cover medically necessary abortion.

For over three decades, however, federal funding of certain public health insurance programs has been a leverage point to disrupt access to abortion services. These restrictions create coverage disparities between women enrolled in federally funded health plans and those in private plans. Women enrolled in the Federal Employees Health Benefits Plan (FEHB), military health plans, Medicaid, and Medicare are not insured for abortion services, except in the cases of rape, incest and where the life of the pregnant woman is in jeopardy.⁸ This is in contrast to the private health insurance market, where the majority of women enrolled are covered for abortion services.⁹

In the beginning stages of health reform, Congressional leaders stipulated that federal funds would not be used to pay for health insurance coverage of abortion for the newly subsidy-eligible population. An early proposal offered by Representative Lois Capps (D-CA) provided a segregation mechanism to ensure federal funds would not be used to pay for abortion services.¹⁰ Pro-life members of Congress rejected the Capps proposal and conditioned support of health reform on the inclusion of more restrictive language.¹¹ As a result, Congress attached abortion coverage restrictions introduced by Senator Ben Nelson (R-NE) to the Affordable Care Act.¹² As described below, these restrictions establish an elaborate “two payment” premium segregation and enforcement scheme that extends beyond what many believe is necessary to ensure that federal funds do not pay for abortion services.

The ACA’s extensive abortion coverage rules may prompt insurers to drop abortion coverage for newly established exchange-based plans.¹³ As exchanges grow, such shifts could result in widespread losses of abortion coverage for previously insured populations.¹⁴ Although under the ACA insurers may continue to offer coverage in markets outside of exchanges, insurers may instead choose to drop coverage in outside-exchange plans to standardize offerings across both markets.¹⁵

Even if carriers offer benefit packages with abortion coverage, consumer demand may be lowered if consumers are unwilling to incur burdens associated with the two-payment system. In that case, it is possible that consumer demand could be too low to support abortion coverage

Coverage Mandates, 2002, 36 PERSP. ON SEXUAL & REPROD. HEALTH 72, 76 (2004).

⁷ THOMSON REUTERS, NATIONAL SURVEY OF HEALTHCARE CONSUMERS: ABORTION 2 (2011), available at http://www.factsforhealthcare.com/pressroom/NPR_report_Abortion.pdf.

⁸ See Heather D. Boonstra, *The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States*, 10 GUTTMACHER POL’Y REV. 12 (2007).

⁹ Sonfield et al., *supra* note 6, at 75.

¹⁰ Chris Good, *Interview: DeGette on Abortion in the Health Reform Debate*, THE ATLANTIC (Nov. 7, 2009, 4:20 PM), <http://www.theatlantic.com/politics/archive/2009/11/interview-degette-on-abortion-in-the-health-reform-debate/30342/>.

¹¹ Alec MacGillis, *Health-care Reform and Abortion Coverage: Questions and Answers*, WASH. POST, Nov. 15, 2009, <http://www.washingtonpost.com/wp-dyn/content/article/2009/11/14/AR2009111401597.html>.

¹² Jeffrey Young, *Nelson Offers Abortion Amendment to Senate Healthcare Reform Legislation*, THE HILL (Dec. 7, 2009, 2:26 PM), <http://thehill.com/homenews/senate/70921-nelson-offers-senate-abortion-amendment->

¹³ ROSENBAUM ET AL., *supra* note 3, at 9.

¹⁴ *Id.*

¹⁵ *See id.*

altogether.¹⁶ Some suggest abortion coverage could be made available through separate “riders”; however, there is little evidence to indicate that such riders are viable insurance products.¹⁷

In the absence of abortion coverage, the necessity to pay for abortions out-of-pocket will disparately impact lower income women.¹⁸ Those faced with financial hardship often require additional time to gather funds to pay for abortion services. This delay can result in later term abortions that carry both increased health risk and increased costs.¹⁹ Delays can also mean that women may lose the option to terminate pregnancy using medication as opposed to surgery.²⁰

Health reform implementation provides an opportunity to structure rules that either support or discourage the continued availability of health insurance coverage for medically necessary abortion. Even within constraints established by the ACA, state policymakers can take steps to promote access to abortion coverage when structuring health insurance exchanges established by the ACA.

This Article provides background on abortion financing, analyzes possible effects of health care reform on abortion coverage and access, and identifies options for policymakers seeking to promote continued availability of insurance coverage for abortion. Section I reviews recent federal and state-based legislation related to abortion coverage. Section II examines the frequency of and payment mechanisms for abortions in the United States. Section III reviews abortion coverage restrictions prior to health reform. Section IV compares divergent abortion coverage proposals debated leading up to the passage of the ACA. Section V presents the final rules and regulations outlined in the ACA, Presidential Executive Order, pre-regulatory model guidelines, and the final rule issued by the Department of Health and Human Services (HHS). Section VI appraises state and federal abortion coverage restrictions introduced since health reform passed in March 2010. Section VII contextualizes abortion coverage relative to the new essential health benefits package created by health reform. Section VIII identifies and considers key options available to states to promote health insurance coverage for abortion and estimates the price of an abortion benefit under the rules established by the ACA.

I. BACKGROUND: ABORTION FREQUENCY AND FINANCING

Nearly half of pregnancies among American women are unintended.²¹ Twenty-two percent of all pregnancies end in abortion.²² In 2008, approximately 1,210,000 abortions were performed in the United States.²³

¹⁶ *Id.*

¹⁷ Peter Slevin, *Insurers Report on Use of Abortion Riders*, WASH. POST, Mar. 14, 2010, <http://www.washingtonpost.com/wp-dyn/content/article/2010/03/13/AR2010031302139.html>.

¹⁸ See CHAVKIN & ROSENBAUM, *supra* note 4, at 12.

¹⁹ *In-Clinic Abortion Procedures*, PLANNED PARENTHOOD, <http://www.plannedparenthood.org/health-topics/abortion/in-clinic-abortion-procedures-4359.asp> (last visited Mar. 15, 2012); see also Danielle Bessett et al., *Out of Time and Out-of-Pocket: Experiences of Women Seeking State-Subsidized Insurance for Abortion Care in Massachusetts*, 21 WOMEN’S HEALTH ISSUES S21 (2011).

²⁰ Danielle Bessett et al., *supra* note 19, at S23.

²¹ Lawrence B. Finer & Mia R. Zolna, *Unintended Pregnancy in the United States: Incidence and Disparities*, 2006, 84 CONTRACEPTION 478, 478 (2011).

²² GUTTMACHER INST., FACTS ON INDUCED ABORTION IN THE UNITED STATES (2011), available at http://www.guttmacher.org/pubs/fb_induced_abortion.html#6. This figure excludes pregnancies ending in miscarriage.

²³ Rachel K. Jones & Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States*,

Abortions are frequently categorized as either therapeutic or non-therapeutic (sometimes referred to as elective abortions).²⁴ There are legal, medical, and insurance implications associated with labels purporting to identify the reason a woman seeks an abortion. For example, many states restrict access to or funding for abortion unless the abortion is deemed medically necessary.²⁵ “Medically necessary” abortions are usually defined as abortions that are necessary to protect the physical or mental health of the woman.²⁶ However, the exact definitions of health and necessity vary from state to state and from health plan to health plan.²⁷

Abortion services in the United States are paid for through a patchwork of payment methods. To pay for abortion, women generally use private health insurance, public health insurance, provider subsidies, their own private funds and/or borrowed money.²⁸

In the United States, abortion is most commonly (approximately seventy-four percent) paid for out-of-pocket while thirteen percent of abortions are paid for by a health insurer.²⁹ Although abortion may be a covered benefit, many forgo coverage in favor of out-of-pocket payment. Reasons for this are explored in Section C2 below. Another twelve percent of abortions are paid for on a provider-administered sliding scale basis or through a different type of subsidy or discount.³⁰ Roughly two percent of people report borrowing money to pay for an abortion.³¹

Low-income women are more likely to be uninsured or covered by Medicaid than have private insurance.³² As discussed below, most Medicaid enrollees do not have access to abortion coverage.³³ One study found that sixty percent of women on Medicaid seeking abortions face

2008, 43 PERSP. ON SEXUAL & REPROD. HEALTH 41, 41–50 (2011). This figure includes both medical abortions (elective abortions induced through a prescribed medication) and surgical abortions (elective abortion procedures performed by a clinician). Additionally, in the context of this Article, the term “abortion” refers to “induced abortions” or pregnancies that are deliberately terminated, and should not be confused with “spontaneous abortions” or miscarriages.

²⁴ See Stanley Henshaw et al., *The Incidence of Abortion Worldwide*, 25 INT’L FAMILY PLANNING PERSP. S30, S30–S38 (1999), available at <http://www.guttmacher.org/pubs/journals/25s3099.html>.

²⁵ Kaiser Family Foundation, *State Funding of Abortions Under Medicaid, as of August 1, 2011*, STATEHEALTHFACTS.ORG, <http://www.statehealthfacts.org/comparetable.jsp?ind=462&cat=10> (last visited Feb. 29, 2012) [hereinafter Kaiser Family Foundation, *State Funding of Abortions Under Medicaid*]; see also GUTTMACHER INST., STATE POLICIES IN BRIEF: BANS ON “PARTIAL BIRTH” ABORTION (2012), available at http://www.guttmacher.org/statecenter/spibs/spib_BPBA.pdf.

²⁶ See STANLEY K. HENSHAW ET AL., GUTTMACHER INST., RESTRICTIONS ON MEDICAID FUNDING FOR ABORTIONS: A LITERATURE REVIEW 3 (2009), available at <http://www.guttmacher.org/pubs/MedicaidLitReview.pdf> (pointing out the distinction between medical necessary abortions, which protect the health of the pregnant woman, and “life endangerment” abortions, which refer more specifically to situations in which the woman’s life is in immediate danger).

²⁷ Kaiser Family Foundation, *State Later-Term Abortion Policies, as of August 1, 2011*, STATEHEALTHFACTS.ORG, <http://www.statehealthfacts.org/comparetable.jsp?ind=462&cat=10> (last visited Apr. 11, 2012).

²⁸ Stanley K. Henshaw & Lawrence B. Finer, *The Accessibility of Abortion Services in the United States*, 2001, 35 PERSP. ON SEXUAL & REPROD. HEALTH 16, 20 (2003).

²⁹ *Id.*

³⁰ *Id.*

³¹ RACHEL JONES ET AL., GUTTMACHER INST., CHARACTERISTICS OF U.S. ABORTION PATIENTS, 2008, at 11 (2010), available at <http://www.guttmacher.org/pubs/US-Abortion-Patients.pdf>.

³² *Id.* at 10.

³³ See Kaiser Family Foundation, *State Funding of Abortions Under Medicaid*, *supra* note 25.

additional financial hardships and often forgo necessities such as food, clothing, and rent for themselves and their dependents in order to pay for the procedure.³⁴

A lack of funds often results in delayed access to abortion; in addition to increased costs, the longer the delay, the greater the health risks associated with later term abortions.³⁵ Prolonged delays can also mean that medical abortions (those performed using medication rather than surgery) are no longer an option.³⁶ Women who delay abortions into the second trimester of pregnancy are disproportionately people of color and more likely to be lower-income than those who obtain abortions in the first trimester.³⁷ History demonstrates that without access to safe and legal abortion services, women may turn to illegal or unsafe alternatives including self-induced abortion or abortion by an unlicensed provider.³⁸

The impact of the abortion coverage restrictions established by the ACA is currently unknown but could eliminate previously widespread coverage. Some may dismiss this concern by claiming that because less than half of women with private health insurance who obtain abortions use their insurance to pay for abortion procedures, a loss of abortion coverage would not affect access.³⁹ But to pay out-of-pocket for treatment for a covered service appears antithetical to the concept of insurance and reveals the marginalization of abortion relative to other health care. For women, especially low-income women, to forgo insurance coverage of abortion care in favor of out-of-pocket payment using scarce resources suggests barriers to coverage even among the insured that should be further explored.⁴⁰

Notably, increased access to insurance coverage for abortion does not appear to increase the incidence of abortion.⁴¹ After passing health reform in 2006, rates of abortion in Massachusetts decreased despite significant increases in the number of individuals with insurance that included abortion coverage.⁴² Studies show that increased access to and coverage of contraception is the most effective method to reduce the abortion rate.⁴³ Therefore, health coverage of both contraception and termination simultaneously reduces the risk of unintended pregnancy and guarantees access to abortion services when needed.⁴⁴

³⁴ Heather Boonstra & Adam Sonfield, *Rights Without Access: Revisiting Public Funding of Abortion for Poor Women*, 3 GUTTMACHER REP. ON PUB. POL'Y 8, 10 (2000).

³⁵ Bessett et al., *supra* note 19, at S21.

³⁶ Linda Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 OBSTETRICS & GYNECOLOGY 729, 736 (2004); Bessett et al., *supra* note 19, at S21–S22.

³⁷ Boonstra & Sonfield, *Rights Without Access*, *supra* note 34, at 10.

³⁸ Rachel Benson Gold, *Lessons from Before Roe: Will Past be Prologue?*, 6 GUTTMACHER REP. ON PUB. POL'Y 1, 2 (2003), available at <http://www.guttmacher.org/pubs/tgr/06/1/gr060108.html>.

³⁹ JONES ET AL., *supra* note 31, at 11 (2010); Stephanie L. Van Bebber et al., *Patient Costs for Medication Abortion: Results From a Study of Five Clinical Practices*, 16 WOMEN'S HEALTH ISSUES 4, 7 (2006).

⁴⁰ J.A. Lee et al., *Insured Women and Payment for Elective Abortion*, 18 WOMEN'S HEALTH ISSUES 347, 347–350 (2008).

⁴¹ Patrick Whelan, *Abortion Rates and Universal Health Care*, 362 NEW ENG. J. MED. e45, e45(3) (2010), <http://www.nejm.org/doi/full/10.1056/NEJMp1002985>.

⁴² *Id.* at e45(1) (“[I]n Massachusetts . . . universal health care coverage has been associated with a decrease in the number of abortions performed, despite public and private funding of abortion that is substantially more liberal . . .”).

⁴³ See Gilda Sedgh et al., *Induced Abortion: Estimated Rates & Trends Worldwide*, 370 THE LANCET 1338, 1341, 1344 (2007).

⁴⁴ Amy Deschner & Susan A. Cohen, *Contraceptive Use Is Key to Reducing Abortion Worldwide*, 6

Subsections below provide an overview of abortion frequency, cost, and coverage in the United States.

A. Frequency and Types of Abortion

Of the estimated 1,210,000 million abortions per year, the majority (87.6%) are performed using a surgical method.⁴⁵ Approximately seventeen percent of nonhospital abortions were induced by medication, as opposed to surgery.⁴⁶ According to the United States Centers for Disease Control (CDC), the majority (approximately sixty-two percent) of abortions are performed at less than eight weeks gestation. The percentage of abortions before eight weeks has increased in recent years, up by 11.7% from 1997 to 2006.⁴⁷ The percentage of abortions occurring at sixteen weeks or later stayed relatively constant (at about five percent to six percent) over this time period.⁴⁸

B. The Approximate Price of an Abortion

Medical abortions using the medication mifepristone cost \$490 on average in 2009.⁴⁹ The average cost of a first trimester surgical abortion is \$451 (at ten weeks gestation).⁵⁰ Most abortion clinics try to keep prices for surgical and medical abortions at comparable rates to avoid creating financial incentives for clients to choose one method over another.⁵¹ Costs increase as abortion procedures become more complicated later in pregnancy. For example, the median cost of an abortion at twenty weeks was \$1,500 in 2009.⁵² Abortions performed in hospitals are considerably more expensive.⁵³ Notably, the cost of a first trimester abortion has stayed constant—even decreased in some cities—for three decades, despite considerable medical inflation.⁵⁴

GUTTMACHER REP. ON PUB. POL'Y 7, 10 (2003); Cicely Marston & John Cleland, *Relationships Between Contraception and Abortion: A Review of the Evidence*, 29 INT'L FAMILY PLANNING PERSP. 6, 6 (2003).

⁴⁵ Rachel K. Jones & Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States*, 2008, 43 PERSP. ON SEXUAL & REPROD. HEALTH 41, 41–50 (2011); Karen Pazol et al., *Abortion Surveillance — United States, 2006*, 58 MORBIDITY & MORTALITY WKLY. REP. 1, 1 (2009), available at http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5808a1.htm?s_cid=ss5808a1_e. The surgical method is known as curettage, which includes vacuum aspiration, sharp curettage, and dilation and evacuation.

⁴⁶ Jones & Kooistra, *supra* note 45, at 46.

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ Jones & Kooistra, *supra* note 45, at 47–48.

⁵⁰ *Id.* at 48; *In-Clinic Abortion Procedures*, PLANNED PARENTHOOD, <http://www.plannedparenthood.org/health-topics/abortion/in-clinic-abortion-procedures-4359.asp> (last visited Feb. 29, 2012).

⁵¹ David Grimes & Mitchell Creinin, *Induced Abortion: An Overview for Internists*, 140 ANNALS OF INTERNAL MED. 620, 625 (2004); Michelle Seelig et al., *Determinants of Physician Unwillingness to Offer Medical Abortion using Mifepristone*, 16 WOMEN'S HEALTH ISSUES 14, 15 (2006).

⁵² Jones & Kooistra, *supra* note 45, at 48.

⁵³ Stanley Henshaw, *Factors Hindering Access to Abortion Services*, 27 FAMILY PLANNING PERSP. 54, 58 (1995).

⁵⁴ See Gina Kolata, *As Abortion Rate Decreases, Clinics Compete for Patients*, N.Y. TIMES, Dec. 30, 2000, <http://www.nytimes.com/2000/12/30/us/as-abortion-rate-decreases-clinics-compete-for-patients.html>.

C. Health Insurance Coverage Patterns in the United States

The majority of Americans—approximately fifty-four percent—are enrolled in private health insurance, purchased either through their employer or in the individual market.⁵⁵ The American health care system is largely based on employer-sponsored private insurance and employers are encouraged to contribute to health insurance coverage.⁵⁶ Approximately 150,000,000 people receive insurance coverage through their employer⁵⁷ and another 14,000,000 people purchase private coverage on their own in the individual market.⁵⁸

United States consumers appear to want abortion included in health benefit packages. The National Survey of Healthcare Consumers performed by Thomson Reuters in March of 2011 analyzed responses from 3,013 participants and reports that the majority of respondents believe private insurance plans should cover all or most of the cost of an abortion (a sentiment that is correlated with income and education).⁵⁹ In addition, the majority of public comments received by HHS during the formal rulemaking process initiated after the passage of health reform are supportive of medically necessary abortions being a covered health benefit.⁶⁰

1. Private Health Insurance

An estimated forty-nine percent of individuals are covered by employer-sponsored insurance.⁶¹ The majority (approximately sixty percent) of people with employer-sponsored coverage are, however, covered by self-insured plans.⁶² If an employer self-insures, the financial

⁵⁵ See Kaiser Family Foundation, *Health Insurance Coverage of the Total Population, States (2009–2010), U.S. (2010)*, STATEHEALTHFACTS.ORG, <http://www.statehealthfacts.org/comparetable.jsp?typ=1&ind=125&cat=3&sub=39> (last visited Mar. 13, 2012) [hereinafter Kaiser Family Foundation, *Health Insurance Coverage*].

⁵⁶ See MARK W. STANTON, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP'T OF HEALTH & HUMAN SERVS., *EMPLOYER-SPONSORED HEALTH INSURANCE: TRENDS IN COST AND ACCESS (2004)*, available at <http://www.ahrq.gov/research/empspria/empspria.pdf>.

⁵⁷ See Kaiser Family Foundation, *Health Insurance Coverage*, *supra* note 55.

⁵⁸ *Id.*

⁵⁹ THOMSON REUTERS, *NATIONAL SURVEY OF HEALTHCARE CONSUMERS: ABORTION 5 (2011)*, available at http://www.factsforhealthcare.com/pressroom/NPR_report_Abortion.pdf.

⁶⁰ A search was performed on www.regulations.gov, within HHS and CMS, from March 2010 to November 2011, using the term “abortion.” 68,207 public comments were displayed. Approximately 2,000 of the comments were surveyed and no negative comments were located. Comments from religiously-affiliated organizations represented a minority of total comments and generally advocated for an exemption from contraception coverage. A search using both “abortion” and “section 156.280” was performed on comments submitted for the most recent proposed rule on PPACA and the Establishment of Exchanges and Qualified Health Plans. The search yielded forty-two separate comments (identical comments submitted through advocacy organizations were displayed as an aggregate).

⁶¹ See Kaiser Family Foundation, *Health Insurance Coverage*, *supra* note 55. This includes both fully-insured and self-funded plans.

⁶² KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, *EMPLOYER HEALTH BENEFITS 2011 ANNUAL SURVEY 150 (2012)* [hereinafter *EMPLOYER HEALTH BENEFITS 2011 ANNUAL SURVEY*]. For more detailed definitions of the different types of insurance plans available, see *Glossary*, HEALTHCARE.GOV, <http://www.healthcare.gov/glossary/04262011a.pdf> (last visited Apr. 12, 2012). Forty nine percent of the total population is in an employer-sponsored plans, be they fully-insured or self-funded. Kaiser Family Foundation, *Health Insurance Coverage*, *supra* note 55. Because we can infer that forty percent of people in employer-sponsored plans are in fully insured plans, roughly thirty percent of the entire population is in a self-insured, employer-sponsored plan, and roughly twenty percent of the

risk associated with claims payment is borne by the employer itself and rather than a commercial insurance carrier.⁶³ Employers who self-insure may contract with an insurer or third party administrator to serve administrative functions.⁶⁴ The Employee Retirement Income Security Act (ERISA)⁶⁵ mandates that self-insured plans are regulated at the federal level, whereas other types of commercial health insurance plans (individual, small group and large group) are subject to both federal and state regulation.⁶⁶ The federal preemption clause in ERISA prevents state laws from applying to self-insured groups, therefore if a state were to mandate coverage of abortion, such a mandate would not apply to self-insured plans.⁶⁷ A federal coverage mandate, on the other hand, would apply to self-insured plans.⁶⁸

Most employer-sponsored health insurance plans currently include coverage for abortion.⁶⁹ One survey of private insurers found that approximately eighty-seven percent of employer-sponsored plans include coverage for both medical and surgical abortions.⁷⁰ This

entire population is in a fully-insured employer-sponsored plan.

⁶³ *Glossary – Self-Insured Plan*, HEALTHCARE.GOV, <http://www.healthcare.gov/glossary/s/sip.html> (last visited Mar. 17, 2010).

Self-Insured Plan: Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third party administrator, or they can be self-administered.

Id. See also Mary Ann Chirba-Martin & Troyen A. Brennan, *The Critical Role of ERISA in State Health Reform*, 13 HEALTH AFFAIRS 142, 145 (1994).

⁶⁴ U.S. BUREAU OF LABOR & STATISTICS, DEFINITIONS OF HEALTH INSURANCE TERMS 6 (2002), <http://www.bls.gov/ncs/ebs/sp/healthterms.pdf> (last visited Apr. 12, 2012).

⁶⁵ *Glossary of Health Insurance Terms - ERISA*, NAT'L ASS'N OF INS. COMM'RS & CTR. FOR INS. POL'Y & RESEARCH, http://www.naic.org/documents/index_health_reform_glossary.pdf (last visited Mar. 17, 2012) ("The Employee Retirement Income Security Act of 1974 (ERISA) is a comprehensive and complex statute that federalizes the law of employee benefits. ERISA applies to most kinds of employee benefit plans, including plans covering health care benefits, which are called employee welfare benefit plans.").

⁶⁶ Chirba-Martin & Brennan, *supra* note 63, at 145–46.

⁶⁷ David J. Brummond, *Federal Preemption of State Insurance Regulation Under ERISA*, 62 IOWA L. REV. 57, 112 (1976).

⁶⁸ *Chapter 15: Federal Health Benefits Mandates and ERISA Fiduciary Standards*, in WILLIS COMPLIANCE MANUAL 4–5 (2011), available at <https://welcome2.willis.com/compliance/WillisComplianceManualChapters/Forms/AllItems.aspx>.

Before enactment of the health care reform law, self-insured nonfederal governmental plans could opt out of most of the HIPAA portability and nondiscrimination requirements and some of the Federal Mandates by filing an annual election not to be covered with HHS. The opt-out will continue to be available after health care reform becomes effective with respect to four of the Federal Mandates: NMHPA, MHPAEA, Michelle's Law and WHCRA. . . . None of the Federal Mandates other than the NMHPA, MHPAEA, Michelle's Law and WHCRA are affected by the opt-out election.

Id.

⁶⁹ *Memo on Insurance Coverage of Abortion*, GUTTMACHER INST. (Sept. 18, 2009), <http://www.guttmacher.org/media/inthenews/2009/07/22/index.html> (last visited Apr. 12, 2012).

⁷⁰ Adam Sonfield et al., *U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Coverage Mandates, 2002*, 36 PERSP. ON SEXUAL & REPROD. HEALTH 72, 76 (2004).

coverage pattern remains fairly consistent across different plan types.⁷¹ However, this statistic does not account for self-insured plans, which, as described above, provide coverage to a sizable portion of the insured population.⁷² The rate of abortion coverage among self-insured employers is unknown.⁷³

2. Insured Women Often Forgo Coverage for Abortion Services

Among privately insured women who obtain abortions, sixty-three percent pay out-of-pocket rather than use their insurance.⁷⁴ As noted above, research indicates that approximately thirteen percent of United States abortions are paid for by a health insurer.⁷⁵ Another study examining payment for medication (as opposed to surgical) abortion found that although seventy-two percent of women interviewed had coverage, only one percent used insurance to pay for abortion services.⁷⁶ The most common reason reported for not using existing coverage were concerns over privacy and confidentiality. Other reasons for the low use of existing private insurance to fund abortion include high deductibles and a lack of knowledge of available coverage.⁷⁷

Women and adolescent girls appear to avoid insurance reimbursement as an effort to guarantee confidentiality.⁷⁸ Women are more likely than men to be covered as dependents on health insurance plans in which a spouse or parent is the primary policyholder.⁷⁹ Fearing disclosure of the abortion to the primary policyholder (husband or parent) by the insurer or provider, many females choose to pay out-of-pocket or seek other funding. Although unintentional, state-based explanations of benefit (EOB) laws can conflict with other state laws that guarantee confidential access to health services. EOB laws often mandate itemization of care provided be sent, by mail, to the policyholder in order to confirm that services for which the provider is billing the plan were indeed provided and to fight fraud.⁸⁰ Such itemization can

⁷¹ *Id.* at 75. Rates of abortion coverage by insurance policies sold in the individual market could not be found for this analysis.

⁷² *Memo on Insurance Coverage of Abortion*, GUTTMACHER INST., *supra* note 69, at 74. The Guttmacher study did not include self-insured plans.

⁷³ See GARY CLAXTON ET AL., KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS 2003 ANNUAL SURVEY 109 (2003), available at <http://www.kff.org/insurance/upload/Kaiser-Family-Foundation-2003-Employer-Health-Benefits-Survey-Full-Report.pdf>. This report, which queries human resource departments of both traditional insurers and self-insured employers, estimated that forty-six percent of employer-sponsored plans offer abortion coverage. However, the high rate of “don’t know” responses (twenty-six percent) suggests that the forty-six percent number may be an underestimate. *Id.*

⁷⁴ JONES ET AL., *supra* note 31, at 11. Although the women in this survey maintain private health insurance coverage, respondents’ policies may not include coverage for elective abortion.

⁷⁵ Henshaw & Finer, *supra* note 28, at 20.

⁷⁶ Van Bebber et al., *supra* note 39, at 7.

⁷⁷ Lee et al., *supra* note 40, at 347; see also Steven Ertelt, *Study Shows Half of Women Getting Second Abortion, Don’t Use Private Insurance*, LIFE NEWS.COM, May 4, 2010, <http://www.lifenews.com/2010/05/04/nat-6301/>.

⁷⁸ Lee et al., *supra* note 40, at 348; JONES ET AL., *supra* note 31, at 12 (“[T]he deductible may have exceeded the cost of abortion, [and] it is quite possible that the deductible prevented these women from using their private insurance for this purpose.”).

⁷⁹ See KAISER FAMILY FOUND., WOMEN’S HEALTH INSURANCE COVERAGE (2007), http://www.kff.org/womenshealth/upload/6000_05.pdf (last visited Apr. 12, 2012).

⁸⁰ *Glossary of Terms—Explanation of Benefits (EOB)*, FAIRHEALTHCONSUMER.ORG, <http://fairhealth>

affirmatively identify the very care a dependent may intend to keep confidential. As a result, the EOB requirements associated with health insurance billing can end up serving as a deterrent for enrollees to use insurance coverage to pay for abortion services.⁸¹ It is incongruous that enrollees, for any reason, would need to avoid using their insurance coverage. As discussed below, the establishment of an exchange market could provide an opportunity for a new framework that aligns confidentiality protections with billing practices as a means to ensure access to covered abortion benefits.⁸²

In addition, although an enrollee's benefit package may include abortion care, the policy may have a significant deductible.⁸³ Because the cost of the average first trimester abortion is lower than the average deductible, the enrollee may be obligated to pay this cost under the terms of the plan.⁸⁴

Finally, women with private coverage may not seek insurance reimbursement because they may not be aware that their insurance plan covers abortion services. Knowledge of specific benefits is generally low and individuals are less likely to know which outpatient services are covered.⁸⁵ One study found that forty-four percent of women surveyed were unaware of whether their insurance covered elective abortion.⁸⁶

3. Public Health Insurance

Approximately 90,500,000 Americans obtain health insurance coverage through a public

consumer.org/glossary.aspx#E (last visited Mar. 17, 2012).

Your insurer will provide you with an EOB after you have submitted a healthcare claim to your insurer or after a provider has submitted a claim to your insurer on your behalf. The EOB will include a detailed explanation of how your insurer/administrator determined the amount of reimbursement it made to your provider or to you for a particular medical service. The EOB will also include information on how to appeal or challenge your insurer's reimbursement decision.

Id.

⁸¹ Rachel Benson Gold, *Unintended Consequences: How Insurance Processes Inadvertently Abrogate Patient Confidentiality*, 12 GUTTMACHER POL'Y REV. 12, 14 (2009) [hereinafter Gold, *Unintended Consequences*].

⁸² *Id.* at 12 ("And, health care reform — both by increasing the number of insured individuals and potentially by broadening the group eligible to be covered as dependents — could greatly expand the size of the [group affected by breaches of confidentiality].").

⁸³ JONES ET AL., *supra* note 31, at 12. A deductible is the amount of money per year that a person must spend on medical care before his or her insurance begins to cover medical expenses. As a large portion of women receiving abortions are relatively young and healthy, they are not likely to have spent to their deductible, and thus would still have to pay out-of-pocket for the abortion procedure even if they have insurance coverage. For more detailed definitions of deductibles, see *Glossary*, HEALTHCARE.GOV, <http://www.healthcare.gov/glossary/d/deductible.html> (last visited Apr. 12, 2012).

⁸⁴ JONES ET AL., *supra* note 31, at 12. Average annual deductibles vary greatly by plan type. For example, among employer-sponsored plans that had deductibles in 2011, the average annual deductible ranged from approximately \$900 for HMO plans to nearly \$2,000 for high deductible health plans. EMPLOYER HEALTH BENEFITS 2011 ANNUAL SURVEY, *supra* note 62, at 2.

⁸⁵ M. SUSAN MARQUIS, CONSUMERS' KNOWLEDGE ABOUT THEIR HEALTH INSURANCE COVERAGE 14 (1981), available at <http://www.rand.org/content/dam/rand/pubs/reports/2007/R2753.pdf> (finding that "families substantially underreported their outpatient physician and drug coverage").

⁸⁶ Van Bebber et al., *supra* note 39, at 7.

program.⁸⁷ Of these, over thirty-eight million are enrolled in Medicare, the federally funded public insurance program for adults sixty-five years of age and older, as well as people with certain types of disabilities.⁸⁸ Forty-eight million people are enrolled in Medicaid, a program funded through a combination of federal and state dollars to provide health insurance to low-income Americans.⁸⁹ Another 3,900,000 people are enrolled in other public programs, such as TRI Care, the plan for military personnel, and the Federal Employees Health Benefits Program (FEHBP).⁹⁰ Due to federal restrictions known as the Hyde Amendment,⁹¹ enrollees in public health insurance programs including Medicare, TRI Care, FEHBP, and most Medicaid plans lack coverage for abortion except in cases of rape, incest, or life endangerment of the pregnant woman.⁹² In addition, fifteen states restrict private health insurance coverage of abortion for public employees.⁹³

The prohibition on federal funding of abortion services has been challenged and, to this point, upheld. Although a constitutionally protected right to abortion exists, no right to have an abortion paid for by federal funds has been recognized. Specifically, in *Roe v. Wade* and its progeny, the United States Supreme Court recognized that women (and abortion providers) have a constitutionally protected right to privacy giving rise to a right to abortion.⁹⁴ In the 1977 case of *Maher v. Roe*, the Court found that although a woman may have a right to abortion, there is no corresponding right to have an abortion funded by the government.⁹⁵ Although the Hyde

⁸⁷ See Kaiser Family Foundation, *Health Insurance Coverage*, *supra* note 55.

⁸⁸ *Id.*

⁸⁹ *Id.* The forty-eight million includes people who are dually eligible for Medicaid and Medicare, as well as CHIP enrollees. *Id.*

⁹⁰ *Id.*

⁹¹ See *infra* notes 107–22 and accompanying text for details on the Hyde Amendment.

⁹² *Public Funding for Abortion*, AMERICAN CIVIL LIBERTIES UNION (July 21, 2004), <http://www.aclu.org/reproductive-freedom/public-funding-abortion> (last visited Apr. 12, 2012).

⁹³ GUTTMACHER INST., STATE POLICIES IN BRIEF: RESTRICTING INSURANCE COVERAGE OF ABORTION 1 (2012), available at http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf. Out of those fifteen states, five states limit coverage to life endangerment, eight “to some combination of life endangerment, threat to the woman’s health, rape, incest or fetal abnormality,” and two prohibit all abortion coverage. *Id.*

⁹⁴ *Roe v. Wade*, 410 U.S. 113, 154 (1973) (“We . . . conclude that the right of personal privacy includes the abortion decision, but that this right is not unqualified and must be considered against important state interests in regulation.”); see also *Maher v. Roe*, 432 U.S. 464, 473–74 (1977) (“[T]he [due process] right protects the woman from unduly burdensome interference with her freedom to decide whether to terminate her pregnancy.”); *Hodgson v. Minnesota*, 497 U.S. 417, 434 (1990) (“A woman’s decision to conceive or to bear a child is a component of her liberty that is protected by the Due Process Clause of the Fourteenth Amendment to the Constitution.”); *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 846 (1992) (holding that that a woman has a protected right “to choose to have an abortion before viability and to obtain it without undue interference from the State.”); *Gonzales v. Carhart*, 550 U.S. 124, 146 (2007) (internal citations omitted) (“Before viability, a State ‘may not prohibit any woman from making the ultimate decision to terminate her pregnancy.’”).

⁹⁵ *Maher*, 432 U.S. at 474 (upholding Connecticut’s ban on state funding for abortions). The case was brought as a challenge to a Connecticut welfare policy that paid for childbirth but did not fund abortions without a doctor’s certification that the abortion was medically necessary. In *Maher*, the court rejected a claim that this violated the Fourteenth Amendment’s Equal Protection Clause. *Id.* See also *Beal v. Doe*, 432 U.S. 438, 447 (1997) (upholding Pennsylvania’s ban on state funding for abortion); *Harris v. McRae*, 448 U.S. 297, 318 (1980) (holding that the Hyde Amendment did “not impinge on the due process liberty recognized in [*Roe v. Wade*].”). See generally Gary J. Simson, *Abortion, Poverty and the Equal Protection of the Laws*, 13 GA. L. REV. 505, 505 (1979) (arguing that “the Court’s

Amendment prohibits the use of federal Medicaid funds for abortions except in the cases of rape, incest, or life of the pregnant woman, seventeen states use state-only money to fund abortions through their Medicaid programs.⁹⁶ About twenty percent of people who had abortions reported using Medicaid to pay for the procedure, according to a national survey conducted in 2008–2009.⁹⁷ Notably, of women seeking abortions who were covered by Medicaid in a state that uses state funds to cover non-Hyde abortions, ninety-two percent used Medicaid to cover the cost of their abortion.⁹⁸

D. Provider Subsidies and Private Donations

Some providers offer a “sliding scale”—an arrangement in which patients pay for health services based on their individual financial resources. Providers may defray financial losses associated with providing care below cost by cross-subsidizing (charging higher rates to another patient to make up the difference in the reduced rate offered to another), by securing donations from outside sources, or by absorbing the lost earnings themselves. One poll found thirteen percent of women received some form of financial assistance from their provider to pay for their abortion procedure.⁹⁹ Most provider subsidies reduce the fee charged to a patient but rarely cover the entire cost of the procedure. This leaves many low-income women to contribute some of their own funds.¹⁰⁰

A substantial safety net, funded entirely by private donations, exists to support access to abortion and other critical women’s health services.¹⁰¹ These private funds or provider subsidies are intended for women who lack sufficient coverage.¹⁰² Because charitable funds are both limited and rationed on a needs basis, it appears inefficient for insured women to forgo insurance coverage to instead use scarce safety net resources to pay for abortion or any other health

determination in *Maher* that Connecticut’s spending practices do not affect the enjoyment of a fundamental interest depends upon an implicit mischaracterization of the interest denominated in *Roe*.”)

⁹⁶ GUTTMACHER INST., STATE POLICIES IN BRIEF: STATE FUNDING OF ABORTION UNDER MEDICAID 1 (2012), available at http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf. Of the seventeen states that use state-only money to pay for abortions under Medicaid, only four do so voluntarily. The other thirteen states do so under court ordered mandates. *Id.*

⁹⁷ JONES ET AL., *supra* note 31, at 11.

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ George L. Rubin et al., *Response of Low Income Women and Abortion Facilities To Restriction of Public Funds for Abortion: A Study of a Large Metropolitan Area*, 69 AM. J. OF PUB. HEALTH 948, 949 (1979) (“Subsidization of legally induced abortion during the 1977 period was usually in the form of a fee reduction . . . and never covered the entire cost of the procedure. Thus, most low-income women were using their personal funds to cover a portion of the cost of the abortion.”).

¹⁰¹ Examples of national-level private money for abortion include National Network of Abortion Funds and National Abortion Federation, while examples of state-level private money for abortions are Women’s Medical Fund (Wisconsin) and New York Abortion Access Fund.

¹⁰² All of the foundations listed in note 101 fund abortions for women who otherwise cannot afford them and specifically state in their missions that their work is intended to alleviate disparities for women of color and/or lower socio-economic standing. See e.g., *Our Story*, FUND ABORTION NOW, <http://www.fundabortionnow.org/about/our-story> (last visited Feb. 19, 2012); WOMEN’S MEDICAL FUND, INC., <http://womensmedicalfundwis.org/> (last visited Feb. 19, 2012).

service.¹⁰³

E. Abortions Funded Through Borrowed Money

Some individuals borrow money to pay for abortion services. Approximately two percent of women surveyed in 2008 and 2009 reported borrowing money from friends or family to cover the cost.¹⁰⁴ This fact suggests that even with high rates of provider subsidies, abortion can still be unaffordable to some women.¹⁰⁵

F. Forgone Abortion Due to Inability to Pay

The frequency with which women carry pregnancies to term due to inability to pay for abortions is difficult to measure using individual data. The most reliable data comes from population-level studies examining rates of abortions and live births before and after state based changes to abortion coverage under Medicaid. Three studies found that between eighteen and thirty-seven percent of pregnancies that would have been terminated if funding had been available through the state's Medicaid program, were instead carried to term.¹⁰⁶

II. THE HYDE AMENDMENT¹⁰⁷

Federal appropriations law has restricted federal financing of abortion for some thirty-five years. In 1976, Representative Henry Hyde (R-IL) sponsored the key provision related to federal funding of abortion services.¹⁰⁸ The specific conditions have changed over time but the Hyde Amendment, as it is commonly known, is the major restriction on federal funding of abortion services and is briefly reviewed in this section.

Major federal programs including Medicaid, TriCare, The Federal Employees Health Benefits Package (FEHBP), the Indian Health Service, federal prison health care, and community health centers¹⁰⁹ are funded through the annual Labor/Health and Human Services

¹⁰³ See JONES ET AL., *supra* note 31, at 12 (“Additionally, organizations . . . receive charitable donations that are used to help low -income women pay for abortion services.”). See also GUTTMACHER INST., A REAL-TIME LOOK AT THE IMPACT OF THE RECESSION ON PUBLICLY FUNDED FAMILY PLANNING CENTERS 4 (2009), available at <http://www.guttmacher.org/pubs/RecessionFPC.pdf>. (“These centers typically serve a wide range of clients, including women whose income makes them ineligible for free or reduced-fee services”); *id.* at 7 (“Family planning centers report a variety of service delivery challenges due to the financial pressures of the recession.”).

¹⁰⁴ JONES ET AL., *supra* note 31, at 11.

¹⁰⁵ *Id.*

¹⁰⁶ James Trussell et al., *The Impact of Restricting Medicaid Financing for Abortion*, 12 FAM. PLANNING PERSP. 120, 129 (1980); M. Chrissman et al., *Effects of Restricting Federal Funds for Abortion—Texas*, 29 MORBIDITY & MORTALITY WKLY. REP. 253, 253 (1980); S. Philip Morgan & Allan M. Parnell, *Effects on Pregnancy Outcomes of Changes in the North Carolina State Abortion Fund*, 21 POPULATION RES. & POL'Y REV. 319, 322 (2002).

¹⁰⁷ The Hyde Amendment refers and applies to the funds appropriated by each Fiscal Year's Labor-HHS appropriations bill. It states: “None of the funds appropriated in *this act*” (emphasis added). See Consolidated Appropriations Act, 2011, Div. D, tit. V, §§ 506–507.

¹⁰⁸ See Boonstra, *supra* note 8, at 12 (quoting Congressman Hyde during the 1977 congressional debate over Medicaid funding as saying “I certainly would like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle-class woman, or a poor woman. Unfortunately, the only vehicle available is the . . . Medicaid bill.”).

¹⁰⁹ Medicaid is a partnership program between federal and state governments, in which both entities

(HHS)/Education appropriations process.¹¹⁰ The Hyde Amendment is attached to the spending bills approved annually during this process.¹¹¹ The annual appropriations process provides an opportunity for the Hyde Amendment to be reevaluated, renewed, or repealed.¹¹² The Hyde Amendment's attachment to underlying funding for critical health care programs results, according to some observers, in repeated renewal without dedicated deliberation.¹¹³

The Hyde Amendment currently provides an exception that allows federal funding of abortion in cases where the pregnancy is the result of rape, incest, or when the woman's life would be endangered if the abortion were not performed.¹¹⁴ Notably, the Amendment explicitly permits the use of state-only funds to finance abortion services, and, as discussed below, some states take this option.¹¹⁵

financially contribute to financing an insurance program for impoverished state residents. Heather D. Boonstra, *supra* note 8, at 12.. Until the ACA, each state decided the income eligibility ceiling that would qualify its residents to be able to enroll in Medicaid (the average was sixty-five percent of the Federal Poverty Line). *Id.* Since 1973, the federal portion of the Medicaid contribution has been restricted from financing abortion services except in the strictest circumstances described by the Hyde Amendment. *Id.* at 13. TRICARE is a military healthcare system that serves active duty military personnel, retired personnel and members of their families. *Id.* at 14. Enrollment data is not available, but the system is open to 212,000 women of reproductive age currently on active duty, as well as 1.6 million female veterans, eighty percent of whom are under the age of sixty-five. *Id.* Abortion funding for military personnel has been prohibited by the Department of Defense since 1979, except in cases where the life of the pregnant woman is in danger. *Id.* Performance of abortion procedures in military hospitals overseas has also been prohibited since 1997, regardless of the origin of payment, except in cases of rape, incest, or life endangerment. *Id.* The Federal Employees Health Benefits Package (FEHBP) covers federal employees and their dependents. The program has been barred from covering abortion services since 1983. *Id.* The exceptions under which coverage is allowed have changed from just the circumstance in which the life of the pregnant woman is in jeopardy to also including circumstances of rape and incest. *Id.* Prior to the ACA, Community Health Centers (CHC) had been prohibited from using federal funds by the Hyde Amendment, as they are recipients of a portion of the annually appropriated Labor—HHS funds. See *The Community Health Center Fund*, HEALTH & HUMAN SERVICES, http://motherjones.com/files/CHC_-_FINAL.pdf (last visited Apr. 12, 2012). The ACA establishes a new Community Health Center Fund within HHS, which provides additional federal funds for the CHC program. Affordable Care Act § 10503, 42 U.S.C. § 254b-2 (2010). The CHCs are prohibited from using federal dollars for providing abortion services both by Presidential Executive Order 13535, as well as long-standing regulations that will apply to newly allocated CHC funding. *The Community Health Center Fund*, HEALTH & HUMAN SERVS., http://motherjones.com/files/CHC_-_FINAL.pdf (last visited Apr. 11, 2012)

¹¹⁰ Willard Cates, Jr., *The Hyde Amendment in Action: How Did the Restriction of Federal Funds for Abortion Affect Low-Income Women?*, 246 J. AM. MED. ASSOC., 1109, 1109 (1981); Julie Rovner, *Abortion Funding Ban Has Evolved Over The Years*, NATIONAL PUBLIC RADIO (Dec. 14, 2009), <http://www.npr.org/templates/story/story.php?storyId=121402281>; see also Jeannie I. Rosoff, *The Hyde Amendment & the Future*, 12 FAM. PLANNING PERSP. 172, 172 (1980); Jacqueline Darroch Forrest et al., *Abortion in the United States, 1977-1978*, 11 FAM. PLANNING PERSP. 329, 340 (1979).

¹¹¹ Sarah Kliff, *The Hyde Amendment at 35: A New Abortion Divide*, EZRA KLEIN'S WONKBLOG (Oct. 2, 2011, 12:50 PM), http://www.washingtonpost.com/blogs/ezra-klein/post/the-hyde-amendment-at-35-a-new-abortion-divide/2011/10/02/gIQApQ6cFL_blog.html (“Unfortunately, this idea that there shouldn't be public insurance coverage for abortion got cemented in the public's mind,” says Jessica Arons, director of the women's health and rights program at the Center for American Progress. “Politicians have gotten used to saying that.”).

¹¹² The Hyde Amendment refers and applies to the funds appropriated by each Fiscal Year's Labor-HHS appropriations bill. It states: “None of the funds appropriated in *this act* . . .” (emphasis added). See Consolidated Appropriations Act, 2011, Div. D, tit. V, §§ 506–507..

¹¹³ See Rovner, *supra* note 110.

¹¹⁴ *Id.*; Cates, *supra* note 110, at 1109–1112.

¹¹⁵ See Consolidated Appropriations Act, 2011, Div. D, tit. V, §§ 506–507.

The original text of the Hyde Amendment restricted funding except in cases “where the life of the mother would be endangered if the fetus were carried to term” without exception for cases of rape or incest.¹¹⁶ The language of the Hyde Amendment fluctuated throughout the 1970s and 80s from the more restrictive, including only the life exception, to the “least” restrictive, permitting exceptions for circumstances of rape, incest, serious health condition of the woman, and life endangerment of the woman.¹¹⁷ In 1989, the list of exceptions that is in effect today was settled upon, and today permits federal funding of abortions performed due to rape, incest, or if pregnancy poses danger to the life of the pregnant woman.¹¹⁸

Pro-choice advocates have long sought to repeal the Hyde Amendment in order to secure access to legal abortion services for low-income women, federal employees, and women in the military.¹¹⁹ In the early 1990s, however, former President Bill Clinton included the repeal of Hyde as part of his campaign platform.¹²⁰ Simultaneously, pro-life advocates continue to seek restrictions on abortion beyond the Hyde Amendment.¹²¹

During the 2009 and 2010 health reform debates, the Hyde Amendment served as a benchmark for advocates on both sides of the abortion debate. Because the ACA allocates federal funds to a newly subsidized population, the question arose early in health reform whether those funds would also be subject to restrictions similar to Hyde. The current Hyde Amendment restrictions are reflected in Section 1303 of the ACA,¹²² and reiterated in President Obama’s Executive Order, both described below.

III. DIVERGENT ABORTION COVERAGE RESTRICTION PROPOSALS CONSIDERED IN THE HEALTH REFORM DEBATE

Three abortion coverage proposals received significant Congressional attention during the health reform debate leading to passage of the Affordable Care Act.¹²³ The proposals are

(b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State’s or locality’s contribution of Medicaid matching funds).

(c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State’s or locality’s contribution of Medicaid matching funds).

Id.

¹¹⁶ See Rovner, *supra* note 110.

¹¹⁷ See Cates, *supra* note 110, at 1109.

¹¹⁸ See Rovner, *supra* note 110.

¹¹⁹ NARAL PRO-CHOICE AMERICA, DISCRIMINATORY RESTRICTIONS ON ABORTION FUNDING THREATEN WOMEN’S HEALTH 1, 3 (2011), available at <http://www.naral.org/media/fact-sheets/abortion-funding-restrictions.pdf>.

¹²⁰ Robin Toner, *Clinton Would End Ban on Aid to Poor Seeking Abortions*, N.Y. TIMES, Mar. 30, 1993, <http://www.nytimes.com/1993/03/30/us/clinton-would-end-ban-on-aid-to-poor-seeking-abortions.html>.

¹²¹ See *History of the Federal Abortion Ban*, PLANNED PARENTHOOD ACTION CENTER, <http://www.plannedparenthoodaction.org/positions/history-federal-abortion-ban-637.htm> (last visited Apr. 8, 2012) (explaining Congressional attempts to ban partial birth abortion, vetoed twice under President Clinton, and finally signed into law under President Bush.)

¹²² Affordable Care Act § 1303, 42 U.S.C. § 18023 (2010).

¹²³ Although other proposals were introduced, the Capps, Stupak-Pitts, and Nelson Amendments were the

distinguishable based on the degree to which each would have maintained or increased federal restrictions on public and private funding of abortion coverage. None of the proposals would have decreased pre-health reform federal restrictions on abortion funding. Each proposal can be described based on its relationship to the current iteration of the Hyde Amendment.

Notably, a federal mandate for coverage of medically necessary abortions was deliberated during the failed Clinton health reform effort of the 1990s. The health reform plan proposed by President Clinton included a “Family Planning Services” category as part of the Comprehensive Benefits Package.¹²⁴ Although abortion coverage was not explicitly listed, the proposed legislation included “voluntary family planning services.”¹²⁵ Transcripts of Congressional hearings on the proposed plan indicate explicitly that the authors of the health care legislation understood and intended that the benefit would be part of the essential benefits package.¹²⁶ During the January 26, 1994 hearing before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce of the House of Representatives, Representative Henry Waxman (D-CA) stated that: “[t]he Clinton health care plan . . . does, of course, cover all reproductive health care services, including a woman’s right to plan her pregnancy and receive prenatal and postnatal services and to terminate her pregnancy.”¹²⁷ In addition, Clinton’s health plan extended religious and moral exemptions to providers and health care facilities, but not to health insurers or health insurance plans.¹²⁸

major proposals to receive Congressional consideration. Senators Hatch and Enzi also introduced seven amendments to restrict abortion access to a far greater degree than the Capps Amendment. The Enzi Amendments would have prohibited the federal government from mandating any coverage of abortion services, blocked the “assured variability” provision of the Capps Amendment, prohibited any federal funds to cover abortion services other than under Hyde, instilled heightened preemption and conscience protections, and required women to purchase separate “abortion riders” for coverage of abortion services. The Hatch amendments would have restored funding for abstinence education, prohibited funding authorized by the Senate proposal from being used for either elective abortions or for plans that cover such abortions, and included additional conscience protections. The pro-choice community did not support the Enzi/Hatch Amendments and threatened to withdraw support for the Senate proposal if those Amendments passed. Press Release, Center for Reprod. Rights, Amendments to Baucus Health Bill Unfairly Limit Abortion Coverage (Sept. 21, 2009), *available at* <http://reproductiverights.org/en/press-room/amendments-to-baucus-health-bill-unfairly-limit-abortion-coverage>. Section 5(e)(1) of the Capps Amendment proposed “assured variability,” which would have ensured that there existed within an exchange a plan that provided abortion coverage. *See* SUBCOMM. ON ENERGY & THE ENVIRONMENT OF THE H. COMM. ON ENERGY & COMMERCE 111TH CONG., Amendment to H.R. 3200 (offered by Lois Capps) (Comm. Print July 17, 2009) (Aug. 30, 2009, 4:32 PM), *available at* http://republicans.energycommerce.house.gov/Media/file/Markups/FullCmte/071709_Health_Reform/Capps.pdf.

¹²⁴ Health Security Act, S. 1757, 103rd Cong. § 1116 (1993) (“Family Planning Services and Services for Pregnant Women”). The services described in this section are the following items and services: (1) Voluntary family planning services; (2) Contraceptive devices that (A) may only be dispensed upon prescription; and (B) are subject to approval by the Secretary of Health and Human Services under the Federal Food, Drug, and Cosmetic Act; (3) Services for pregnant women.

¹²⁵ *Id.*

¹²⁶ *Women’s Healthcare in President’s Healthcare Plan: Hearing on S. 1757 Before the Subcomm. on Aging of the S. Comm. on Labor & Human Resources*, 103rd Cong., 103–109 (1994).

¹²⁷ *Health Care Reform Women’s Health: Hearing Before the Subcomm. on Health and the Environment of the H. Comm. on Energy and Commerce*, 103rd Cong. 1 (1994) (statement of Rep. Henry A. Waxman, Chairman, H. Subcomm. on Health and the Environment), *available at* <http://ia700309.us.archive.org/20/items/healthcarereform08unit/healthcarereform08unit.pdf>.

¹²⁸ Health Security Act, S. 1757, 103rd Cong. § 1162 (1993) (“A health professional or a health facility may not be required to provide an item or service in the comprehensive benefit package if the professional or facility objects to

The health reform debate of 2009—2010 yielded considerably different proposals and results.

A. *The Capps Amendment*

Introduced in the House of Representatives on July 30, 2009 by Representative Lois Capps (D-CA), the Capps proposal was viewed by some as the leading compromise offered by pro-choice Congressional leadership.¹²⁹ Briefly, the Capps proposal would have: (1) maintained Hyde restrictions; (2) prohibited mandatory coverage of abortion services in the newly defined essential health benefits package; (3) prohibited federal subsidies from being used to pay for any non-Hyde abortion services;¹³⁰ (4) required health plans to establish an actuarial system to ensure that federal subsidies would not be used to pay for non-Hyde abortions; (5) left in place federal “conscience clause” protections, specifying that no exchange-participating plan could discriminate against any health care provider or facility for its willingness or unwillingness to provide, pay for, or refer for abortions; and (6) guaranteed “assured variability” thereby requiring the exchanges to include at least one plan that covered abortion services beyond those permitted by Hyde.¹³¹ Pro-choice leaders considered the decision to leave the Hyde amendment intact a significant compromise.¹³²

Critics of the Capps proposal, however, quickly claimed its insurer-administered segregation requirements amounted to an “accounting gimmick”¹³³ and contended it would be an insufficient firewall to prevent federal funds from paying for abortions.¹³⁴ Objectors questioned the technical capacity of insurers to segregate public and private funds and instead preferred premiums for abortion and all other health coverage be separated by the consumers before payment to the insurer.¹³⁵ Then-Minority Leader John Boehner agreed with such objections. Boehner published an Op-Ed piece in the *National Review* under the headline “Taxpayer-Funded Abortion is Not Health-Care Reform” explicitly alleging, among other things, that the health reform bill with the Capps Amendment would require Americans “to subsidize abortion with their hard-earned tax dollars” and that “the House bill contains provisions that will result in federally mandated coverage of abortion on demand in virtually all of America’s health plans.”¹³⁶

doing so on the basis of a religious belief or moral conviction.”).

¹²⁹ See *The Truth About the Capps Amendment*, CONGRESSWOMAN LOIS CAPPS, <http://capps.house.gov/truth-about-capps-amendment> (last visited Mar. 23, 2012).

¹³⁰ “Non-Hyde abortion services” are those abortions provided in circumstances other than rape, incest or for the life of the pregnant woman.

¹³¹ SUBCOMM. ON ENERGY & THE ENVIRONMENT OF THE H. COMM. ON ENERGY & COMMERCE 111TH CONG., Amendment to H.R. 3200 (offered by Lois Capps) (Comm. Print July 17, 2009) (Aug. 30, 2009, 4:32 PM), http://republicans.energycommerce.house.gov/Media/file/Markups/FullCmte/071709_Health_Reform/Capps.pdf (adopted by subcommittee roll call vote of 30 “Yeas” and 28 “Nays”).

¹³² See, e.g., *The Truth About the Capps Amendment*, *supra* note 129.

¹³³ *Capps Amendment is a ‘Phony Compromise,’ Rep. Stupak says*, CATH. NEWS AGENCY (Aug. 3, 2009, 5:11 PM), http://www.catholicnewsagency.com/news/capps_amendment_is_a_phony_compromise_rep_stupak_says; Kathleen Gilbert, *Sen. Nelson: I Won’t Support a Health Bill Without Stupak Language*, LIFE SITE NEWS, Dec. 2, 2009, <http://www.lifesitenews.com/news/archive/ldn/2009/dec/09120201>.

¹³⁴ Alan Ota, *Democratic Split on Abortion is Obstacle to Health Bill*, CONG. Q. (2009).

¹³⁵ See *Capps Amendment is a ‘Phony Compromise,’ supra* note 133.

¹³⁶ John Boehner, *Taxpayer-Funded Abortion Is Not Health-Care Reform*, NAT’L REV. ONLINE (July 23,

Representative Capps responded to Boehner's mischaracterizations of her proposal in a letter to Boehner.¹³⁷

A group of pro-life Democrats, led by Representative Bart Stupak (D-MI), quickly claimed the ability to block passage of health reform should the bill not include language more restrictive of abortion than that of the Hyde Amendment.¹³⁸ In a public statement on February 23, 2010, Stupak reiterated his objection to the Capps proposal stating that "the Senate language allowing public funding of abortion . . . is a significant departure from current law and is unacceptable. While the President has laid out a health care proposal that brings us closer to resolving our differences, there is still work to be done before Congress can pass comprehensive health care reform."¹³⁹

B. *The Stupak-Pitts Amendment*

Galvanizing pro-life Democrats, Representative Stupak (D-MI) introduced the Stupak-Pitts Amendment to modify the health reform bill H.R. 3962 then pending in the House of

2009, 4:00 AM), <http://www.nationalreview.com/critical-condition/48614/taxpayer-funded-abortion-not-health-care-reform/john-boehner>.

¹³⁷ Press Release, Lois Capps, Capps Corrects Minority Leader Boehner's Inaccurate Statements on Common Ground Capps Amendment (Aug. 11, 2009), <http://capps.house.gov/press-release/capps-corrects-minority-leader-boehners-inaccurate-statements-common-ground-capps> (last visited Feb. 7, 2012). Representative Capps responded in a letter to Minority Leader Boehner, stating in relevant part, as follows:

I hope you merely misunderstood and did not intentionally misrepresent my amendment's impact when you said "it's going to be pretty clear to me that this will force every provider to have to provide abortions whether they want to or not." I would like to take this opportunity to correct your inaccurate statements about my amendment to the bill.

The amendment I offered preserves the status quo in abortion policy. Specifically to your point, no doctor or hospital or even insurance plan can be required to participate in providing or covering abortion services. No federal laws are weakened by my amendment regarding conscience protection or refusal to provide or pay for abortions.

. . .

Under my amendment, no federal funds may be used to pay for abortions that are not allowed by the Hyde Amendment, which, as you know, prohibits federal funding for abortions except in the case of rape, incest, or to protect the life of the woman. . . .

In addition, my amendment specifically prohibited abortion coverage as part of the essential benefits package. . . . Finally, no State laws are affected about abortion coverage, funding, procedural requirements, parental notification or consent. . . .

Id.

¹³⁸ Pete Winn, *Rep. Stupak: White Housing Pressuring Me to Keep Quiet on Abortion Language in Senate Health Bill*, CNSNEWS.COM, Dec. 22, 2009, <http://www.cnsnews.com/news/article/rep-stupak-white-house-pressuring-me-keep-quiet-abortion-language-senate-health-bill>.

¹³⁹ Laura Colarusso, *Stupak Criticizes Abortion Language in White House Health Care Proposal*, TPM LIVE WIRE, TALKING POINTS MEMO (Feb. 23, 2010, 2:27 PM), <http://tpmlivewire.talkingpointsmemo.com/2010/02/stupak-criticizes-abortion-language-in-white-house-health-care-proposal.php>. Contrary to the statement by then Rep. Stupak, at no time did a Senate proposal allow public funding of abortion. See S. COMM. ON FINANCE, 111TH CONG., CHAIRMAN'S MARK, AMERICA'S HEALTHY FUTURE ACT 25, available at <http://finance.senate.gov/issue/?id=32be19bd-491e-4192-812f-f65215c1ba65>.

Representatives.¹⁴⁰ The Stupak proposal included the most severe restrictions on abortion coverage of any proposal to receive Congressional consideration.¹⁴¹ After intense debate, the Stupak Amendment, which would have prohibited the coverage of abortion in exchanges nationwide, was adopted in the House version of the bill to amend H.R. 3962 and passed the House on November 7, 2009.¹⁴²

The Stupak-Pitts Amendment would have prohibited coverage of abortion in exchanges nationwide. It would have also barred federal subsidy of any health plan that covered abortion in cases other than rape, incest or for the life of the pregnant woman.¹⁴³ Specifically, under the Stupak Amendment, once an exchange-based health plan offered abortion coverage, the entire plan would be ineligible to receive any federal premium subsidies.¹⁴⁴ Analysts expected that over time, and in combination with the Hyde Amendment, the Stupak Amendment would erode coverage, on a widespread basis, for abortions in cases other than rape, incest or for the life of the pregnant woman.¹⁴⁵

Although the Stupak Amendment restricted coverage only within exchanges, its impact was predicted to reach markets outside exchanges. The regulatory frameworks established for exchanges are expected to have industry-wide influence by prompting outside exchange markets to mimic exchange structure.¹⁴⁶ As a result, some analysts predicted a “spillover” effect from the Stupak rules into non-exchange markets, with the likely result being complete erosion of abortion coverage nationwide.¹⁴⁷ In the end, Congressional pro-choice leadership was unwilling to support the restrictions in the Stupak Amendment.¹⁴⁸

¹⁴⁰ See Amendment to H.R. 3962, 111th Cong. (2009) (offered by Rep. Stupak and Rep. Pitts), 155 CONG. REC. H12,921 (Nov. 7, 2009), available at <http://documents.nytimes.com/the-stupak-amendment>.

¹⁴¹ See, e.g., SECRETARIAT OF PRO-LIFE ACTIVITIES, U. S. CONFERENCE OF CATHOLIC BISHOPS, WHAT DOES THE STUPAK AMENDMENT REALLY DO? (2009), available at <http://www.nrlc.org/AHC/USCCBwhatdoesStupakAmtdo.pdf>; KAISER FAMILY FOUND., SIDE-BY-SIDE COMPARISON OF MAJOR HEALTH CARE REFORM PROPOSALS 16–17 (2010), available at http://www.kff.org/healthreform/upload/housesenatebill_final.pdf; *Pro-lifers Praise, Pro-choicers Condemn Stupak Amendment*, THE HILL’S BLOG BRIEFING ROOM (Nov. 8, 2009, 5:33 PM), <http://thehill.com/blogs/blog-briefing-room/news/66891-pro-lifers-praise-pro-choicers-condemn-stupak-amendment>.

¹⁴² See *Final Vote Results for Roll Call 884*, CLERK.HOUSE.GOV (Nov. 7, 2009, 10:20 PM), <http://clerk.house.gov/evs/2009/roll884.xml> (reporting roll call vote on the Stupak-Pitts Amendment as 240 “Yeas” and 194 “Nays”).

¹⁴³ See ROSENBAUM ET AL., *supra* note 3 (analyzing the impact of the Stupak-Pitts Amendment on the availability of insurance coverage for abortion).

¹⁴⁴ See *id.*

¹⁴⁵ *Id.* at 12.

¹⁴⁶ *Id.* at 1.

¹⁴⁷ *Id.*

¹⁴⁸ See Press Release, Louise M. Slaughter & Diana DeGette, Joint Statement From Pro-Choice Caucus On Stupak-Pitts Vote (Nov. 8, 2009), http://degette.house.gov/index.php?option=com_content&view=article&id=877:joint-statement-from-pro-choice-caucus-on-stupak-pitts-vote&catid=76:press-releases-&Itemid=227 (last visited Apr. 12, 2012). U.S. Rep. Louise M. Slaughter of New York and U.S. Rep. Diana DeGette of Colorado, co-chairs of the Congressional Pro-Choice Caucus, issued a joint statement following the vote on the House floor on the Stupak-Pitts amendment to the health care reform bill:

Placing onerous new restrictions on a woman’s right to choose sets a terrible precedent and marks a significant step backwards. This effort will effectively ban abortion coverage in all plans, both private and public—marking a significant scaling back of the options offered under existing laws. Such a terrible, last minute amendment to a critical, historic piece of legislation is a shame. This

Ultimately, the Senate adopted the Nelson proposal, described in detail below, to replace all other proposed amendments. Because the Senate bill served as the foundation for the ACA, the Nelson Amendment became the law on abortion coverage under the ACA. Although apparently relieved that the Stupak proposal failed, the Congressional Pro-Choice Caucus objected to the shift from Capps to the more restrictive Nelson language¹⁴⁹ that also stands to impact the nationwide markets for abortion coverage as discussed herein.¹⁵⁰ The United States Conference of Catholic Bishops (USCCB), dissatisfied with the Nelson Amendment for its retreat from the Stupak proposal, continues to pursue restrictions consistent with the proposal.¹⁵¹

IV. SOURCES OF ABORTION COVERAGE RESTRICTIONS IN HEALTH REFORM: THE ACA, THE EXECUTIVE ORDER AND THE REGULATIONS

The ACA mandates that all states establish health insurance exchanges by January 1, 2014. The federal government will operate exchanges in states that fail to meet this deadline.¹⁵²

kind of outrageous interference in health care by the government marks a sad day in this struggle and will result in women across America losing the right to health care.

Id.

¹⁴⁹ Sarah Kliff, *The New Abortion Divide*, THE DAILY BEAST (Dec. 22, 2009, 7:00 PM), <http://www.thedailybeast.com/newsweek/2009/12/22/the-new-abortion-divide.html>.

When the Stupak amendment passed, there was common outrage among pro-choice organizations and their counterparts in Congress. But this time, it's different: while leaders of pro-choice groups call the Nelson language 'outrageous' and 'absurd,' a number of their strongest supporters in Congress are taking a nuanced stance: we don't love it, we don't even like it, but if this is what it takes to move forward with health-care reform, we will live with it.

¹⁵⁰ Press Release, Lois Capps, Rep. Capps Statement on the Senate Abortion Compromise (Dec. 19, 2009), available at <http://capps.house.gov/press-release/capps-statement-senate-abortion-compromise> ("I am pleased the Senate appears to be moving forward on health reform, however, I am disappointed that women's access to full reproductive health care is again paying the price.").

¹⁵¹ *Health Care Reform*, U.S. CONFERENCE OF CATHOLIC BISHOPS (Feb. 2011), <http://old.usccb.org/sdwp/national/Health-Care-backgrounder-2011%20final.pdf> (last visited Dec. 13, 2011) ("[T]he Catholic bishops opposed final passage because there is compelling evidence that it would expand the role of the federal government in funding and facilitating abortion and plans that cover abortion. . . . Additionally, the statute forces all those who choose federally subsidized plans that cover abortion to pay for other peoples' abortions with their own funds.").

¹⁵² 42 U.S.C. § 18041 (2010).

(b) STATE ACTION.—Each State that elects, at such time and in such manner as the Secretary may prescribe, to apply the requirements described in subsection (a) shall, not later than January 1, 2014, adopt and have in effect— (1) the Federal standards established under subsection (a);

or (2) a State law or regulation that the Secretary determines implements the standards within the State.

(c) FAILURE TO ESTABLISH EXCHANGE OR IMPLEMENT REQUIREMENTS.— (1) IN GENERAL.—If—(A) a State is not an electing State under subsection (b); or (B) the Secretary determines, on or before January 1, 2013, that an electing State—(i) will not have any required Exchange operational by January 1, 2014; or (ii) has not taken the actions the Secretary determines necessary to implement—(I) the other requirements set forth in the standards under subsection (a); or (II) the requirements set forth in subtitles A and C and the amendments made by such subtitles; the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate

Exchanges are marketplaces where individuals and small groups and, beginning in 2017, large groups, can purchase health insurance. Through an exchange, individuals can enroll in public health insurance programs, purchase coverage using federal subsidies, or purchase unsubsidized private health insurance.¹⁵³ Exchanges are designed to facilitate organized and competitive health insurance markets nationwide by standardizing rules for and pricing of insurance plans. Exchanges are also intended to improve competition in insurance markets by standardizing health insurance products and making plans easier to compare. Through an exchange, individuals can enroll in public health insurance programs, purchase coverage using federal subsidies, or purchase unsubsidized private health insurance.

The ACA also establishes federal subsidies for eligible individuals to purchase private health insurance beginning in 2014.¹⁵⁴ These individuals have incomes above the Medicaid-eligibility threshold but are, according to guidelines set in the legislation, unable to afford private health insurance without financial assistance.¹⁵⁵ Subsidy-eligible individuals must purchase a qualified health plan (QHP)¹⁵⁶ from an insurer offering coverage through an exchange.¹⁵⁷

As described below, exchanges are also the platform for new abortion coverage restrictions in the private health insurance market. The restrictions are found in four sources: Section 1303 of the ACA, Executive Order 13,535, the Pre-Regulatory Model Guidelines, and the Final Rule Regarding Establishment of Exchanges. Together, the ACA, regulations, and the Executive Order (from here referred to as “the abortion coverage restrictions” or “the restrictions”) establish the parameters for abortion coverage offerings in the exchanges.¹⁵⁸

such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.

Id.; see also ALAN DESMARAIS ET AL., MILLIMAN HEALTHCARE REFORM BRIEFING PAPER, OPERATION OF A HEALTH EXCHANGE WITHIN THE PPACA 1 (2010).

¹⁵³ See DESMARAIS ET AL., *supra* note 152, for more information about how health exchanges operate.

¹⁵⁴ Affordable Care Act § 1402, 42 U.S.C. § 18071 (2010) (“Reduced cost-sharing for individuals enrolled in qualified health plans”).

¹⁵⁵ *Id.*

¹⁵⁶ For purposes of this paper, the terms “QHP” and “exchange-based plan” are used interchangeably. Affordable Care Act § 1301, 42 U.S.C. § 18021 (2010).

‘[Q]ualified health plan’ means a health plan that—(A) has in effect a certification (which may include a seal or other indication of approval) that such plan meets the criteria for certification described in section 18031(c) of the title issued or recognized by each Exchange through which such plan is offered; (B) provides the essential health benefits package described in section 18022(a) of this title; and; (C) is offered by a health insurance issuer that- (i) is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage under this title; (ii) agrees to offer at least one qualified health plan in the silver level and at least one plan in the gold level in each such Exchange; (iii) agrees to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent; and (iv) complies with the regulations developed by the Secretary under section 18031(d) and such other requirements as an applicable Exchange may establish.

Id.

¹⁵⁷ Affordable Care Act § 1402, 42 U.S.C. § 18071 (2010).

¹⁵⁸ Affordable Care Act § 1303, 42 U.S.C. § 18023 (2010); see also DANIEL I. WERFEL, OFFICE OF MGMT. & BUDGET, EXEC. OFFICE OF THE PRESIDENT, & ELLEN MURRAY, DEP’T OF HEALTH & HUMAN SERVS., PRE-

A. *The ACA Abortion Coverage Restrictions*

Section 1303¹⁵⁹ of the ACA establishes special rules to govern exchange-based insurance coverage of abortion services. The ACA: (1) perpetuates pre-health reform prohibitions of federal funding restrictions for most abortions; (2) creates administrative requirements for QHPs that offer abortion coverage; (3) establishes a payment segregation scheme for individuals who purchase abortion coverage offered as part of an exchange-based plan; and (4) institutes compliance and enforcement duties for State health insurance commissioners.¹⁶⁰

These restrictions appear to reinforce coverage disparities between federally subsidized and unsubsidized individuals to the extent they do not apply to unsubsidized populations. The majority of unsubsidized enrollees purchasing coverage outside of exchanges may maintain coverage for abortion services without comparable limitations or administrative requirements faced by subsidized individuals.¹⁶¹

Section 1303 of the ACA incorporates and bases new coverage limitations on the language used in the Hyde amendment.¹⁶² The ACA does not explicitly mention the Hyde Amendment or its exceptions. Rather, Section 1303 categorizes two types of circumstances in which women seek abortion services, one for which federal funding is allowable and the second for which federal funding is prohibited. The two categories are defined based on the appropriations law that is in “effect as of the date that is 6 months before the beginning of the plan year involved.”¹⁶³ Thus, if the Hyde Amendment is not in effect, its restrictions would not apply.

If the Hyde Amendment is in effect six months before the beginning of a plan year, the ACA applies Hyde’s categorization of abortion services, “Abortions for which public funding is allowed” and “Abortions for which public funding is prohibited.”¹⁶⁴ Using Hyde Amendment definitions, the first category identified in Section 1303, “Abortions for which public funding is allowed” refers to circumstances in which the pregnancy is the result of rape or incest or if the

REGULATORY MODEL GUIDELINES UNDER SECTION 1303 OF THE AFFORDABLE CARE ACT (2010), *available at* http://www.whitehouse.gov/sites/default/files/omb/assets/financial_pdf/segregation_2010-09-20.pdf; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866, 41866, 41903 (Dep’t. of Health & Human Servs. proposed July 15, 2011), *available at* <http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf>; Exec. Order No. 13,535, 75 Fed. Reg. 15,599 (Mar. 24, 2010) [hereinafter Exec. Order No. 13,535], *available at* <http://www.whitehouse.gov/the-press-office/2010/03/24/13535>.

¹⁵⁹ Affordable Care Act § 1303, 42 U.S.C. § 18023 (2010). The article use section numbers from the bill-as-adopted which are commonly used by scholars.

¹⁶⁰ *Id.*

¹⁶¹ *See Memo on Insurance Coverage of Abortion*, GUTTMACHER INST., *supra* note 69.

¹⁶² *See* Affordable Care Act § 1303, 42 U.S.C. § 18023(b)(1)(B)(i)–(ii) (2010).

¹⁶³ *Id.*

¹⁶⁴ *Id.*

Abortion services—(i) Abortions for which public funding is prohibited—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved. (ii) Abortions for which public funding is allowed—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

Id.

woman's life is endangered unless an abortion is performed.¹⁶⁵ The second category identified in Section 1303 "Abortions for which public funding is prohibited" includes, under Hyde, abortions in all other circumstances, such as abortion for the health of the pregnant woman.¹⁶⁶

Thus, QHPs may cover abortion services using federal funds where the pregnancy is a result of rape or incest or if the abortion is necessary for the life of the pregnant woman.¹⁶⁷

The ACA neither prohibits QHPs from including abortion coverage nor requires them to offer coverage.¹⁶⁸ The ACA states that insurance providers in the exchange may offer plans that cover comprehensive abortion services, provided the state in which they operate has not banned such coverage.¹⁶⁹ Indeed, ACA section 1301¹⁷⁰ explicitly grants states the option to ban abortion

¹⁶⁵ See Consolidated Appropriations Act of 2012, Div. D, tit. V, §§ 506(a)–(b), 507(a) Pub. L. No. 112-74 (2012).

Sec. 506. (a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion. (b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion. Sec. 507. (a) The limitations established in the preceding section shall not apply to an abortion—(1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

Id.

¹⁶⁶ See *Doe v. Bolton*, 410 U.S. 179, 207 (1973) (referring in a companion case to *Roe v. Wade* to nonconsensual pregnancies as "those resulting from rape and incest."); TED G. JELEN, PERSPECTIVES ON THE POLITICS OF ABORTION 27 (1995).

The Court transformed the cultural presumption that pregnancy is caused by sex into a 'rape and incest exceptions' doctrine. According to this rule, a woman's right to terminate a pregnancy is based on the context of sexual intercourse that preceded the pregnancy. If a woman did not consent to sexual intercourse, as in the contexts of rape or incest, the Court is willing to acknowledge that she should not be forced to continue her pregnancy and even takes seriously arguments that she should be entitled to State funding for an abortion.

Id.

¹⁶⁷ Affordable Care Act § 1303(b)(1)(B)(ii), 42 U.S.C § 18023(b)(1)(B)(ii) (2010) ("Abortions for which public funding is allowed—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved").

¹⁶⁸ Affordable Care Act § 1303(b)(1), 42 U.S.C § 18023(b)(1) (2010).

Voluntary choice of coverage of abortion services—In general—Notwithstanding any other provision of this title (or any amendment made by this title)—Nothing in this title (or any amendment made by this title), shall be construed to require a qualified health plan to provide coverage of services described in subparagraph (B)(i). . . ."

Id.

¹⁶⁹ Affordable Care Act § 1303(c)(1), 42 U.S.C. §18023 (2010) ("Nothing in this Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions. . . .").

¹⁷⁰ Affordable Care Act § 1301, 42 U.S.C § 18021 (2010).

coverage within the exchange¹⁷¹ and sixteen states have done so.¹⁷² Six of those sixteen states have also already banned abortion coverage outside the exchange as well.¹⁷³ The ACA explicitly notes state authority to repeal an abortion coverage ban after it is passed.¹⁷⁴

Section 1303 sets forth the rules insurers, consumers, and regulators must follow if an exchange-based plan offers abortion coverage.¹⁷⁵ Among other things, Section 1303 requires enrollees who choose coverage that includes abortion care to submit segregated payments—referred to as the “two check” requirement. Insurers must separately price the abortion benefit, segregate payments, and establish allocation accounts. The law also directs state insurance regulators to ensure that health plans are in compliance with the segregation requirements.¹⁷⁶

Specifically, Section 1303 of the Affordable Care Act establishes the following parameters:

1. Segregated Premium Collection

QHPs that offer abortion coverage beyond cases for which federal funding is allowed must collect two separate premium payments from each enrollee.¹⁷⁷ The first payment is the amount equal to the actuarial value¹⁷⁸ of abortion care services in circumstances other than rape,

¹⁷¹ Affordable Care Act § 1303(a)(1), 42 U.S.C. § 18023(a)(1) (2010) (“In general—A State may elect to prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law to provide for such prohibition.”).

¹⁷² GUTTMACHER INST., RESTRICTING INSURANCE COVERAGE OF ABORTION, *supra* note 93.

¹⁷³ See *infra* notes 245–94 and accompanying text.

¹⁷⁴ Affordable Care Act § 1303(a)(2), 42 U.S.C. § 18023(a)(2) (2010) (“Termination of opt out—A State may repeal a law described in paragraph (1) [see note 6] and provide for the offering of such services through the Exchange.”).

¹⁷⁵ Any reference to “abortion coverage” or “abortion care” assumes that such coverage or care extends to all legal abortion care, without limitation to circumstances of rape, incest or life of the pregnant woman.

¹⁷⁶ Affordable Care Act § 1303(b)(2), 42 U.S.C. § 18023(b)(2) (2010).

¹⁷⁷ Affordable Care Act § 1303(b)(2)(B)(i), 42 U.S.C. § 18023(b)(2)(B)(i) (2010).

¹⁷⁸ Affordable Care Act § 1303(b)(2)(D), 42 U.S.C. § 18023(b)(2)(D) (2010).

(D) ACTUARIAL VALUE.—(i) IN GENERAL.—The issuer of a qualified health plan shall estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under a qualified health plan of the services described in paragraph (1)(B)(i). (ii) CONSIDERATIONS—In making such estimate, the issuer— (I) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care; (II) shall estimate such costs as if such coverage were included for the entire population covered; and (III) may not estimate such a cost at less than \$1 per enrollee, per month.

Id. See *Glossary*, HEALTHCARE.GOV, <http://www.healthcare.gov/glossary/a/actuarial.html> (last visited Sept. 26, 2011), for a definition of actuarial value:

The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of seventy percent, on average, you would be responsible for thirty percent of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.

incest, or for the life of the pregnant woman.¹⁷⁹ The second payment is for the portion of the premium that is attributable to all other covered health care services.¹⁸⁰ Presumably, the second payment includes a premium to cover abortion services in cases of rape, incest and the life of the pregnant woman. Both payments are exclusive of federal subsidy contributions made on behalf of any enrollee in the form of credits and cost sharing.¹⁸¹

Plans are required to collect segregated premiums from each enrollee purchasing coverage through an exchange. Payments are to be collected on a segregated basis irrespective of age, sex, or family status.¹⁸² Segregation requirements also apply to employee payroll deposits: if an individual makes insurance payments using payroll deposit, or if an employer submits premium payments on behalf of an employee, two separate payments are required.¹⁸³

2. Separate Accounts

Issuers of QHPs must establish “allocation” (separate) accounts for the purposes of receiving premiums and paying claims for abortion services.¹⁸⁴ Into one account the plan must deposit payments from subsidized enrollees¹⁸⁵ to be used for all covered health services including abortions only in the cases of rape, incest, or life of the pregnant woman.¹⁸⁶ Into the other account, the plan must deposit premium payments from subsidized enrollees to be used for abortion services in cases other than rape, incest, or life of the pregnant woman (“excluded abortions”).¹⁸⁷ The administrative feasibility for insurers to price premiums for or reimburse

¹⁷⁹ Affordable Care Act § 1303(b)(2)(B)(i)(II), 42 U.S.C. § 18023(b)(2)(B)(i)(II) (2010).

¹⁸⁰ Affordable Care Act § 1303 (b)(2)(B)(i)(I), 42 U.S.C. § 18023(b)(2)(B)(i)(I) (2010).

¹⁸¹ Affordable Care Act § 1303 (b)(2)(C)(i), 42 U.S.C. § 18023(b)(2)(C)(i) (2010).

(C) Segregation of funds—(i) In general—The issuer of a plan to which subparagraph (A) applies shall establish allocation accounts described in clause (ii) for enrollees receiving amounts described in subparagraph (A). (ii) Allocation accounts—The issuer of a plan to which subparagraph (A) applies shall deposit—(I) all payments described in subparagraph (B)(i)(I) into a separate account that consists solely of such payments and that is used exclusively to pay for services other than services described in paragraph (1)(B)(i); and (II) all payments described in subparagraph (B)(i)(II) into a separate account that consists solely of such payments and that is used exclusively to pay for services described in paragraph (1)(B)(i).

Id.

¹⁸² Affordable Care Act § 1303(b)(2)(B)(i), 42 U.S.C. § 18023(b)(2)(B)(i) (2010).

¹⁸³ Affordable Care Act § 1303(b)(2)(B)(ii), 42 U.S.C. § 18023(b)(2)(B)(ii) (2010).

¹⁸⁴ Affordable Care Act § 1303(b)(2)(C)(ii), 42 U.S.C. § 18023(b)(2)(C)(ii) (2010).

Allocation accounts—The issuer of a plan to which subparagraph (A) applies shall deposit—(I) all payments described in subparagraph (B)(i)(I) into a separate account that consists solely of such payments and that is used exclusively to pay for services other than services described in paragraph (1)(B)(i); and (II) all payments described in subparagraph (B)(i)(II) into a separate account that consists solely of such payments and that is used exclusively to pay for services described in paragraph (1)(B)(i).

Id.

¹⁸⁵ The ACA does not specify an accounting structure for the segregated premiums collected from unsubsidized enrollees.

¹⁸⁶ Affordable Care Act § 1303(b)(2)(C)(ii)(I), 42 U.S.C. § 18023(b)(2)(C)(ii)(I) (2010).

¹⁸⁷ Affordable Care Act § 1303(b)(2)(C)(ii)(II), 42 U.S.C. § 18023(b)(2)(C)(ii)(II) (2010) (. . . into a

abortion services by circumstances¹⁸⁸ of pregnancy is presumed but may prove problematic.

Indeed, the number of allocation accounts that are needed to meet legislative requirements is not specified in the ACA. Because two categories of enrollees (those subsidized and those unsubsidized) will purchase coverage from exchanges, there could be up to five accounts needed to meet segregation requirements for each insurance plan: one account for federal tax credit subsidies for subsidized individuals; a second for private payments made by subsidized individuals; a third for private payments for abortion coverage for subsidized individuals; a fourth account for premiums for unsubsidized individuals; and a fifth account for payments for abortion coverage for unsubsidized individuals. Current guidance does not specify whether the segregated accounts are to be managed by their respective insurance carrier, or be pooled into one exchange fund. Regulators will need to consider pool stability when making risk pooling decisions.

3. Abortion Benefit Pricing

In order to establish the premium for an abortion benefit, insurers must estimate the per enrollee monthly actuarial average cost of excluded abortions.¹⁸⁹ Under the ACA, when performing this calculation, insurers may consider the impact on overall costs of including the abortion benefit, but may not take into account any potential cost savings resulting from pregnancy termination—namely costs avoided for pre- or post-natal care, and delivery.¹⁹⁰

The ACA establishes that the premium for abortion services must not be less than \$1 per member per month, even if the estimate is determined to be less than this amount.¹⁹¹ The source and intent of the \$1 minimum price is unknown. If a segregated abortion benefit is to be viable, the segregated pool must maintain enough funds to pay out claims. Until the segregated premium pool for the abortion benefit is stabilized, \$1 per member per month appears a reasonable initial price in order to sustain the estimated costs described below and to satisfy the minimum pricing requirement set forth by the ACA. The legislation does not address the potential for excess funds in the segregated accounts. In order to ensure adequate reserves for claims and support possible

separate account that consists solely of such payments and that is used exclusively to pay for services described in paragraph (1)(B)(i)).

¹⁸⁸ These circumstances include if pregnancy was a result of rape or incest or if termination is needed to save the life of the pregnant woman.

¹⁸⁹ Affordable Care Act § 1303(b)(2)(D), 42 U.S.C. § 18023(b)(2)(D) (2010).

Actuarial value—(i) In general—The issuer of a qualified health plan shall estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under the qualified health plan of the services described in paragraph (1)(B)(i). (ii) Considerations—In making such estimate, the issuer—(I) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care; (II) shall estimate such costs as if such coverage were included for the entire population covered; and (III) may not estimate such a cost at less than \$1 per enrollee, per month.

Id.

¹⁹⁰ Affordable Care Act § 1303(b)(2)(D)(ii)(I), 42 U.S.C. § 18023(b)(2)(D)(ii)(I) (2010).

¹⁹¹ Affordable Care Act § 1303(b)(2)(D)(ii)(III), 42 U.S.C. § 18023(b)(2)(D)(ii)(III) (2010). The premium estimates calculated in this Article did in fact yield estimates lower than \$1. See *infra* Section VIII (“Payment Mechanisms”).

coverage expansion, excess funds could remain in the segregated accounts.

Under the ACA, the premium for an abortion benefit is to be calculated as if the entire covered population, regardless of gender, selects the coverage.¹⁹² “Covered population” is not defined in the legislation and could be interpreted to mean only the pool of enrollees in one or multiple plan(s) that include(s) abortion coverage, or a broader pool of enrollees in plans within the exchange without abortion coverage. The legislation is silent, but presumably an insurer could, for ease of administration, charge one price for *all* abortion coverage without categorizing coverage by circumstance (e.g. carriers could price all abortions together rather than generate separate prices for abortions in the event of rape, incest or for the life of the pregnant woman and another price for all other abortions). Between 4 and 13.5% of abortions are performed annually for reasons of rape, incest or life of the pregnant woman.¹⁹³ Because so few abortions are performed for these reasons, the cost of adding coverage for abortion in these circumstances to coverage for abortion in other circumstances would likely be *de minimis*.

To be sure, the rate of benefit uptake has a significant effect on the pricing range of the benefit. As the pool of individuals with normal risk profile grows, the price of a benefit usually decreases.¹⁹⁴ If too few people purchase the plan that includes abortion coverage then the viability of the benefit could be undermined. Overpricing the benefit could lead to artificially low take up because some consumers would refuse abortion coverage due to an exaggeratedly high premium. Although the \$1 statutory minimum price may be higher than the actual price of the benefit, the difference between the two is small and may be without significant effect. Section VIII below provides an example using New York State data for how an abortion benefit might be priced.

4. Coverage Information for Enrollees

QHPs are required to provide notice of coverage for abortion services to enrollees at the time of enrollment “only as part of the summary of benefits and coverage explanation.”¹⁹⁵ Any advertising used by the issuer with respect to the plan and any other related plan information required by the “Secretary of HHS shall refer only to the total amount of the combined payments

¹⁹² Affordable Care Act § 1303(b)(2)(D)(ii)(II), 42 U.S.C. § 18023(b)(2)(D)(ii)(II) (2010); *see also* WERFEL & MURRAY, *supra* note 158.

¹⁹³ Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 PERSP. ON SEXUAL & REPROD. HEALTH 110, 112–14 (2005).

¹⁹⁴ Willard G. Manning & M. Susan Marquis, *Health Insurance: The Tradeoff Between Risk Pooling and Moral Hazard*, 15 J. HEALTH ECON. 609, 610 (1996).

¹⁹⁵ Affordable Care Act § 1303(b)(3), 42 U.S.C. § 18023(b)(3) (2010).

Rules relating to notice—(A) Notice—A qualified health plan that provides for coverage of the services described in paragraph (1)(B)(i) shall provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage. (B) Rules relating to payments—The notice described in subparagraph (A), any advertising used by the issuer with respect to the plan, any information provided by the Exchange, and any other information specified by the Secretary shall provide information only with respect to the total amount of the combined payments for services described in paragraph (1)(B)(i) and other services covered by the plan.

Id.

for all services covered by the plan.”¹⁹⁶ It is unclear how these restrictions will be reconciled with coverage disclosure and transparency requirements elsewhere in the legislation.

5. Non-discrimination Protection for Refusal to Provide Abortion Services

Section 1303 mandates that QHPs not discriminate against “any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions.”¹⁹⁷ However, the Act does not contain equivalent protection from discrimination for providers or facilities based on their willingness to provide abortion services.

6. Preemption

Section 1303 specifies that the ACA does not preempt state laws that either prohibit or require coverage or funding of abortion.¹⁹⁸ As discussed in Section VI(A), sixteen states currently prohibit coverage of abortion. No state currently requires abortion coverage in private health insurance policies, although Washington State recently considered such a requirement.¹⁹⁹ The ACA also does not preempt state-level procedural requirements for abortions including parental notification or parental consent requirements.²⁰⁰ In addition to the non-discrimination protections, Section 1303 also states that the Act does not preempt any federal laws regarding willingness or refusal to provide abortions, or discrimination on the basis of willingness or refusal to provide, pay for, cover, refer for abortion, or to provide or participate in training providers.²⁰¹

¹⁹⁶ Affordable Care Act § 1303(b)(3)(B), 42 U.S.C. § 18023(b)(3)(B) (2010).

¹⁹⁷ Affordable Care Act § 1303(b)(4), 42 U.S.C. § 18023(b)(4) (2010).

¹⁹⁸ Affordable Care Act § 1303(c)(1), 42 U.S.C. § 18023(c)(1) (2010).

¹⁹⁹ See *infra* notes 267–71 and accompanying text.

²⁰⁰ Affordable Care Act § 1303(c)(2)(A), 42 U.S.C. § 18023(c)(2)(A) (2010); see also GUTTMACHER INST., STATE POLICIES IN BRIEF: AN OVERVIEW OF ABORTION LAWS (2012), available at http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf (“37 states require some type of parental involvement in a minor’s decision to have an abortion. 22 states require one or both parents to consent to the procedure, while 11 require that one or both parents be notified and 4 states require both parental consent and notification.”).

²⁰¹ Affordable Care Act § 1303(b)(4), 42 U.S.C. § 18023(b)(4) (2010) (“No discrimination on basis of provision of abortion—No qualified health plan offered through an Exchange may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions.”); see also Randolph Pate, *Protection of Health Care Providers’ Right of Conscience: What Federal Law Says*, HERITAGE FOUND. (Apr. 7, 2009), <http://www.heritage.org/research/reports/2009/04/protection-of-health-care-providers-right-of-conscience-what-federal-law-says> (last visited Apr. 12, 2012). There are three health care conscience protection laws: The Weldon Amendment, first adopted in 2004 as part of the annual Labor-HHS appropriations bill, prohibits governmental bodies from discriminating against a broad set of healthcare entities that do not want to cover, provide, or refer for abortions; Public Health Service Act Section 245 prohibits governmental bodies from discriminating against healthcare providers and institutions on the basis of their refusal to train, require or provide training in, provide referrals for, perform, or make arrangements of any kind for, abortions; The Church Amendments provide broad protections for individuals who refuse to participate in abortions or sterilizations, prohibits courts and public officials from requiring recipients of grants under certain federal programs from being involved in abortions or sterilizations, and protects individuals participating in federally-funded research if they want to refuse to participate in research they morally object to. *Id.*

7. Emergency Services and Federal Civil Rights Laws

Section 1303 explicitly maintains current requirements for health care providers regarding the provision of emergency services under state or federal law including EMTALA.²⁰²

8. Multi-State Plans

Section 1334 directs the Office of Personnel Management (OPM) to contract with insurers to offer at least two multi-state plans in each exchange and requires that at least one of the plans exclude coverage for abortion services for which public funding is prohibited.²⁰³ No comparable rule requires OPM to ensure that a plan is offered that does cover abortion.

9. One-sided Protections

Notably, several provisions of the ACA explicitly protect rights and privileges of individuals and entities that refuse to provide abortions, yet do not extend equivalent protections to individuals and entities that seek to cover, provide, or refer for abortions. For instance, the non-discrimination protections apply only to “individual health care provider[s] or health care facilit[ies] because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions.”²⁰⁴ The ACA does not provide comparable non-discrimination protection for health care providers or health care facilities that provide, pay for, provide coverage of, or refer for abortions. Similarly, the requirement that multi-state plans include at least one plan that does not offer abortion coverage does not provide a corresponding requirement for inclusion of at least one plan that does offer abortion coverage.²⁰⁵

B. *The Executive Order*²⁰⁶

On March 24, 2010, one day after signing the ACA into law, President Obama issued Executive Order 13535 entitled “Ensuring Enforcement and Implementation of Abortion

²⁰² *Contra id.* But see Affordable Care Act § 1303(c)(4), 42 U.S.C. § 18023(c)(4) (2010).

²⁰³ Affordable Care Act § 10104, 42 U.S.C. § 18054 (2010).

Multi-state plans—(1) In general—The Director of the Office of Personnel Management (referred to in this section as the “Director”) shall enter into contracts with health insurance issuers (which may include a group of health insurance issuers affiliated either by common ownership and control or by the common use of a nationally licensed service mark), without regard to section 5 of title 41, United States Code, or other statutes requiring competitive bidding, to offer at least 2 multi-State qualified health plans through each Exchange in each State. Such plans shall provide individual, or in the case of small employers, group coverage. . . .

(6) Assured availability of varied coverage—In entering into contracts under this subsection, the Director shall ensure that with respect to multi-State qualified health plans offered in an Exchange, there is at least one such plan that does not provide coverage of services described in section 18023 (b)(1)(B)(i) of this title.

Id.

²⁰⁴ Affordable Care Act § 1303(b)(4), 42 U.S.C. § 18023(b)(4) (2010).

²⁰⁵ *Id.*

²⁰⁶ Exec. Order No. 13,535, *supra* note 158.

Restrictions in the Patient Protection and Affordable Care Act.”²⁰⁷ The President stated that “[f]ollowing the recent enactment of the Patient Protection and Affordable Care Act (“the Act”), it is necessary to establish an adequate enforcement mechanism to ensure that Federal funds are not used for abortion services (except in cases of rape or incest, or when the life of the woman would be endangered), consistent with a longstanding Federal statutory restriction that is commonly known as the Hyde amendment.”²⁰⁸ The Executive Order declared its purpose to “establish a comprehensive, Government-wide set of policies and procedures to achieve this goal and to make certain that all relevant actors . . . are aware of their responsibilities”²⁰⁹ The Order sought to make all “relevant actors” including federal and state officials, as well as health care providers, aware of their responsibilities via the abortion coverage restrictions in the ACA.²¹⁰

Specifically, the order required the Director of the Office of Management and Budget (OMB) and Secretary of Health and Human Services (HHS) to develop “model segregation guidelines” within 180 days.²¹¹ As required, HHS and OMB issued pre-regulatory model guidelines on September 20, 2010.²¹² Following completion of the guidelines, and as required by the Executive Order, the Secretary of HHS initiated a rulemaking to issue regulations.²¹³ The final rule, discussed more fully below, was open for public comment until September 28, 2011.²¹⁴ State Insurance Commissioners will use these guidelines to determine plan compliance with funding restrictions, audit criteria, and incorporated accounting principles.²¹⁵

²⁰⁷ *Id.* An Executive Order is a directive issued by the President and allows the executive branch to enact laws or amend policy without needing approval from either the judicial or legislative branch. See Kenneth R. Mayer, *Executive Order and Presidential Power*, 61 J. POL. 445, 445 (May 1999); see also VANESSA K. BURROWS, CONG. RESEARCH SERV., EXECUTIVE ORDERS: ISSUANCE AND REVOCATION 1 (2010), available at http://assets.opencrs.com/rpts/RS20846_20100325.pdf.

²⁰⁸ Exec. Order No. 13,535, *supra* note 158.

²⁰⁹ *Id.*; see also KENNETH R. MAYER, WITH THE STROKE OF A PEN: EXECUTIVE ORDERS AND PRESIDENTIAL POWER 4 (2001) (“Executive orders are, loosely speaking, presidential directives that require or authorize some action within the executive branch (though they often extend far beyond the government). They are presidential edicts, legal instruments that create or modify laws, procedures, and policy by fiat.”). In addition, the Executive Order states that:

The Act maintains current Hyde Amendment restrictions governing abortion policy and extends those restrictions to the newly created health insurance exchanges. Under the Act, longstanding Federal laws to protect conscience (such as the Church Amendment, 42 U.S.C. § 300a-7, and the Weldon Amendment, section 508(d)(1) of Public Law 111-8) remain intact and new protections prohibit discrimination against health care facilities and health care providers because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.

Exec. Order No. 13,535, *supra* note 158.

²¹⁰ Exec. Order No. 13,535, *supra* note 158.

²¹¹ *Id.*

²¹² See WERFEL & MURRAY, *supra* note 158.

²¹³ *Id.*

²¹⁴ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310 (Mar. 27, 2012) (to be codified at 45 C.F.R. pts. 155, 156, & 157).

²¹⁵ Exec. Order No. 13,535, *supra* note 158. The Order suggests that multiple agencies are obligated to enforce the abortion restrictions set forth in the ACA, including but not limited to HHS, OMB, the Office of Personnel Management, the Department of the Treasury and the Government Accountability Office. To fulfill their obligations under the ACA, each of these agencies will need to be in continued communication with state insurance commissioners. *Id.*

Although the Executive Order effectively affirmed the abortion restrictions in the ACA,²¹⁶ some suggested that the Executive Order served to appease pro-life advocates and assure final passage of the ACA.²¹⁷ Despite such suggestions, public statements from some members of the pro-life community expressed continued dissatisfaction with the Executive Order and the restrictions set forth in the ACA as not being restrictive enough.²¹⁸

In addition to maintaining current restrictions, the Executive Order pronounces the continued applicability of federal conscience clause laws including the Church and the Weldon Amendments.²¹⁹ The Order also restates the ACA's requirement for payment and accounting practices to ensure the prohibition of the use of tax credits and cost-sharing reduction payments to pay for abortion services (except in cases of rape, incest or when the life of the woman would be endangered) within exchanges.²²⁰

²¹⁶ Dan Pfeiffer, *One More Step Towards Health Insurance Reform*, THE WHITE HOUSE BLOG (March 21, 2010, 04:16 PM), <http://www.whitehouse.gov/blog/2010/03/21/one-more-step-towards-health-insurance-reform>.

While the legislation as written maintains current law, the executive order provides additional safeguards to ensure that the status quo is upheld and enforced, and that the health care legislation's restrictions against the public funding of abortions cannot be circumvented. The President has said from the start that this health insurance reform should not be the forum to upset longstanding precedent. The health care legislation and this executive order are consistent with this principle.

Id.

²¹⁷ *Obama Signs Executive Order on Abortion Funding Limits*, CNN (Mar. 24, 2010), http://articles.cnn.com/2010-03-24/politics/obama.abortion_1_offer-abortions-abortion-funding-abortion-opponents?_s=PM:POLITICS (last visited Apr. 12, 2012); Patricia Zengerle, *Obama signs order on abortion and healthcare*, REUTERS (Mar. 24, 2010, 06:00 PM), <http://www.reuters.com/article/2010/03/24/us-usa-healthcare-obama-idUSTRE62N61Y20100324>. Terry O'Neill, president of the National Organization for Women, expressed that the order fell short and was incensed by the fact that such action was taken to "appease a handful of anti-choice Democrats who have held up health care reform in an effort to restrict women's access to abortion." Press Release, National Organization for Women, Statement of NOW President Terry O'Neill: Health Care Reform Victory Comes with Tragic Setback for Women's Rights (Mar. 21, 2010), available at <http://www.now.org/press/03-10/03-21b.html>.

²¹⁸ Memorandum from the U.S. Conference of Catholic Bishops Office of the Gen. Counsel on Legal Analysis of The Provisions of The Patient Protection and Affordable Care Act and Corresponding Executive Order Regarding Abortion Funding and Conscience Protection (Mar. 25, 2010), available at <http://old.usccb.org/ogc/Healthcare-EO-Memo.pdf>.

There are two parts to the Hyde Amendment. . . . The first says no appropriated federal funds can be used for elective abortions. . . . The second says no such funds can be used to pay for health insurance coverage that includes such abortions. . . . PPACA violates both parts of this policy, and the Executive Order does not rectify those violations.

Id.

²¹⁹ Exec. Order No. 13,535, *supra* note 158.

The Act maintains current Hyde Amendment restrictions governing abortion policy and extends those restrictions to the newly created health insurance exchanges. Under the Act, longstanding Federal laws to protect conscience (such as the Church Amendment, 42 U.S.C. 300a-7, and the Weldon Amendment, section 508(d)(1) of Public Law 111-8) remain intact and new protections prohibit discrimination against health care facilities and health care providers because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.

Id.

²²⁰ *Id.*

Another component of the Executive Order relates to the additional Federal resources allocated by the ACA to the Community Health Centers (CHC) Fund.²²¹ Under current law, CHCs are prohibited from using federal funds for abortion in circumstances other than rape, incest or preserving the life of the woman.²²² The Executive Order reiterates this point.

C. *The Pre-Regulatory Model Guidelines*

On September 20, 2010, the Department of Health and Human Services and the Office of Management and Budget issued a set of model guidelines for state insurance regulators.²²³ The guidelines reiterate definitions related to abortion provided in the ACA, the rules for establishing allocation accounts, fund segregation, actuarial value calculation, and advertising to enrollees, provide new guidance on how insurers are to account for payments and costs, and outline the role of state insurance commissioners.²²⁴ In essence, the guidelines only provide new information with respect to accounting and methods for compliance standards. Although the guidelines provide some insight regarding implementation of the restrictions, many unanswered questions are expected to be clarified in the final rule. The accounting guidelines and obligations for state regulators included in the model guidelines are described below.

1. Accounting Guidelines for Insurance Carriers

Qualified health plans that provide coverage for abortion for which public funding is prohibited must comply with specific administrative and accounting requirements as well as maintain a strict system of internal controls outlined in the ACA and in the model guidelines.²²⁵ As a condition of participation in an exchange, insurers must submit a “segregation plan” to the state health insurance commissioner in the state where the coverage is sold.²²⁶ The plan must detail the process and methodology for meeting fund segregation requirements required by legislation.²²⁷ The segregation plan must also include a description of the health plan’s “financial accounting systems, including appropriate accounting documentation and internal controls,” and an explanation of how the plan meets segregation requirements for both premiums and reimbursements.²²⁸ Section VIII below reviews options for states with respect to segregation planning.

²²¹ *Id.* (“Community Health Center Program. The Act establishes a new Community Health Center (CHC) Fund within HHS, which provides additional Federal funds for the community health center program.”).

²²² *Id.* (“Existing law prohibits these centers from using Federal funds to provide abortion services (except in cases of rape or incest, or when the life of the woman would be endangered), as a result of both the Hyde Amendment and longstanding regulations containing the Hyde language. Under the Act, the Hyde language shall apply to the authorization and appropriations of funds for Community Health Centers under section 10503 and all other relevant provisions.”).

²²³ See WERFEL & MURRAY, *supra* note 158.

²²⁴ *Id.*

²²⁵ *Id.*; Affordable Care Act § 1303, 42 U.S.C. § 18023 (2010).

²²⁶ Affordable Care Act § 1303(b)(2), 42 U.S.C. § 18023(b)(2)(C)–(D) (2010).

²²⁷ See WERFEL & MURRAY, *supra* note 158.

²²⁸ *Id.*

2. State Obligations: Compliance and Enforcement

Under the ACA, states, insurers, and to some extent consumers each face unique compliance obligations regarding exchange-based abortion coverage. Insurance commissioners must, among other things, ensure that plans segregate abortion premiums from federal funds.²²⁹ As states establish exchanges, restrictions on abortion funding may pose several challenges to regulators.

First, state insurance regulators must determine whether exchange plans are in compliance with segregation requirements for enrollees receiving federal assistance.²³⁰ Second, regulators must conduct independent regular financial audits of participating health plans and ensure funds are segregated in compliance with the “generally accepted accounting principles” of the OMB and GAO.²³¹ The “segregation plan” is to be the foundation for subsequent audits of the QHP, either as part of or consistent with the audits ensuring compliance with other exchange requirements.²³² The audits must include methods to test for compliance as required. State commissioners must also obtain annual assurance statements from issuers of QHPs that ensure compliance with all regulations. Audit reports and working papers related to compliance are to be obtained by states and maintained on file for a specified period of years.²³³

Finally, the insurance regulator in each state must ensure compliance with multi-state plan requirements.²³⁴ Under the ACA, multi-state plans must offer uniform benefit packages in exchanges.²³⁵ The legislation does not specify how offerings between states with divergent abortion coverage laws are to be regulated or rectified.²³⁶ The model guidelines state that prior to establishing exchanges, OMB Circular A-133 Compliance Supplement will be provided to “assist auditors of State governments regarding compliance with Section 1303.”²³⁷

²²⁹ Exec. Order No. 13,535, *supra* note 158.

²³⁰ Susan Randall, *Insurance Regulation in the United States: Regulatory Federalism and the National Association of Insurance Commissioners*, 26 FLA. ST. U. L. REV. 625, 629 (1998).

Each state has a department within the executive branch to regulate insurance. The head of the department is usually called the commissioner or director of insurance. A handful of states elect their insurance commissioner. In the remaining states, the insurance commissioner is appointed by the governor and serves at the governor’s pleasure. The insurance department typically has broad, legislatively delegated powers to enforce state insurance laws, promulgate rules and regulations, and conduct hearings to resolve disputed matters.

Id.

²³¹ Exec. Order No. 13,535, *supra* note 158; *see also* Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310 (Mar. 27, 2012) (to be codified at 45 C.F.R. pts. 155, 156, & 157).

²³² *See* WERFEL & MURRAY, *supra* note 158.

²³³ *Id.*

²³⁴ Affordable Care Act § 10104(a)(6), 42 U.S.C. § 18054(a)(6) (2010) (“ASSURED AVAILABILITY OF VARIED COVERAGE.—In entering into contracts under this subsection, the Director shall ensure that with respect to multi-State qualified health plans offered in an Exchange, there is at least one such plan that does not provide coverage of services described in section 1303(b)(1)(B)(i).”).

²³⁵ Affordable Care Act § 10104(c)(1)(a), 42 U.S.C. § 18054(c)(1)(a) (2010).

²³⁶ *See* Section VIII *infra* for recommendations on this point.

²³⁷ WERFEL & MURRAY, *supra* note 158.

D. The HHS Final Rule Regarding Establishment of Exchanges and Qualified Health Plans Issued March 2012

On March 27, 2012, HHS issued a final rule related to establishment of exchanges and qualified health plans.²³⁸ Some 166 pages long, the rule primarily addresses exchange planning, of which the abortion coverage restrictions are only a small part.²³⁹ The final rule establishes the regulatory framework for exchanges nationwide and thereby implements the abortion provisions in Section 1303 of the ACA.²⁴⁰ The final rule codifies the provisions of Section 1303 of the ACA and the proposed rule.²⁴¹ It also incorporates, consolidates and codifies the OMB/ HHS pre-regulatory model guidelines on fund segregation described above.²⁴² HHS solicited public comments on the proposed rule and a total of 881 comments mentioned abortion coverage.²⁴³

V. POST HEALTH REFORM LEGISLATION: FURTHER RESTRICTIONS ON ABORTION COVERAGE

Since the passage of federal health reform, numerous states have passed legislation further restricting or banning private health insurance plans—in and outside the exchanges—from covering abortion. To date, no state has passed a law either requiring abortion coverage or providing state funds for abortion coverage in an exchange.²⁴⁴ Federal legislation has also been introduced in the House to restrict abortion access and coverage beyond the provisions of the ACA. This section reviews these legislative efforts and assesses the potential impact on state exchanges.

²³⁸ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310 (Mar. 27, 2012) (to be codified at 45 C.F.R. pts. 155, 156, & 157).

²³⁹ The word “abortion” is found on six of one hundred sixty-six pages in the final rule. *Id.*

²⁴⁰ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310 (Mar. 27, 2012) (to be codified at 45 C.F.R. pts. 155, 156, & 157). Specifically, the final rule codifies Section 1303 of the ACA by including “the non-discrimination clause for providers and facilities, a voluntary choice clause for issuers with respect to abortion services, the standards for the segregation of funds for QHP issuers that elect to cover abortion services for which public funding is prohibited, and the associated communication requirements related to such services.” *Id.* at 18,429–18,430.

²⁴¹ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866 (proposed July 15, 2011) (to be codified at 45 C.F.R. Pts. 155 & 156).

²⁴² “We are finalizing the provisions proposed in § 156.280 of the proposed rule, with the following modifications: we redesignated paragraph (e)(5)(ii) as (e)(5)(iv). In new paragraphs (e)(5)(ii) and (e)(5)(iii), we codified the pre-regulatory model guidelines on segregation of funds published by the Office of Management and Budget and the Assistant Secretary for Financial Resources as proposed.” Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,340 (Mar. 27, 2012).

²⁴³ Comments on the proposed rule were due September 28, 2011. *See* Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,406, 18,430 (Mar. 27, 2012) (to be codified at 45 C.F.R. Pts. 155, 156, & 157) (summarizing comments on the proposed rule). To see all 881 comments, visit <http://www.regulations.gov>, search for “Establishment of Exchanges and Qualified Health Plans,” open the docket folder for the rule, and search for “abortion” with the public submission box checked.

²⁴⁴ *See infra* Section VIII for a discussion of these options.

A. *Snapshot of the States: New and Old Laws Restrict Exchange-Based Abortion Coverage*

Five states had bans of private health insurance coverage for abortion in effect prior to health reform.²⁴⁵ Taken together with the eleven states that passed coverage bans since passage of the ACA, a total of sixteen states now have laws that will ban some form of abortion coverage in their health insurance exchanges.²⁴⁶ Eight of the sixteen states (Idaho, Kansas, Kentucky, Missouri, Nebraska, North Dakota, Oklahoma, and Utah) ban coverage of abortion outside as well as inside the exchange.²⁴⁷

1. Limited Exceptions to State-Based Coverage Bans

Of the sixteen states with exchange-based abortion coverage restrictions, fourteen states include limited exceptions to an otherwise outright coverage ban.²⁴⁸ Specifically, six states include exceptions that allow coverage in cases of life endangerment of the pregnant woman; five states permit coverage in cases of life endangerment, rape or incest; and three states allow coverage in cases of life endangerment or to avert “substantial and irreversible” impairment of a bodily function or physical health of the pregnant woman.²⁴⁹

In Louisiana and Tennessee, private health insurers may not cover abortion in any circumstance—not in cases of rape, incest or to protect the life of the pregnant woman. Tennessee was the first state to pass legislation restricting health plans in an exchange from offering abortion coverage without any exceptions.²⁵⁰ The Tennessee bill became law without

²⁴⁵ *State Laws that Restrict Insurance Coverage for Abortion Enacted before the Affordable Care Act*, NATIONAL CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/?TabId=21099__ (last visited Mar. 17, 2010). Idaho, Kentucky, Missouri and North Dakota provide one exception to allow coverage for abortion in the case of life endangerment; the Oklahoma law also allowed coverage in the case of rape or incest. GUTTMACHER INST., RESTRICTING INSURANCE COVERAGE OF ABORTION, *supra* note 93.

²⁴⁶ These states are Arizona, Florida, Idaho, Indiana, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, North Dakota, Ohio, Oklahoma, Tennessee, Utah, and Virginia. GUTTMACHER INST., RESTRICTING INSURANCE COVERAGE OF ABORTION, *supra* note 93.

²⁴⁷ *Id.*; see also NAT’L WOMEN’S LAW CTR., STATE BANS ON INSURANCE COVERAGE OF ABORTION ARE SWEEPING THE NATION, ENDANGERING WOMEN’S HEALTH AND TAKING HEALTH BENEFITS AWAY FROM WOMEN (2011), available at http://www.nwlc.org/sites/default/files/pdfs/state_bans_on_abortion_coverage_6-13-11.pdf.

²⁴⁸ The number “sixteen” includes Kentucky and North Dakota, both of which passed exchange-based abortion coverage restrictions prior to federal health reform, plus the fourteen states that passed these laws after health reform. The extent to which states interpret abortion coverage restrictions that pre-date health reform and do not specifically address exchanges to apply to coverage sold within exchanges is unknown. KY. REV. STAT. ANN. § 304.5-160 (West 2011), available at <http://www.lrc.ky.gov/krs/304-05/160.pdf> (prohibiting state coverage of elective abortion unless an additional premium is paid); N.D. CENT. CODE ANN. § 14-02.3-03 (2011), available at <http://legis.nd.gov/assembly/62-2011/documents/11-0506-02006m.pdf> (prohibiting health insurance plans from covering abortions unless an additional premium is paid); see also NAT’L WOMEN’S LAW CTR., STATE BANS ON INSURANCE COVERAGE, *supra* note 247.

²⁴⁹ Three states, Arizona, Indiana, and Utah, allow insurance coverage of abortion in cases of substantial and irreversible impairment. See S.B. 1305, 49th Leg., Reg. Sess. (Az. 2010); H. Enrolled Act 1210, 117th Gen. Assemb., Reg. Sess. (In. 2011); H.B. 354, 2011 Gen. Sess. (Ut. 2011). See also NAT’L WOMEN’S LAW CTR., STATE BANS ON INSURANCE COVERAGE *supra* note 247; GUTTMACHER INST., RESTRICTING INSURANCE COVERAGE OF ABORTION, *supra* note 93. Utah also includes an exception to allow coverage in the case of fetal “defect” that is “uniformly diagnosable” and “uniformly lethal.” H.B. 354, 2011 Gen. Sess. (Ut. 2011).

²⁵⁰ TENN. CODE ANN. § 56-26-134 (2010), available at <http://www.capitol.tn.gov/Bills/106/Bill/SB2686.pdf>.

Governor Phil Bredesen's signature.²⁵¹ In Louisiana, Governor Bobby Jindal signed a similar bill prohibiting plans in state-based exchange(s) from covering abortions, without any exceptions.²⁵² This ban passed before Governor Jindal announced that Louisiana would not operate its own health insurance exchange.²⁵³ In states that do not establish exchanges themselves, the federal government will establish and operate the exchange.²⁵⁴ It is unclear how state-based abortion coverage bans would function in such states.

In 2011, Indiana passed multi-faceted anti-abortion legislation that includes and extends beyond the exchange.²⁵⁵ The law prohibits qualified health plans purchased through an exchange in the state from covering abortions, except in the case of rape, incest, or to avert impairment or death of the pregnant woman.²⁵⁶ On December 21, 2011, Ohio Governor John Kasich signed House Bill 79, which prohibits qualified health plans purchased through an exchange from covering "nontherapeutic" abortions and defined "nontherapeutic" abortions as those performed for reasons other than rape, incest, or to avert death of the pregnant woman.²⁵⁷

Utah: The First Exchange-Based Abortion Coverage Ban in Effect

Utah is the first state in the country with an operational exchange that includes an abortion coverage ban.²⁵⁸ The state's abortion restriction went into effect January 1, 2012 and limits the type of abortion coverage that may be offered by group health benefit plans inside and outside the exchange. Expansive effects of the Utah ban are already evident by Regence BlueCross BlueShield of Utah's elimination of abortion coverage from new individual/family health plan products, despite the law not requiring this level of restriction.²⁵⁹

²⁵¹ In a statement Governor Bredesen (D) notes that while he is "concerned about potential unintended consequences of this legislation," he allowed it to become law because "the health care exchanges that would be impacted by this legislation would not become operational until 2014, giving the General Assembly time to rethink this issue and address concern created by the bill." Letter from Phil Bredesen, Governor, to the Honorable Kent Williams, Speaker of the House (May 5, 2010), available at <http://blogs.knoxnews.com/humphrey/document2010-05-05-095500.pdf>.

²⁵² See LA. REV. STAT. ANN. § 22:1014 (2011), available at <http://www.legis.state.la.us/billdata/streamdocument.asp?did=722961>.

²⁵³ Jan Moller, *Louisiana to Opt Out of Health Insurance Exchanges in Federal Law*, NOLA.COM, (Mar. 23, 2011, 3:00 PM), http://www.nola.com/politics/index.ssf/2011/03/louisiana_to_opt_out_of_health.html.

²⁵⁴ *Id.*

²⁵⁵ H.B. 1210, 117th Gen. Assemb., Reg. Sess. (Ind. 2011). On May 5, 2011, Governor Mitch Daniels (R) signed H.B. 1210, which prohibits qualified health plans purchased through an exchange in Indiana from covering abortions, except in the case of rape, incest, or to avert impairment or death of the pregnant woman. In addition to the coverage ban, the law's numerous new restrictions include: additional limits on the gestational age up to which an abortion can be performed; requirements that physicians inform pregnant women orally and in writing of risks and alternatives to abortion before the procedure is performed; and requirements that physicians to show photographs of the fetus and recite specific words regarding conception and fetal capacity to feel pain. *Id.*

²⁵⁶ *Id.*

²⁵⁷ H.B. 79, 129th Leg. Gen. Sess. (Oh. 2011), codified as OHIO REV. CODE ANN. § 2901.87 (2011). The law refers to a previous statute to define "nontherapeutic" abortions as those performed in situations other than rape, incest, or to avert death of the pregnant woman. *Id.* The law also states that Ohio "affirmatively [opts] out of allowing qualified health plans that cover nontherapeutic abortions to participate in Exchanges within this state, as permitted under section 1303 of the "Patient Protection and Affordable Care Act," 42 U.S.C. 18023." *Id.*

²⁵⁸ H.B. 354, 2011 Gen. Sess. (Ut. 2011).

²⁵⁹ *Changes to Regence Product Suite Resulting From Utah Abortion Mandate*, REGENCE BLUECROSS

Rhode Island: A Permanently Enjoined Ban

Although Rhode Island law includes longstanding abortion coverage bans for private health insurance, the bans are without effect after both statutes were challenged and enforcement was permanently enjoined by court order.²⁶⁰ In 1983, Rhode Island passed double-pronged legislation to prohibit coverage of abortion in all private plans and in municipal employee plans.²⁶¹ The first law barred coverage of abortion by all private insurers in the state of Rhode Island except in cases of rape, incest or for the life of the pregnant woman. Under the law, coverage for excluded abortions could only be purchased by separate rider with a separate premium paid by consumers. The second statute prohibited, among other things, municipalities within the State of Rhode Island, from providing coverage to public employees for abortion in cases other than rape, incest or for the life of the pregnant woman.²⁶² The US Court of Appeals for the First Circuit struck down the statutes on the grounds that they created unconstitutional obstacles to access the constitutionally protected right to abortion recognized in *Roe v. Wade* and its progeny.²⁶³

Notably, recent legislation to establish a health insurance exchange failed to pass the Rhode Island Legislature after language banning abortion coverage was added to the exchange bill and scuttled support required from pro-choice legislators to secure its passage.²⁶⁴ Because of the state legislature's failure to pass enabling legislation, Governor Lincoln Chafee instead signed an Executive Order to establish the Rhode Island Health Benefit Exchange on September 19, 2011.²⁶⁵ Shortly thereafter, the Rhode Island Right to Life Committee filed a challenge to the Executive Order establishing the exchange claiming the Order violates separation of powers and creates an unconstitutional requirement that individuals opposed to abortion cross-subsidize abortion services.²⁶⁶

BLUESHIELD, <http://ut.regence.com/docs/agent/agent-notice-abortion-mandate.pdf> (last visited Feb. 17, 2012).

²⁶⁰ See Nat'l Educ. Ass'n of Rhode Island v. Garrahy, 598 F. Supp 1374 (D.R.I. 1984), *aff'd* 779 F.2d 790 (1st Cir. 1986).

²⁶¹ R. I. GEN. LAWS ANN. § 27-18-28 (West 1983); R. I. GEN. LAWS ANN. § 36-12-2.1 (West 1983).

²⁶² R. I. GEN. LAWS ANN. § 36-12-2.1 (West 1983).

²⁶³ *Id.* Specifically, referring to the coverage ban and rider scheme for private insurers, the Court stated:

The restriction will burden, in that it will unquestionably have a 'significant impact' on, many women's right to choose abortion. The record states, and defendants concede, that solely as a result of the enforcement of the statute, some women who wish to terminate their pregnancies will be deterred from, or at least delayed in, doing so. Defendants further concede that medically unnecessary delay is detrimental to women's health, and that deterrence due to financial inability may likewise be detrimental to women's health.

Id. at 1385.

²⁶⁴ See Felice Freyer, *Chafee Seeks Change in Abortion Wording in Health-Care Bill*, PROVIDENCE J., Apr. 6, 2011, <http://news.providencejournal.com/breaking-news/2011/04/chafee-asks-for-change-to-abor.html#.T0g9HphuG5R>; see also *Abortion Issues Derail Approval of R.I. Health Exchange Bill*, NAT'L PARTNERSHIP FOR WOMEN & FAMILIES (Jul. 12, 2011), http://www.nationalpartnership.org/site/News2?abbr=daily2_&page=News_Article&id=29430 (last visited Apr. 12, 2012).

²⁶⁵ See R.I. Exec. Order 11-09, Establishment of the Rhode Island Health Benefits Exchange, *available at* http://www.governor.ri.gov/documents/executiveorders/2011/Executive_Order_11-09.pdf.

²⁶⁶ Complaint for Declaratory Judgment and Injunctive Relief, R.I. State Right to Life Committee v. Chafee (R.I. Super. Ct. Dec. 2011), *available at* <http://wrnihealthcareblog.files.wordpress.com/2011/12/rirtl-separation-of-powers->

The State of Washington: The Only Abortion Coverage Mandate Proposed to Date

In a stark departure from the trend of state-based abortion coverage bans, the Washington state legislature considered a bill²⁶⁷ (the “Reproductive Parity Act”) that would have required health insurers who cover maternity care to also cover voluntary pregnancy termination. If passed, the law would have applied to all state-regulated insurance markets, including the exchange, with coverage exceptions allowed only for religious or conscience-based objections. The law would not have applied to multistate plans. Representative Eileen Cody, the bill sponsor, commented that “We weren’t sure that abortion would be offered in the exchanges because the federal law sets up a lot of barriers to that. . . . We wanted to make sure that choice would be available.”²⁶⁸ The bill has passed the Washington State House,²⁶⁹ but ultimately failed to reach a vote in the state Senate due to unrelated budget issues.²⁷⁰ The bill has drawn controversy but may be brought before the legislature again.²⁷¹

Riders: Often Mentioned but Hardly Offered

A “rider” is an amendment to a health insurance policy that can add specific coverage.²⁷² Arizona, Florida, Kentucky, North Dakota, Nebraska, and Oklahoma bar abortion coverage from inclusion within health benefit packages but explicitly allow insurance coverage for abortion to be purchased separately in the form of a rider.²⁷³ Riders for abortion coverage do not, however,

complaint.pdf; see also Richard Asinof, *Lawsuit Challenges Health Benefits Exchange*, PROVIDENCE BUS. NEWS, Dec. 1, 2011, available at <http://www.pbn.com/Lawsuit-challenges-Health-Benefits-Exchange-,62939>.

²⁶⁷ H. B. 2330, 2011–2012 Leg. Sess. (Wa. 2012).

²⁶⁸ Sarah Kliff, *In Washington State, Requiring Health Insurers to Cover Abortion*, EZRA KLEIN’S WONK BLOG, (Feb. 22, 2012, 9:00 AM) http://www.washingtonpost.com/blogs/ezra-klein/post/in-washington-state-requiring-health-insurers-to-cover-abortion/2012/02/21/gIQA3HxxRR_blog.html.

²⁶⁹ *Id.*

²⁷⁰ Jonathan Kaminsky, *Washington Lawmakers Vow To Push Abortion Insurance Bill*, INS. J., Mar. 22, 2012, <http://www.insurancejournal.com/news/west/2012/03/22/240454.htm>; see also Christian Torres, *Wash. Bill Mandating Abortion Coverage Fails To Reach Vote*, Kaiser Health News, Mar. 6, 2012, <http://capsules.kaiserhealthnews.org/index.php/2012/03/wash-bill-mandating-abortion-coverage-fails-to-reach-vote/>.

²⁷¹ *Id.*

²⁷² *Glossary – Rider*, HEALTHCARE.GOV, <http://www.healthcare.gov/glossary/r/rider.html> (last visited Mar. 18, 2012) (“A rider is an amendment to an insurance policy. Some riders will add coverage (for example, if you buy a maternity rider to add coverage for pregnancy to your policy).”).

²⁷³ S.B. 1305, 49th Leg., 2d Reg. Sess. (Ariz. 2010), available at <http://www.azleg.gov/legtext/49leg/2r/bills/sb1305h.pdf> (“Consistent with the Provisions of the Patient Protection and Affordable Care Act . . . any qualified health insurance policy, contract or plan offered through any state health care exchange . . . shall not provide coverage for abortions unless the coverage is offered as a separate optional rider for which an additional insurance premium is charged”); S.B. 547, 53d Leg., 1st Reg. Sess (Okla. 2011). In addition to stating that optional, supplemental coverage may be offered for abortions outside of those intended to prevent the death of the pregnant woman, the legislation provides instructions for plan issuers on how premiums are to be calculated for that additional benefit, on how to provide notice to enrollees concerning the abortion coverage (both plan issuers and employers have specific laws to abide by), and instructs issuers of health plans to collect separate signatures of enrollment if an enrollee chooses to purchase additional abortion coverage. Depending on how the Notice to Enrollees portion (b)(3) of § 18021 of the ACA will be interpreted, the Oklahoma statute may stand in conflict with federal law. See also H.B. 97, 2011 Reg. Sess. (Fla. 2011) (“(2) This section does not prohibit a health insurance policy from offering separate coverage for an abortion if such

appear documented to exist in these states.²⁷⁴ Because consumers do not “plan” for, or insure against, an unplanned pregnancy, stand alone abortion coverage is not likely to be sought after by consumers or offered by insurers.²⁷⁵ Critics suggest that publicity surrounding “permission” to offer riders for abortion coverage creates the appearance of compromise by anti-abortion advocates without actually creating a viable mechanism for abortion coverage.²⁷⁶

Although six states plainly permit abortion coverage through riders, Missouri, Kansas, and Virginia explicitly prohibit plans operating within their exchanges from offering abortion riders. Missouri’s law prohibits exchanges from including policies or riders that provide abortion coverage except in cases of life endangerment of the pregnant woman.²⁷⁷ Missouri and Kansas allow for riders to be sold outside of exchanges within those states but no evidence of viable rider products is found.

coverage is not purchased in whole or in part with state or federal funds.”); KY. REV. STAT. ANN. § 304.5-160 (West 2011), <http://www.lrc.ky.gov/krs/304-05/160.pdf>; H.B. 1297, 62nd Legis. Assemb. (N.D. 2011) (amending N.D. CENT. CODE § 14-02.3-03, Payment for abortions by health insurance policies delivered or issued in North Dakota restricted).

No health insurance contracts, plans, or policies delivered or issued for delivery in this state may provide coverage for abortions, including the elimination of one or more unborn children in a multi-fetal pregnancy, except by an optional rider for which there must be paid an additional premium. Provided, however, that this section does not apply to the performance of an abortion necessary to prevent the death of the woman.

Id. See also GUTTMACHER INST., STATE POLICIES IN BRIEF: RESTRICTING INSURANCE COVERAGE OF ABORTION, *supra* note 93; L.B. 22, 102d Leg., 1st Sess. (Neb. 2011) (“No health insurance plan, contract, or policy delivered or issued for delivery in the State of Nebraska shall provide coverage for an elective abortion except through an optional rider to the policy for which an additional premium is paid solely by the insured.”).

²⁷⁴ Julie Appleby, *How The House Abortion Restrictions Would Work*, KAISER HEALTH NEWS, Nov. 10, 2009, <http://www.kaiserhealthnews.org/Stories/2009/November/10/abortion-explainer.aspx>.

Insurance departments in Idaho, Kentucky and Missouri state that they do not track abortion riders, so it isn’t clear if any are offered. North Dakota and Oklahoma say insurers do not offer abortion riders to individuals. In Oklahoma, however, one insurer has filed for a rider to offer abortion coverage to small groups. And in Idaho, one of the state’s major insurers offers abortion coverage to small groups if they pay an additional premium charge.

Id.

²⁷⁵ NARAL PRO-CHOICE AMERICA FOUND., THE STUPAK- PITTS AMENDMENT GOES FAR BEYOND CURRENT LAW, IMPOSES UNPRECEDENTED RESTRICTIONS ON ABORTION COVERAGE FOR MILLIONS OF WOMEN 2 (2009), <http://www.naral.org/media/fact-sheets/abortion-health-care-stupak.pdf>.

²⁷⁶ *Id.*

²⁷⁷ MO. REV. STAT. § 376.805 (2011).

No health insurance exchange established within this state or any health insurance exchange administered by the federal government or its agencies within this state shall offer health insurance contracts, plans, or policies that provide coverage for elective abortions, nor shall any health insurance exchange operating within this state offer coverage for elective abortions through the purchase of an optional rider.

Id. Missouri’s Governor, Jay Nixon (D), allowed the measure to pass without a signature because the “legislation was approved by an overwhelming, bipartisan majority in both houses.” Jason Hancock, *Jay Nixon Allows New Abortion Restrictions To Become Law*, STLTODAY.COM (Jul. 15, 2011, 12:15 AM), http://www.stltoday.com/news/local/govt-and-politics/article_1f822a61-f5d6-5018-98aa-6db84805ae8d.html.

Virginia passed legislation in 2011 declaring the state's intent to establish an exchange.²⁷⁸ The law prohibits QHPs offered through the exchange from covering abortions, with few exceptions, and also makes clear that no abortion coverage can be sold in the form of rider policies through the exchange.²⁷⁹

Kansas: A Court Challenge to the Kansas Law

Kansas Governor Sam Brownback called "on the Legislature to bring to [his] desk legislation that protects the unborn, establishing a culture of life in Kansas" during his first State of the State address.²⁸⁰ Soon thereafter the Kansas Legislature passed and Governor Brownback signed, among other laws to restrict abortion access, House Bill 2025 specific to insurance coverage. This law prohibits health plans within Kansas from providing coverage for abortion unless the life of the pregnant woman is in danger.²⁸¹ The law also prohibits all plans offered

²⁷⁸ H. 2434, 2011 Reconvened Sess. (Va. 2011), available at <http://lis.virginia.gov/cgi-bin/legp604.exe?111+ful+CHAP0823+pdf>. Although North Dakota has also enacted legislation outlining the state's intent to create a state-based health insurance exchange that will be operational by January 1, 2014, the North Dakota abortion restriction pre-dates the passage of this legislation. See H.B. 1126, 62nd Legis. Assemb., Reg. Sess. (N.D. 2011) (announcing the state's intent to create a Health Benefit Exchange).

²⁷⁹ H. 2434, 2011 Reconvened Sess. (Va. 2011). The President of the Family Foundation of Virginia notes that this legislation was merely "taking advantage of what was clearly written into the law," implying the opportunity for restriction of private health insurance coverage of abortion was made explicit in health reform. Sabrina Tavernise, *Abortion Opponents Use Health Law to Put Restrictions in Private Insurance*, N.Y. TIMES, Apr. 9, 2011, at A13, available at <http://www.nytimes.com/2011/04/09/health/policy/09abortion.html>.

²⁸⁰ Erik Eckholm, *Across Country, Lawmakers Push Abortion Curbs*, N.Y. TIMES, Jan. 21, 2011, <http://www.nytimes.com/2011/01/22/us/politics/22abortion.html>.

²⁸¹ H.B. 2075, 2011 Reg. Sess. (Kan. 2011), available at http://www.kslegislature.org/li/b2011_12/year/1/measures/documents/hb2075_enrolled.pdf.

New Sec. 8. (a) Any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization, municipal group-funded pool and the state employee health care benefits plan which is delivered, issued for delivery, amended or renewed on or after July 1, 2011, shall exclude coverage for elective abortions, unless the procedure is necessary to preserve the life of the mother. Coverage for abortions may be obtained through an optional rider for which an additional premium is paid. The premium for the optional rider shall be calculated so that it fully covers the estimated cost of covering elective abortions per enrollee as determined on an average actuarial basis.

(b) No health insurance exchange established within this state or any health insurance exchange administered by the federal government or its agencies within this state shall offer health insurance contracts, plans, or policies that provide coverage for elective abortions, nor shall any health insurance exchange operating within this state offer coverage for elective abortions through the purchase of an optional rider.

(c) For the purposes of this section: (1) "Abortion" means the use or prescription of any instrument, medicine, drug or any other substance or device to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead unborn child who died as the result of natural causes in utero, accidental trauma or a criminal assault on the pregnant woman or her unborn child and which causes the premature termination of the pregnancy. (2) "Elective" means an abortion for any reason other than to prevent the death of the mother upon whom the

through the Kansas exchange from offering abortion coverage. Policies sold outside the state exchange may offer abortion coverage sold as an “optional rider”, but riders may not be offered within the Kansas exchange.²⁸²

The American Civil Liberties Union of Kansas and Western Missouri (ACLU) named Sandy Praeger, the Kansas Insurance Commissioner, as the defendant in the first, and to date only, case challenging this type of statute.²⁸³ The ACLU argues that the law violates the Due Process and Equal Protection Clauses of the United States Constitution.²⁸⁴ Specifically, plaintiffs assert that the law places an undue burden on the right to abortion by effectively imposing a “tax” requiring women to purchase abortion coverage separate and apart from an otherwise comprehensive health insurance policy.²⁸⁵ The ACLU further contends that because men do not face any comparable restriction on their ability to secure comprehensive health insurance coverage that the law violates the Equal Protection Clause of the United States Constitution. The court denied plaintiff’s request for a preliminary injunction and set an expedited schedule for discovery and summary judgment.²⁸⁶

Model Legislation for States from Americans United for Life

Several states have introduced anti-abortion coverage legislation based on models created by Americans United for Life (AUL).²⁸⁷ The organization drafted two distinct templates for legislation, one for states seeking to ban abortion coverage within the exchange (“The Federal Abortion Mandate Opt-Out Act”),²⁸⁸ and one for states wanting to impose a broad ban on abortion coverage in all insurance markets regulated by the state including those outside the exchange (“The Abortion Coverage Prohibition Act”).²⁸⁹ The model legislation that applies solely to the

abortion is performed; provided, that an abortion may not be deemed one to prevent the death of the mother based on a claim or diagnosis that she will engage in conduct which will result in her death.

(d) The provisions of this section shall be effective from and after July 1, 2011.

Id.

²⁸² *Id.* For a discussion on abortion riders, see *supra* notes 272–79 and accompanying text.

²⁸³ *Am. Civil Liberties Union of Kan. & Western Mo. v. Praeger*, 2011 WL 4537736 (D.Kan. 2011). An amicus brief filed to the Supreme Court by a coalition of pro-life health-provider groups in opposition to the minimum coverage provision of the ACA asserted that the ACA’s requirement to purchase health insurance “violates the Free Exercise Clause of the First Amendment by effectively forcing millions of individuals to personally pay a separate abortion premium in violation of their sincerely held religious beliefs.” Brief for Am. College of Pediatricians et al., as Amici Curiae Supporting Respondents, *U.S. Dep’t. of Health & Hum. Servs. v. Florida*, (No. 11-398) 2012 WL 484063, at *1.

²⁸⁴ *Am. Civil Liberties Union v. Praeger*, 2011 WL 4537736 at *1.

²⁸⁵ *Id.* at *13.

²⁸⁶ *Id.* at *9.

²⁸⁷ See generally AMERICANS UNITED FOR LIFE, <http://www.aul.org> (last visited Apr. 12, 2012).

²⁸⁸ See *Federal Abortion Mandate Opt-Out Act, Model Legislation & Policy Guide*, AMERICANS UNITED FOR LIFE (2011), <http://www.aul.org/wp-content/uploads/2010/04/Abortion-Mandate-Opt-Out-Act-2011-LG.pdf> (last visited Apr. 12, 2012).

²⁸⁹ See *Abortion Coverage Prohibition Act, Model Legislation & Policy Guide*, AMERICANS UNITED FOR LIFE (2011), <http://www.aul.org/wp-content/uploads/2010/12/Abortion-Coverage-Prohibition-Act-2011-LG.pdf> (last visited Apr. 12, 2012).

exchanges provides life endangerment, rape, and incest exceptions.²⁹⁰ It does not, however, include language that would allow for the sale of abortion coverage riders. The Abortion Coverage Prohibition Act bans insurance coverage of abortion in the state except in cases to prevent death of the pregnant woman. It does not specifically address the exchange but does establish a state-wide ban that allows for the purchase of an optional rider to cover abortion services.²⁹¹ Bills passed in Idaho, Louisiana, Mississippi and Nebraska appear to follow AUL language closely.²⁹² Nebraska, for example, passed a law prohibiting exchange-participating plans from covering abortion unless a physician verifies, in writing, that the abortion is necessary to prevent the pregnant woman's death.²⁹³ Specific requirements for the written physician verification are unknown. The Nebraska legislation also bans coverage of abortion for all plans operating statewide outside the exchange, except through a rider.²⁹⁴

B. Federal Abortion Coverage Legislation Introduced After Health Reform

Two key bills introduced and passed in the United States House of Representatives after passage of the ACA seek to further restrict funding for abortion services in exchanges.

The "Protect Life Act" (HB 358)²⁹⁵ introduced on January 20, 2011 by Representative Pitts²⁹⁶ would enact the Stupak Amendment's restrictions that failed during the health reform debate. Specifically, the bill would bar use of federal subsidies to purchase a health plan that offers abortion coverage.²⁹⁷ This differs from restrictions enacted by the ACA. HB 358 would

²⁹⁰ *Federal Abortion Mandate Opt-Out Act*, *supra* note 288, at § 3(b).

²⁹¹ *Abortion Coverage Prohibition Act*, *supra* note 289, at § 3(a).

²⁹² S.B. 3214, 2010. Leg., Reg. Sess. (Miss. 2010) (prohibiting qualified health insurance plans participating in an exchange from covering abortions except in cases of life endangerment of the pregnant woman) (under "Sec 3.2.b the physician is required to maintain sufficient documentation in the medical record that supports the medical necessity for the abortion"); *see also* L.B. 22, 102d Leg., 1st Sess. (Neb. 2011) ("Mandate Opt-Out and Insurance Coverage Clarification Act of 2011"). In April 2011, Governor C.L. Otter of Idaho signed into law a measure prohibiting abortion coverage in the state's health insurance exchange except in cases of life endangerment of the pregnant woman, rape or incest. S.B. 1115, 61st Leg., Reg. Sess. (Id. 2011). While Louisiana allowed for no exceptions to their abortion coverage ban in their health insurance exchange, their legislation mirrored AUL model legislation language. *See* H.B. 1247, 2010 Leg., Reg. Sess. (La. 2010).

²⁹³ L.B. 22, 102d Leg., 1st Sess. (Neb. 2011).

Sec.3. (1) no abortion coverage shall be provided by a qualified health insurance plan offered through a health insurance exchange created pursuant to the federal Patient Protection and Affordable Care act, Public Law 111-148, within the State of Nebraska. This subsection shall not apply to coverage for an abortion which is verified in writing by the attending physician as necessary to prevent the death of the woman or to coverage for medical complications arising for an abortion.

Id.

²⁹⁴ *Id.* at § 3(2).

²⁹⁵ *See* Protect Life Act of 2011, H. R. 358, 112th Cong. (2011).

²⁹⁶ Pete Kasperowicz, *GOP Abortion Bill Passes House*, THE HILL BLOG (Oct. 13, 2011, 6:20 PM), <http://thehill.com/blogs/floor-action/house/187533-gop-abortion-bill-passes-house>. Rep. Pitts was an original co-sponsor of the Stupak Amendment.

²⁹⁷ For analysis of the impact of H.R. 358, *see* NAT'L WOMEN'S LAW CTR., THE PITTS BILL (H.R. 358): A DANGEROUS BILL THAT THREATENS WOMEN'S HEALTH AND LIVES (2011), <http://www.nwlc.org/resource/pitts-bill-hr->

ban the use of federal funds from purchasing a plan that includes abortion coverage within its benefits without allowing for premium segregation to purchase abortion coverage splintered off from the underlying policy.²⁹⁸ This would effectively mean that no insurer participating in a state exchange would likely offer a product covering the abortion benefit.

The bill also seeks to introduce unprecedented “conscience protections” which effectively grant institutions, including hospitals, the ability to refuse to perform an abortion even when a pregnant woman’s life is endangered.²⁹⁹ The “conscience” protections in the Pitts Bill seek to create loopholes to allow insurers to avoid compliance with ACA contraceptive coverage requirements if such coverage is against an insurer’s “conscience.”³⁰⁰ In addition, HB 358 would severely restrict abortion teaching and training for providers.³⁰¹ The bill passed in the House on October 13, 2011 and has been referred to the Senate Committee on Finance, although it is expected to fail in a Senate vote.³⁰² In turn, the White House issued a “Statement of Administration Policy” declaring its opposition and intent to veto to HR 358 because “the legislation intrudes on women’s reproductive freedom and access to health care and unnecessarily restricts the private insurance choices that women and their families have today.”³⁰³

Another bill, HR 3, the “No Taxpayer Funding for Abortion” Act, sponsored by Representative Chris Smith (R-NJ), passed the House on May 4, 2011 and as of April 11, 2012, it is still awaiting a vote in the Senate. The Smith bill would establish a multi-pronged tax structure designed to end abortion coverage by aggressively taxing Americans who select health plans with such coverage.³⁰⁴ Specifically, the Smith Bill would: (1) prohibit the tax deduction typically allowed for medical expenses from being used for abortions; (2) prohibit the use of ACA premium subsidies to purchase coverage from a QHP that offers abortion coverage regardless of

358-dangerous-bill-threatens-women’s-health-and-live (last visited Apr. 12, 2012).

²⁹⁸ See Protect Life Act of 2011, H. R. 358, 112th Cong. (2011).

²⁹⁹ *Id.* at § (c)(5)(C).

³⁰⁰ The term “conscience” is left undefined in the bill. See generally JON O. SHIMABUKURO, CONG. RESEARCH SER., THE HISTORY AND EFFECT OF ABORTION CONSCIENCE CLAUSE LAWS (2008), available at http://assets.opencrs.com/rpts/RL34703_20081008.pdf.

³⁰¹ Protect Life Act of 2011, H. R. 358, 112th Cong. (2011).

(b) Special Rules Relating to Training in and Coverage of Abortion Services- Nothing in this Act (or any amendment made by this Act) shall be construed to require any health plan to provide coverage of or access to abortion services or to allow the Secretary or any other Federal or non-Federal person or entity in implementing this Act (or amendment) to require coverage of, access to, or training in abortion services.

Id.

³⁰² *Id.* H.R. 358 would also allow hospitals that are morally opposed to abortion to deny emergency care to women who require an abortion procedure to save their life. *Id.* at § (g). See also Laura Bassett, *Protect Life Act, Controversial Anti-Abortion, Passes House*, HUFFINGTON POST (Jan. 17, 2012, 6:47 PM), http://www.huffingtonpost.com/2011/10/13/protect-life-act-passes-house-of-representatives_n_1009876.html (“Despite a strong showing in the House, the bill is unlikely to pass in the Democrat-controlled Senate, and the White House said on Wednesday that President Barack Obama will veto the legislation if it ever reaches his desk.”).

³⁰³ OFFICE OF MGMT. & BUDGET, EXEC. OFFICE OF THE PRESIDENT, STATEMENT OF ADMINISTRATIVE POLICY: H.R. 358 (2011), http://www.whitehouse.gov/sites/default/files/omb/legislative/sap/112/saphr358r_20111012.pdf (last visited Apr. 12, 2012).

³⁰⁴ H.R. 3, 112th Cong. (2011), available at <http://www.gpo.gov/fdsys/pkg/BILLS-112hr3pcs/pdf/BILLS-112hr3pcs.pdf>.

whether the enrollee paid for abortion coverage separately using private funds; (3) prohibit the extension of the small business tax credit established in the ACA to small employers that offer health coverage which includes abortion coverage; (4) prohibits the use of pre-tax funds allocated to flexible spending accounts from being used to pay for abortion services. The bill also expands “nondiscrimination” rights and prohibits the District of Columbia from using its local funds to offer abortion services.³⁰⁵ The White House issued a formal statement expressing opposition and a likely presidential veto of HR 3.³⁰⁶

Over time, the ACA will reframe the federal-state relationship regarding health insurance regulation and coverage mandates. Prior to passage of the ACA, states were primarily responsible for regulating health insurance and state efforts to mandate benefit coverage far outpaced federal mandates.³⁰⁷ Among many other changes, the ACA establishes, for the first time, a federally prescribed set of basic health benefits, as described in the next section.³⁰⁸

VI. ABORTION COVERAGE AND THE ESSENTIAL HEALTH BENEFIT PACKAGE

All qualified health plans offered on the newly developed state exchanges must cover an “essential health benefits package” (EHB) often referred to as “minimum essential coverage.”³⁰⁹ The EHB package will establish the floor of standard benefits offered by qualified health plans (QHPs) to be sold in the health insurance exchanges. States and insurance companies will be permitted to respectively mandate and offer additional benefits beyond those required by the Secretary but will not be permitted to exclude any of the benefits from the list of EHBs. Importantly, the EHB is the minimum set of benefits an individual must maintain to satisfy the

³⁰⁵ *Id.*; see also *Bill Summary & Status, 112th Congress (2011–2012), H.R.3, CRS Summary*, LIBRARY OF CONGRESS, available at <http://thomas.loc.gov/cgi-bin/bdquery/z?d112:HR00003:@@D&summ2=m&>; For an analysis of the impact of H.R. 3, see NAT’L WOMEN’S LAW CTR., H.R. 3: A DANGEROUS AND MISLEADING BILL THAT THREATENS WOMEN’S HEALTH (2011), available at http://www.nwlc.org/sites/default/files/pdfs/hr3_long_fact_sheet_rules_final.pdf; U.S. CONFERENCE OF CATHOLIC BISHOPS, HEALTH CARE REFORM (Feb. 2011) (providing a statement in support of H.R. 3 and H.R. 358).

³⁰⁶ OFFICE OF MGMT. & BUDGET, EXEC. OFFICE OF THE PRESIDENT, STATEMENT OF ADMINISTRATIVE POLICY: H.R. 3 – NO TAXPAYER FUNDING FOR ABORTION ACT (2011), http://www.whitehouse.gov/sites/default/files/omb/legislative/sap/112/saphr3r_20110502.pdf (last visited Apr. 12, 2012).

³⁰⁷ ERISA governs self-funded employer health plans and mandates that only four benefits be covered. 29 U.S.C. § 1181 (2011), 29 U.S.C. §§ 1185(a), 1185(b) (1996). The McCarran Ferguson Act grants states the ability to regulate insurance. Amy B. Monahan, *Initial Thoughts on Essential Health Benefits*, Univ. of Minn. Law Sch. Legal Studies Research Paper Series, Research Paper No. 10-36, at 1 (2010). It is important to note that given the high rate of self-insuring, among large employers, more than half (sixty percent) of individuals who receive employer-sponsored coverage are enrolled in plans untouched by state regulation. See KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS 2010 ANNUAL SURVEY 151 (2011).

³⁰⁸ These “essential health benefits” are defined within the Public Health Service Act (PHSA) as amended by the Affordable Care Act. The ACA, in turn, amends the Employee Retirement Income Security Act (ERISA) to apply the requirement of essential benefits codified in the PHSA to ERISA-governed employer groups. See Rosenbaum et al., *The Essential Health Benefits Provisions of the Affordable Care Act: Implications for Peoples with Disabilities*, 3 THE COMMONWEALTH FUND 3 (2011) (“The act exempts large-group health plans, as well as self-insured ERISA plans and ERISA-governed multiemployer welfare arrangements not subject to state insurance law, from the essential benefit requirements.”).

³⁰⁹ See BD. ON HEALTH CARE SERVS., PERSPECTIVES ON ESSENTIAL HEALTH BENEFITS WORKSHOP REPORT (2012), available at <http://www.iom.edu/Reports/2011/Perspectives-on-Essential-Health-Benefits-Workshop-Report.aspx>; see also Affordable Care Act § 1302, 42 U.S.C. § 18022 (2010).

requirement of being “insured” under the individual mandate.³¹⁰ Beginning in 2014, individuals who do not maintain coverage by a QHP will have to pay a penalty.³¹¹

The ACA directs the Secretary of HHS to define the essential health benefits (EHBs) package.³¹² Pursuant to this directive, HHS Secretary Kathleen Sebelius tasked an Institute of Medicine (IOM) committee, as instructed by the ACA, to propose a set of criteria and methods to assist the Secretary in her determination.³¹³ The Secretary was obligated to provide notice and an opportunity for public comment before finalizing the essential health benefits. This comment period ended January 31, 2012.³¹⁴

The IOM report does not specifically list the health services to be included in the EHBs; instead it provides a guideline establishing important considerations to be used to develop the EHBs. The IOM committee released its report “Essential Health Benefits: Balancing Coverage and Cost” in October 2011.³¹⁵ The IOM report emphasized the need for plans to be affordable, and recommended that the standard plan mimic plans currently offered by small businesses, provided it covers the ten general categories described below.³¹⁶

The IOM proposes criteria for determining specific components and for defining and updating the EHBs. The criteria for defining and updating EHBs incorporate principles of transparency, participation, equitability, and consistency.³¹⁷ The proposed criteria represent an attempt to make the EHB package affordable, maximize the number of people with insurance coverage, protect vulnerable populations, promote better provider practices, encourage cost effective preventive services and treatment, address the medical concerns of greatest importance to enrollees in EHB-related plans, and protect against the greatest financial risks.³¹⁸ When determining specific coverage criteria, the encouraged method of evaluation requires the individual service, device or drug to be: safe, medically effective and supported by sufficient evidence, a meaningful improvement in outcomes over current effective services/treatment, a medical service and cost effective.³¹⁹ Although abortion may meet those criteria, it is not included as an essential benefit.

In December 2011, HHS suggested that EHB coverage should model small employer plans.³²⁰ This new model is designed to increase flexibility for states to tailor EHB coverage to

³¹⁰ Affordable Care Act § 1501, 42 U.S.C. § 18091 (2010)

³¹¹ There are limited exceptions to this requirement. *See* Affordable Care Act § 1501, I.R.C. §5000A (2010).

³¹² Affordable Care Act § 1302(b)(1), 42 U.S.C. § 18022(b)(1) (2010).

³¹³ The committee is housed under the IOM’s Board on Health Care Services and includes committee members representing think tanks, schools of medicine, financial firms, universities, insurers, information technology firms, provider organizations and consumer unions. INST. OF MEDICINE, ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COST 1 (2011), *available at* <http://www.iom.edu/~media/Files/Report%20Files/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost/essentialhealthbenefitsreportbrief.pdf> (“The charge of the committee specifically was . . . [to] propose a set of criteria and methods that should be used in deciding what benefits are most important for coverage.”)

³¹⁴ Affordable Care Act § 1302(b)(3), 42. U.S.C. §18022(b)(3) (2010).

³¹⁵ INST. OF MEDICINE, *supra* note 313, at 1.

³¹⁶ *Id.* at 2.

³¹⁷ *Id.* at 2.

³¹⁸ *Id.*

³¹⁹ *Id.* at 2–3.

³²⁰ CTR. FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT, ESSENTIAL HEALTH BENEFITS BULLETIN

state-specific needs.³²¹ States have the option to choose a “benchmark” plan that represents typical coverage within the state to serve as the EHB for that state. If the benchmark a state chooses does not include one of the ten mandated categories under the EHB, the State must look to another one of the eligible benchmark plans to fulfill this requirement. Under the benchmark approach, States are not required to pay through 2015 for benefits mandated by that state that go beyond the federal EHB at which time this policy will be revisited by HHS.³²² The extent to which this recent HHS pronouncement conflicts with provisions in the ACA requiring states to pay for these additional benefits is unclear.

A. *Mandatory Benefits under the ACA*

The ACA mandates that the essential benefits package include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care).³²³ The ACA requires the Secretary to periodically review the EHBs and to submit reports of the review to Congress and make the reports publically available.³²⁴

B. *Women’s Health and the Essential Health Benefits Package*

The IOM guidelines, released on August 1, 2011, include coverage for the following women’s preventive health services without copayments or deductibles: annual preventive-care medical visits and exams, contraceptives (all products approved by the FDA), mammograms, colonoscopies, blood pressure tests, childhood immunizations, screenings for interpersonal and domestic violence, H.I.V. screenings, breast feeding counseling and equipment (including breast pumps), gestational diabetes screening, and DNA tests for HPV as part of cervical cancer screening.³²⁵ The ACA states that “nothing shall be construed to require” the abortion benefit to

9 (2011), available at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

³²¹ DEP’T OF HEALTH & HUMAN SERVICES, ESSENTIAL HEALTH BENEFITS: HHS INFORMATIONAL BULLETIN (Dec. 16, 2011), <http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html> (last visited Apr. 12, 2012).

³²² CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, ESSENTIAL HEALTH BENEFITS BULLETIN 9–10 (2011), available at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

In the transitional years of 2014 and 2015, if a State chooses a benchmark subject to State mandates – such as a small group market plan – that benchmark would include those mandates in the State EHB package. Alternatively, under our intended approach a State could also select a benchmark such as an FEHBP plan that may not include some or all of the State’s benefit mandates, and therefore under Section 1311(d)(3)(B), the State would be required to cover the cost of those mandates outside the State EHB package. HHS intends to evaluate the benchmark approach for the calendar year 2016 and will develop an approach that may exclude some State benefit mandates from inclusion in the State EHB package.

Id.

³²³ Affordable Care Act § 1302(b), 42 U.S.C. § 18022(b) (2010).

³²⁴ Affordable Care Act § 1302(b)(4)(g), 42 U.S.C. § 18022(b)(4)(G) (2010).

³²⁵ See Press Release, U.S. Dep’t of Health & Human Servs., Affordable Care Act Ensures Women Receive

be a part of the EHB package,³²⁶ even though, as noted in the IOM Report, abortion is generally covered by or is an option in small business plans, which is the recommended benefit model.³²⁷

C. Benefits Beyond Those Required in the EHB

The ACA does not disrupt state authority to mandate health insurance benefits.³²⁸ In fact, the Act explicitly acknowledges that states have the discretion to mandate additional benefits beyond those required as EHBs.³²⁹ Under the ACA, however, states are required to assume the cost of mandated benefits beyond the EHB.³³⁰ Given current fiscal crises faced by most states, state willingness or ability to finance additional benefits beyond the EHB appears limited.

Per the recent HHS announcement noted above, states appear to have additional discretion to use state-specific benchmarked plans in lieu of federally-prescribed EHBs.³³¹ In contrast to the ACA, the HHS benchmark model suggests that states that select a benchmarked plan may not be required to assume the cost of benchmarked benefits beyond those in the EHB through 2015.³³² The reconciliation between the ACA and the HHS benchmark option and any potential impact on abortion coverage is unknown at this time.

The ACA requires individual and small group plans sold by private insurers on exchanges to incorporate the EHB. However, it also makes clear that insurers have the option to offer benefits beyond those included in the EHBs.³³³

Section VIII discusses the possibility of state mandates for abortion coverage in greater

Preventive Services at No Additional Cost, August 1, 2011, *available at* <http://www.hhs.gov/news/press/2011pres/08/20110801b.html>.

³²⁶ Affordable Care Act § 1303(b)(1)(A)(i), 42 U.S.C. § 18023(b)(1)(A)(i) (2010) (“[N]othing in this title (or any amendment made by this title), shall be construed to require a qualified health plan to provide coverage of services described in subparagraph (B)(i) or (B)(ii) as part of its essential health benefits for any plan year.”).

³²⁷ See CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, ESSENTIAL HEALTH BENEFITS BULLETIN 9 (2011), *available at* http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf; CHOICE ADMINISTRATORS EXCHANGE SOLUTIONS, ESSENTIAL HEALTH BENEFITS: KEY ISSUES FOR STATES (2011), *available at* http://www.choiceadminexchanges.com/wp-content/uploads/2011/12/HE10243_12-22_EHB-White-Paper1.pdf; INST. OF MEDICINE, *supra* note 313, at app. E (describing small group market benefits, which often includes abortion coverage in typical small group plans).

³²⁸ Affordable Care Act § 1311(d)(3)(B), 42 U.S.C. § 18031(d)(3)(B) (2010).

³²⁹ *Id.*

³³⁰ *Id.*

³³¹ See DEP’T OF HEALTH & HUMAN SERVS., ESSENTIAL HEALTH BENEFITS: HHS INFORMATIONAL BULLETIN (Dec. 16, 2011), <http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html> (last visited Apr. 12, 2012).

³³² Affordable Care Act § 1311(d)(3)(B)(ii), 42 U.S.C. § 18031(d)(3)(B)(ii) (2010); *see also* OFFICE OF HEALTH REFORM INTEGRATION, POLICY ISSUES WITHIN THE EXCHANGE NO. 2, at 1 (2011), *available at* <http://hcr.amerigroupcorp.com/wp-content/uploads/2011/06/Exchange-Standard-Benefit-Packages.pdf>; *see also* Phil Galewitz & Julie Appleby, *Advisory Panel Says Essential Health Benefits Package Must Be Affordable*, KAISER HEALTH NEWS, Oct. 6, 2011, <http://www.kaiserhealthnews.org/Stories/2011/October/06/iom-essential-health-benefits-package.aspx> (“[T]he federal government should allow states that administer their own exchanges to make changes to the list of essential benefits as long as those variations are consistent with the health law and are as comprehensive as the required benefits list.”).

³³³ Affordable Care Act § 1302(b)(5), 42 U.S.C. § 18022(b)(5) (“Nothing in this title shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this sub-section.”).

detail.

VII. STATE OPTIONS TO SUPPORT EXCHANGE-BASED ABORTION COVERAGE

States are uniquely positioned to promote continued access to abortion coverage. Insurers and consumers can also serve important roles to preserve abortion coverage.³³⁴ This section describes key non-legislative options available to states to ensure accessibility of coverage for a full range of reproductive health services. Although legislative options to support coverage for abortion exist, states may, for the reasons described below, opt instead for regulatory mechanisms.

Despite evidence that a majority of Americans support a woman's right to choose to terminate pregnancy and that consumers indicate a preference for benefit packages to include abortion coverage, no state has passed legislation to support exchange-based availability of abortion coverage.³³⁵ State legislation to secure abortion coverage may be absent for several reasons. First, because the likelihood of unplanned or problematic pregnancy may seem remote, people may underestimate the utility of abortion coverage and, as a result, individuals do not demand action from their legislature to secure it.

Coverage legislation may be absent from historically pro-choice states because even basic non-abortion-related legislation necessary to establish exchanges appears exceedingly difficult to pass in many states as described above.³³⁶ State-level hostility toward health reform can be measured by unwillingness to pass exchange-enabling legislation or by participation in one of the challenges of the ACA pending in federal court.³³⁷ Even in states where support for health

³³⁴ Other non-legislative actors including insurance regulators may impact the offer and uptake of abortion coverage.

³³⁵ Several indicators of consumer demand—a national healthcare consumer survey, a self-identification poll, and a survey of public comments during formal rulemaking processes—suggest that abortion is a benefit desired by the public. The National Survey of Healthcare Consumers performed by Thomson Reuters in March of 2011 analyzed responses from 3,013 participants (interviewed between March 1 and 14, 2011) reports that the majority of respondents believe that private insurance plans should cover all or most of the cost of an abortion (a sentiment that increased with income and education). See THOMSON REUTERS, NATIONAL SURVEY OF HEALTHCARE CONSUMERS: ABORTION (2011), available at http://www.factsforhealthcare.com/pressroom/NPR_report_Abortion.pdf (indicating that 52.5% responded that private insurance plans should pay some or all of the costs of an abortion). The most recent Gallup poll on the issue as well as a recent Rasmussen report both suggest that people who identify as pro-choice form a majority. The majority of respondents in both polls call themselves “pro-choice.” Rasmussen Reports, *49% Consider Themselves Pro-Choice, 41% Pro-Life*, May 26, 2011, http://www.rasmussenreports.com/public_content/politics/current_events/abortion/49_consider_themselves_pro_choice_41_pro_life; Lydia Saad, *Americans Still Split Along “Pro-Choice,” “Pro-Life” Lines*, GALLUP (May 23, 2011), <http://www.gallup.com/poll/147734/americans-split-along-pro-choice-pro-life-lines.aspx> (last visited Apr. 12, 2012). The majority of public comments posted on the federal registry during formal rulemaking processes initiated after the passage of health reform are supportive of medically necessary abortions being a part of healthcare, and indicate a desire for the abortion benefit to be included in private health insurance plans. See *supra* notes 60, 238–43, and accompanying text.

³³⁶ As of March 1, 2012, fourteen states have established an exchange, three are planning to establish an exchange, twenty are studying their options, twelve have not engaged in any significant activity with respect to exchange, and two have made a decision not to create one. Kaiser Family Foundation, *State Action Toward Creating Health Insurance Exchanges, as of March 1, 2012*, STATEHEALTHFACTS.ORG, <http://statehealthfacts.kff.org/comparemaptable.jsp?ind=962&cat=17> (last visited Mar. 31, 2012).

³³⁷ See T.R. Goldman, *Health Reform Gets Its Day In Court: The Supreme One*, 31 HEALTH AFFAIRS 8, 8–11 (2012); Mark A. Hall, *Health Care Reform — What Went Wrong on the Way to the Courthouse*, 364 N. ENG. J. MED.

reform appears strong, legislatures experience delay and difficulty in passing key legislation to create an exchange.³³⁸ States concerned about delay may seek to draft exchange legislation leanly in order to avoid the legislation being bogged down in additional controversy. For these reasons, regulatory or quasi-regulatory as opposed to legislative mechanisms may prove more accessible to states that wish to support abortion coverage offerings.

States seeking to support abortion coverage offerings within exchanges can: (1) maintain individual and small group health insurance markets outside the exchange; (2) recognize single payment instruments as reasonable means to satisfy federal segregation requirements; (3) review state abortion access protections to ensure compliance with state law; (4) ensure access to confidential care and coverage consistent with state law; (5) provide guidance to industry; (6) consider opportunities to mandate abortion coverage; (7) structure the exchange to segregate funds for insurers; (8) provide state financing for exchange-based abortion coverage; (9) exempt abortion coverage from requirements that multi-state plans offer uniform benefit package; and (10) estimate the cost of an abortion benefit to ensure fair pricing. This section presents these ten options available to states and discusses the implications of each.

A. *Maintain Individual and Small Group Health Insurance Markets Outside State-Based Exchanges*

States have the option to bring individual and small group markets exclusively within the exchange or to allow the pre-exchange individual and small group markets to continue to operate outside the exchange.³³⁹ As previously mentioned, insurance products offered in non-exchange markets tend to provide abortion coverage. Because insurers operating outside exchanges are not subject to ACA abortion coverage restrictions, they provide a natural platform for abortion coverage to remain available. States seeking to ensure availability of this coverage might therefore support continuation of non-exchange-based individual and small group coverage.³⁴⁰ Decisions regarding pooling of segregated funds should in any case consider long-term sustainability of the pool to ensure access to abortion services for enrollees.

B. *Streamline Payment Instruments*

As state regulators await additional guidance from HHS, states could use this opportunity to create state-specific compliance and enforcement schemes. For example, minimizing administrative burden could increase the likelihood of insurer offer and consumer purchase of abortion coverage. Similarly, states might take a new look at payment mechanisms and medical loss ratio (MLR) calculations.³⁴¹

295, 295–297 (2011) (explaining that more than twenty states brought suit challenging the constitutionality of the act); Timothy S. Jost, *Can the States Nullify Health Care Reform?* 362 N. ENG. J. MED. 869, 869–871 (2010).

³³⁸ Editorial, *Dropping the Ball on Health Exchanges*, N.Y. TIMES, Jul. 10, 2011, http://www.nytimes.com/2011/07/11/opinion/11mon3.html?_r=1&scp=1&sq=healthcare%20exchange%20legislation.

³³⁹ See JOHN JACOBI, RUTGERS CTR. FOR STATE HEALTH POL'Y, HEALTH INSURANCE EXCHANGES: GOVERNANCE ISSUES FOR NEW JERSEY 13–14 (2011). The Jacobi report also notes that states might support continuation of outside exchange individual and small group markets for other reasons as well, including guaranteeing coverage options for undocumented persons who are prohibited from buying coverage in the exchange. *Id.* at v.

³⁴⁰ *Id.* at 13–14.

³⁴¹ See Timothy Jost, *Implementing Health Reform: Medical Loss Ratios*, HEALTH AFFAIRS BLOG, (Nov. 23,

1. Payment Mechanisms

States could streamline payment mechanisms to reduce the administrative burden on both carriers and consumers. As described above, insurers that offer and consumers enrolled in plans that provide abortion coverage must comply with the potentially burdensome two-payment rule, an inconvenience that could itself deter enrollment in abortion coverage. These potentially costly compliance burdens may also dissuade carriers from offering abortion coverage altogether.³⁴²

However, insurance companies could receive a single check that includes two payments from consumers to decrease administrative burden on both consumers and carriers. Financial industry practices routinely permit customers to make several separately priced payments with one check or a single electronic deposit, i.e. using a single “payment instrument.” In such a scenario, several payments owed by the enrollee, line itemed in the invoice and intended to cover the cost of several distinct products or services, are separated by the recipient using standard accounting principles.

Homeowners, for example, may opt to structure payment to the bank in a way such that they only write one check covering several different obligations. Such a payment is known as “PITI,” an acronym for “principal, interest, taxes, and insurance.”³⁴³ In an analogous scenario, abortion premiums could be priced separately and itemized separately but paid using one instrument (a check, for example) to cover the two payments, then divided into multiple accounts by the insurer. This common financial industry practice could be instructive for states in administering the abortion benefit.

In the above-described PITI scenario, banks ensure the escrow account maintains funds in excess of those required for the next payment.³⁴⁴ These surplus funds are held to protect the bank in the event, for example, property taxes rise. Because the cost of the abortion benefit may

2010, 8:38 AM), <http://healthaffairs.org/blog/2010/11/23/implementing-health-reform-medical-loss-ratios/>. The ACA sets new MLR ratios requiring insurers to spend a certain percentage of premium dollars on claims for medical care and quality improvement, as opposed to administration, marketing, and profit. *Id.* Because the MLR allocates an explicit proportion of each premium dollar (for example, eighty cents of each premium dollar must be paid out for medical claims as opposed to used for administrative costs or profit), inflated administrative costs reduce insurer profit. *Id.* The fixed proportion provides additional incentive for insurers to hold down administrative costs. *Id.* Although the administrative costs associated with the abortion segregation requirements are not yet known, the potential exists for carriers to disfavor these additional administrative costs to the extent they may reduce profits. *Id.* To the extent the new federal rules establish minimum and not maximum (“floor not ceiling”) MLRs, in states where the MLR is set higher than the federal floor, regulators may be able to exclude the cost of compliance with the abortion segregation rules entirely from the MLR calculation to ease the burden on carriers who seek to continue providing this coverage. *Id.*

³⁴² See Memorandum from Sara Rosenbaum to Interested Parties, *Abortion Provisions in the Senate Managers Amendment*, Memorandum, GWU School of Public Health and Health Services, Dec. 21, 2009, available at http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/index.cfm?mdl=pubSearch&evt=view&PublicationID=B30C1DF2-5056-9D20-3D38915B18D7BAAF; see also ROSENBAUM ET AL., *supra* note 3 (examining the implications for coverage of abortion under the Stupak-Pitts amendment).

³⁴³ RALPH TAMPER, *MASTERING REAL ESTATE MATHEMATICS* 156 (7th ed. 2002). When the bank receives this payment, the principal and interest are kept by the bank, and automatically segregated from the tax and insurance payments, which are then deposited into a separate escrow account. The escrow account containing funds for insurance and taxes are held until, for example, the bank pays state taxes on behalf of the homeowner. See ARLYNE GESCHWENDER, *REAL ESTATE PRINCIPLES & PRACTICES* 203, 468 (2008).

³⁴⁴ *Id.*

be less than the \$1 minimum price required, the “abortion account” could similarly hold surplus funds.³⁴⁵ These funds can remain in the segregated “abortion account” and rolled over on an annual basis to ensure sustainability of the pool.

Another analogy drawn from the insurance industry looks to carriers that offer multiple lines of coverage (e.g., auto, home, and life insurance). Customers who purchase three lines of coverage may receive one bill and write one check for three distinct products. This is analogous to the segregation of premiums and reimbursements for abortion coverage within an exchange, as the insurance carrier would receive one check covering multiple payments and then segregate each payment into separate accounts, from which reimbursements would be made. Health insurers could presumably structure abortion coverage in a similar way, and thus would not need to create a new and potentially burdensome mechanism.

Should a single instrument not meet federal requirements, insurers could offer a “one payment per year” option. The actuarial analysis below estimates that the abortion benefit would likely cost under \$1.00 per member per month (PMPM). By collecting a single \$12 payment once per year, rather than \$1 payments each month, insurers could reduce administrative costs associated with segregating premiums. If federal regulations require consumers to write separate checks, an annual payment would likely prove less burdensome for consumers as well as insurers.

C. *Ensure Confidentiality Protection for Coverage and Care Decisions*

The ACA is silent with respect to confidentiality of enrollee coverage decisions. Dependents or employees who elect coverage that includes an abortion benefit may fear disclosure of their decision to their spouse, employer, or parents. Privacy concerns may have broad ramifications on consumer decisions to purchase abortion coverage. Consumers may avoid selecting plans with abortion coverage because of worry over disclosure of coverage decisions.³⁴⁶ It appears states could exercise authority to establish new or strengthen existing confidentiality protections for consumers to ensure privacy. Payment simplification, such as the one check method as described above, could also reduce potentially stigmatizing disclosures of an enrollee’s selection of abortion coverage. Because the ACA requires separate payments even when employer-sponsored coverage is purchased through the exchange, a single payment instrument, whether from the consumer or the employer on the consumers’ behalf, would help maintain privacy for those employees who elect to purchase abortion coverage.

Similarly, statements describing benefit use (Explanation of Benefits or EOB statements) must be cautiously regulated to avoid disclosure of confidential health services to persons other than the patient. States that currently have laws to guarantee confidential access to health services, especially for minors, find those protections at odds with other similarly well-intentioned laws requiring carriers to distribute EOBs that disclose services billed on an enrollee’s behalf.³⁴⁷ Although detailed analysis of confidentiality protections is beyond the scope of this paper, states

³⁴⁵ See *infra* notes 383–91 and accompanying text.

³⁴⁶ Indeed, women with abortion coverage are found to not use it because of fears over breaches of confidentiality. See *supra* notes 74–82 and accompanying text; see also Stanley K. Henshaw, *Unintended Pregnancy and Abortion in the USA: Epidemiology and Public Health Impact*, in MAUREEN PAUL ET AL., *MANAGEMENT OF UNINTENDED AND ABNORMAL PREGNANCY: COMPREHENSIVE ABORTION CARE* 24 (2009), available at <http://onlinelibrary.wiley.com/doi/10.1002/9781444313031.ch3/summary>.

³⁴⁷ Gold, *Unintended Consequences*, *supra* note 81, at 13 (“[t]hese privacy guarantees may be at odds with the ability of health care providers to be compensated for the care they deliver.”)

drafting regulations for exchange operations may consider these issues and recognize the opportunity presented to improve the status quo.

D. Consider State Level Abortion Rights and Equal Protection Laws in the Context of the New Federal Restrictions

The administrative burden on abortion coverage established by the ACA may conflict with legislative protection of a woman's right to access abortion services as guaranteed by some state laws.³⁴⁸ In some states, statutes prohibit interference with a woman's right to choose to terminate a pregnancy.³⁴⁹ Depending on how courts view state implementation of ACA abortion coverage restrictions, it is conceivable that the restrictions may violate state constitutions by obstructing access to abortion services. Although detailed review of state statutes and questions of federalism are beyond the scope of this paper, states should consider these issues and possible courses of action as a result.

For example, under the equal protection clause of the New Jersey Constitution the Medicaid program is required to fund medically necessary abortions for both the life and *health* of the pregnant woman.³⁵⁰ In so holding, the court reasoned:

Once it undertakes to fund medically necessary care attendant upon pregnancy, however, government must proceed in a neutral manner. Given the high priority accorded in this State to the rights of privacy and health, it is not neutral to fund services medically necessary for childbirth while refusing to fund medically necessary abortions.³⁵¹

States may explore the extent to which newly subsidized populations entering exchanges are entitled to similar neutrality, although most subsidy-eligible populations within the exchanges receive federal as opposed to state subsidy and therefore protection under state law may be limited.

E. Provide Support and Guidance to Industry

Regulators can support insurers by identifying and addressing insurer concerns regarding benefit pricing and claims segregation compliance. Regulators can offer templates for reporting requirements to assist carriers and simplify processes in keeping with applicable laws and regulations. For example, for purposes of premium collection and account segregation, "abortion services," if left to state regulators to define, could be defined narrowly to exclude ancillary services beyond the pregnancy termination itself from additional restriction.

³⁴⁸ See generally JACOBI, HEALTH INSURANCE EXCHANGES: GOVERNANCE ISSUES FOR NEW JERSEY, *supra* note 339 (discussing the administrative complexity of the abortion restrictions in the ACA, as applied to the state of New Jersey).

³⁴⁹ See *infra* note 369 for a discussion of state statutes which limit interference with a woman's right to choose.

³⁵⁰ Right to Choose v. Byrne, 450 A.2d 925 (N.J. 1982).

³⁵¹ *Id.* at 935.

F. *Consider the Need For and Viability of an Abortion Coverage Mandate*

In the United States, over 2,000 insurance benefit mandates are currently in effect.³⁵² A “benefit mandate” is a law that requires health insurance contracts to cover specific treatments or services, or medically-necessary care delivered by a specific type of health care provider.³⁵³ A benefit mandate, if defined more broadly, can also take the form of a “population mandate” thus requiring insurance contracts to cover specific populations. Alternatively, a mandate can be defined as a requirement to simply offer coverage for treatments or services.³⁵⁴

The number and types of benefits mandated are highly variable across states. Alcohol and substance abuse treatment, for instance, is one of the most popular mandated benefits across states, and forty nine states have mandated insurance contracts to cover breast reconstruction.³⁵⁵ The federal government under ERISA mandates four substantive benefits to be covered: “minimum hospital stays following childbirth, breast reconstruction following mastectomy, a limitation on the exclusion of pre-existing conditions, and a mental health parity requirement.”³⁵⁶

In contemplating coverage mandates, states must consider cost and other potential impacts on plans operating within their borders. State benefit mandates impact all insurance plans within the state³⁵⁷ except self-insured plans.³⁵⁸ Furthermore, the incremental additional costs attributed to the newly mandated benefit are shifted onto the entire insured population. The premium increases attributable to benefit mandates are quantifiable and vary depending on coverage. For example, in Texas, the addition of the contraceptive coverage mandate increased premiums by 0.3% in the small group market and by 0.4% in the large group market, while the addition of coverage for HIV/AIDS treatment increased premiums by 1.1% in all group markets.³⁵⁹ Because the majority of health plans already cover abortion, the incremental costs

³⁵² VICTORIA CRAIG BUNCE & JP WIESKE, COUNCIL FOR AFFORDABLE HEALTH INSURANCE, HEALTH INSURANCE MANDATES IN THE STATES 2010, available at http://www.cahi.org/cahi_contents/resources/pdf/MandatesintheStates2010ExecSummary.pdf; see also Amy Monahan, *Federalism, Federal Regulation, or Free Market? An Examination of Mandated Health Benefit Reform*, 2007 U. ILL. L. REV. 1361, 1364 (2007) (“States average eighteen health insurance mandates, ranging from a low of two mandates in Idaho to a high of thirty-five mandates in California”). Estimates of the number of mandates currently in effect vary significantly due to variations in the definition of “mandate” (estimates can be expansive or narrow depending on whether population mandates or offer mandates are included) as well as accounting with respect to different laws requiring the same type of coverage within different markets.

³⁵³ CHERYL ULMER ET AL., EDS., INST. OF MEDICINE, ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COSTS, 72–75 (Oct. 2011), available at http://www.nap.edu/catalog.php?record_id=13234.

³⁵⁴ *Id.*

³⁵⁵ VICTORIA CRAIG BUNCE, COUNCIL FOR AFFORDABLE HEALTH INSURANCE, HEALTH INSURANCE MANDATES IN THE STATES 2011, at 3 (2012). A mandate for breast reduction coverage is one of the outliers (only one state has a benefit mandate for this service) as are benefit mandates for circumcision (one state) and brain injuries (three states). *Id.*

³⁵⁶ Monahan, *supra* note 307, at 2.

³⁵⁷ *Id.*

³⁵⁸ *Id.* at 4 (“PPACA does not at all change the substantive regulation of large group plans, or of self-insured plans. Large group plans remain regulated at the state level and through ERISA, while self-insured plans remain subject only to ERISA’s limited substantive provisions.”)

³⁵⁹ SUSAN K. ALBEE ET AL., STATE OF TEXAS DEP’T OF INS., COST IMPACT STUDY OF MANDATED BENEFITS IN TEXAS, at i (2000). Several states also require benefit mandates to be reviewed prior to their implementation. The resulting actuarial estimates are very precise and within narrow margins. See JOHN WELCH ET AL., ANNUAL MANDATED HEALTH INSURANCE SERVICES EVALUATION (2008), available at http://mhcc.maryland.gov/health_insurance/

associated with an abortion coverage mandate are likely to be minimal.

1. The Mechanics of Benefit Mandates Post-ACA³⁶⁰

Coverage offerings between the exchange and outside-exchange markets will vary depending on the degree of divergence between the benefits required within the exchange and the benefits offered in plans operating outside the exchange. Benefits offered by QHPs within exchanges will, at a minimum, include the benefits specified for the EHB. Benefits beyond those required by the EHB will, as mentioned above, depend on state willingness and ability to fund those benefits or state ability to opt for a benchmarked plan. In light of current fiscal crises faced by many states, the stability of benefit mandates that pre-date the ACA but require coverage beyond the EHB is uncertain. As noted above, over time, administrative efficiency and consumer demand may prompt products offered outside the exchange to mimic the inside-exchange market or vice versa.

Although no state currently mandates abortion coverage, a mandate may emerge as a viable vehicle to secure coverage in some states.³⁶¹ As previously mentioned, most commercial carriers voluntarily included abortion coverage in health benefit packages prior to the ACA. The prevalence of voluntary coverage ostensibly precluded the need for such mandates.³⁶²

States seeking to ensure access to comprehensive women's health could, without significant expense, prioritize abortion coverage given its low cost relative to other proposed benefit mandates.³⁶³ For example, Washington State, as discussed above, recently considered a mandate for abortion coverage in the state legislature in order to ensure coverage for abortion despite the restrictions created by the ACA.³⁶⁴ Two potential indicators of the political viability of an abortion coverage mandate in a state may be whether: (1) the state has already taken

annualmandaterpt2008.pdf. For instance, the Annual Mandated Health Insurance Services Evaluation of 2008 performed for the Maryland Health Care Commission estimated the cost of mandated *In Vitro* coverage. *Id.* at 44 (estimating mandated *In Vitro* fertilization coverage to be between 0.44% and 0.71% of the average cost per group policy). The report also estimated the cost of mandated autism treatment. *Id.* at 31 (estimating coverage of mandated Autism treatment between 0.52% and 1.22% of average cost per group policy).

³⁶⁰ The interaction between the state option to mandate abortion coverage as specifically contemplated by the ACA and the federal Weldon Amendment (which prohibits "discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions") is uncertain and outside the scope of this Article. *See Consolidated Appropriations Act of 2012, H.R.2055, 112th Cong. div. F, tit. V, § 507 (d)(1).*

³⁶¹ Both the Guttmacher Institute as well as the National Conference of State Legislators have performed exhaustive analyses of state laws that pertain to abortion. None of the summaries of abortion laws have any mention of a coverage mandate. For a comprehensive review of state laws on abortion, see GUTTMACHER INST., OVERVIEW OF ABORTION LAWS, *supra* note 200; *Abortion Laws*, NAT'L CONF. OF STATE LEGISLATURES (May 2011), <http://www.ncsl.org/default.aspx?tabid=14401> (last visited Apr. 12, 2012).

³⁶² A Guttmacher study from 2002 found that eighty-seven percent of typical employer-sponsored insurance plans covered abortion. *See Sonfield et al., supra* note 6, at 76; *see also Memo on Insurance Coverage of Abortion*, GUTTMACHER INST., *supra* note 69.

³⁶³ *See infra* notes 383–91 and accompanying text for actuarial analysis.

³⁶⁴ *See Sarah Kliff, In Washington State, Requiring Health Insurers to Cover Abortion*, EZRA KLEIN'S WONK BLOG, (Feb. 22, 2012, 9:00 AM) http://www.washingtonpost.com/blogs/ezra-klein/post/in-washington-state-requiring-health-insurers-to-cover-abortion/2012/02/21/gIQA3HxxRR_blog.html; *see also* GUTTMACHER INST., STATE POLICIES IN BRIEF: ABORTION POLICY IN THE ABSENCE OF ROE (2011), *available at* http://www.guttmacher.org/statecenter/spibs/spib_APAR.pdf.

legislative action to secure the right to obtain abortion services in the event *Roe v. Wade* is overturned; and (2) the state voluntarily covers abortion within Medicaid or other public programs.³⁶⁵

First, states can enact legislative protection for access to abortion care—and some already have.³⁶⁶ The fluctuating composition of the Supreme Court has led states to consider the possibility that *Roe v. Wade* could be overturned.³⁶⁷ In the past twenty years, seven states³⁶⁸ passed laws that would continue, in the event that *Roe v. Wade* is overturned, to safeguard a woman's right to choose to terminate her pregnancy prior to viability of the fetus when necessary to protect the woman's life or health.³⁶⁹ Each state's law explicitly acknowledges the woman's

³⁶⁵ See GUTTMACHER INST., STATE POLICIES IN BRIEF: STATE ABORTION FUNDING UNDER MEDICAID (Feb. 2012), available at http://www.gutmacher.org/statecenter/spibs/spib_SFAM.pdf (discussing the seventeen states that use state funds to fund all or most medically necessary abortions under Medicaid, either voluntarily or pursuant to a court order).

³⁶⁶ Importantly, more than seven states have protections for abortion rights in the event *Roe v. Wade* is overturned. Some state constitutions have been interpreted to implicitly protect a woman's right to choose (Alaska, Florida, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, Tennessee, West Virginia), and some states have repealed their pre-*Roe v. Wade* abortion bans, indicating political momentum that dates back almost forty years. These outcomes, although crucial in considering a non-*Roe v. Wade* landscape, cannot serve as indicators of political possibility for an abortion mandate. For the text of the laws, see *infra* note 369.

³⁶⁷ See GUTTMACHER INST., ABORTION POLICY IN THE ABSENCE OF ROE, *supra* note 364; see also Nina Totenberg, *Documents Reveal Battle to Preserve "Roe"*, NATIONAL PUBLIC RADIO (Mar. 4, 2004), <http://www.npr.org/templates/story/story.php?storyId=1745254> (last visited Apr. 12, 2012); *Supreme Court Shift Threatens Abortion Ruling*, ALLEGHENY TIMES, Jan. 25, 1989; Theodore Kettle, *Justice Roberts Hints He Could Overturn Roe*, NEWSMAX (Jan. 24, 2010), <http://www.newsmax.com/InsideCover/johnroberts-supremecourt-abortion-roev-wade/2010/01/24/id/347808> (last visited Apr. 12, 2012).

³⁶⁸ California, Connecticut, Hawaii, Maine, Maryland, Nevada, Washington. GUTTMACHER INST., ABORTION POLICY IN THE ABSENCE OF ROE, *supra* note 364; see also CTR. FOR REPROD. RTS., WHAT IF ROE FELL? (2007), available at http://reproductiverights.org/sites/default/files/documents/Roe_PublicationPF4a.pdf.

³⁶⁹ CAL. HEALTH & SAFETY CODE § 123462 (West 2012).

The Legislature finds and declares that every individual possesses a fundamental right of privacy with respect to personal reproductive decisions. Accordingly, it is the public policy of the State of California that: (a) Every individual has the fundamental right to choose or refuse birth control (b) Every woman has the fundamental right to choose to bear a child or to choose and to obtain an abortion, except as specifically limited by this article (c) The state shall not deny or interfere with a woman's fundamental right to choose to bear a child or to choose to obtain an abortion, except as specifically permitted by this article.

Id. CONN. GEN. STAT. ANN § 19a-602(a) (West 2012) ("The decision to terminate a pregnancy prior to the viability of the fetus shall be solely that of the pregnant woman in consultation with her physician."); HAW. REV. STAT. § 453-16(c) (West 2012) ("The State shall not deny or interfere with a female's right to choose or obtain an abortion of a nonviable fetus or an abortion that is necessary to protect the life or health of the female."); ME. REV. STAT. tit. 22, § 1598 (2012), available at <http://www.mainelegislature.org/legis/statutes/22/title22sec1598.html> ("It is the public policy of the State that the State not restrict a woman's exercise of her private decision to terminate a pregnancy before viability except as provided in section 1597-A. After viability an abortion may be performed only when it is necessary to preserve the life or health of the mother."); MD. CODE ANN., HEALTH – GEN. § 20-209 (West 2012).

Except as otherwise provided in this subtitle, the State may not interfere with the decision of a woman to terminate a pregnancy: (1) Before the fetus is viable; or (2) At any time during the woman's pregnancy, if: (i) The termination procedure is necessary to protect the life or health of the woman; or (ii) The fetus is affected by genetic defect or serious deformity or abnormality.

right to choose to safely³⁷⁰ terminate her pregnancy prior to viability of the fetus without interference from the state.³⁷¹

Four states voluntarily fund abortion coverage in their Medicaid programs. Since the Hyde Amendment took effect, federal funds allocated each year through the Labor-HHS appropriations bill have been restricted from being used to pay for abortions except, as described above, in the limited circumstances of rape, incest, or life endangerment.³⁷² Although the Hyde Amendment restricts federal matching funds from being used to pay for abortion in the Medicaid program, it explicitly allows states to use state-only funds to provide the benefit. Seventeen states currently use state-only funds to provide all or most medically necessary abortions, yet only four of them—Hawaii, Maryland, New York, and Washington—do so voluntarily.³⁷³ Thirteen states provide abortion coverage through Medicaid programs pursuant to court order.³⁷³

Additionally, states have the option to use vehicles other than the Medicaid program to secure access to abortion coverage. For example, abortion services are a covered benefit within the state-administered and funded Commonwealth Care plan in Massachusetts. Commonwealth Care provides insurance coverage at low or no cost to uninsured adults (nineteen years of age or older) who are residents of the state of Massachusetts, ineligible for Medicare or Medicaid, and

Id.; NEV. REV. STAT. ANN. § 442.250 (West 2012), available at <http://www.leg.state.nv.us/nrs/NRS-442.html#NRS442Sec240>.

No abortion may be performed in this state unless the abortion is performed: (a) By a physician licensed to practice in this state or by a physician in the employ of the government of the United States who: (1) Exercises his or her best clinical judgment in the light of all attendant circumstances including the accepted professional standards of medical practice in determining whether to perform an abortion; and (2) Performs the abortion in a manner consistent with accepted medical practices and procedures in the community. (b) Within 24 weeks after the commencement of the pregnancy. (c) After the 24th week of pregnancy only if the physician has reasonable cause to believe that an abortion currently is necessary to preserve the life or health of the pregnant woman.

Id.; WASH. REV. CODE § 9.02.100 (1992), available at <http://apps.leg.wa.gov/rcw/default.aspx?cite=9.02.100> (“The sovereign people hereby declare that every individual possesses a fundamental right of privacy with respect to personal reproductive decisions. . . . Every woman has the fundamental right to choose or refuse to have an abortion . . .”).

³⁷⁰ All the laws mentioned above maintain a requirement for a licensed physician to be performing abortion procedures. See *supra* note 369.

³⁷¹ See *supra* note 369. Many more states have abortion “bans-in-waiting”—bans of abortion that would be immediately triggered if *Roe* is overturned. See CTR. FOR REPROD. RTS., WHAT IF ROE FELL 8–15 (2007), available at http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Roe_PublicationPF4a.pdf.

³⁷² Rovner, *supra* note 110; see also George J. Annas, *Abortion Politics and Health Insurance Reform*, 361 N. ENG. J. MED. 2589–91 (2009); see generally Harris v. McRae, 448 U.S. 297 (1980) (holding that federal funding restrictions under the Hyde Amendment did not violate the U.S. Constitution). The Hyde Amendment has to be approved each year with the Labor-HHS Appropriations Bill cycle and its language has changed throughout the past thirty-four years. See STANLEY HENSHAW ET AL., RESTRICTIONS ON MEDICAID FUNDING FOR ABORTIONS, *supra* note 26; CENTER FOR REPROD. RTS., ROLLING BACK A WOMAN’S RIGHT TO CHOOSE: A TIMELINE OF THE HYDE AMENDMENT AND ITS IMPACT ON ABORTION.

³⁷³ GUTTMACHER INST., STATE FUNDING OF ABORTION UNDER MEDICAID, *supra* note 96. These states are Alaska, Arizona, California, Connecticut, Illinois, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, Oregon, Vermont, and West Virginia. *Id.* The fact that a state provides funds to cover abortion within its Medicaid program pursuant to a court order does not necessarily indicate a state’s unwillingness in this regard. *Id.* However, it is difficult to decipher an ever-changing political environment without other concrete steps taken by a state to insure coverage and/or access. *Id.*

have incomes below 300% of the Federal Poverty Line.³⁷⁴ This coverage is provided through managed care health plans (enrollees have a choice of five plans), each of which has previously contracted with Massachusetts's Medicaid program (MassHealth). The benefits in these plans were designed to mimic MassHealth benefits and include abortion services.³⁷⁵

Any of the above-mentioned states may possess the momentum required to secure an abortion benefit mandate, explicitly directing both exchange and outside-exchange markets to provide coverage.³⁷⁶ A mandate would ensure abortion coverage is included in exchange products by preventing widespread insurer opt-out. Because exchange offerings may become the standard benefit package in most markets, the outside-exchange market may mirror the exchange market. The presence of abortion coverage within the exchange would therefore likely support continued coverage and access in outside-exchange markets.³⁷⁷

Outside of passing legislation to mandate coverage, states may choose to build on political momentum to structure and finance exchanges in ways that would ensure coverage of abortion. States have the option to assume the segregation function within the exchange, finance exchange-based coverage, and to exempt the abortion benefit from the uniform coverage requirement.

G. Structure the Exchange to Segregate Funds

Using funding streams available to states, including the ability for exchanges to charge small administrative fees, it may be feasible for exchanges to collect and segregate premiums, and distribute them to insurers in accordance with federal regulation.³⁷⁸ In such a scenario, the state, as opposed to the insurer, assumes the administrative burden of fund segregation. The operation of the Massachusetts Connector demonstrates a robust capability of an exchange entity to segregate funds.³⁷⁹

³⁷⁴ IBIS REPROD. HEALTH, LOW-INCOME WOMEN'S ACCESS TO CONTRACEPTION AFTER MASSACHUSETTS HEALTH CARE REFORM 1 (2010), available at http://ibisreproductivehealth.org/work/contraception/documents/Ibis-MDPH_womencontracepMAHCR10-09.pdf.

³⁷⁵ *Id.* at 6.

³⁷⁶ Such a mandate would have to be reconciled with the federal Weldon Amendment. The interaction between the state option to mandate abortion coverage and the federal Weldon Amendment which prohibits "discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions" is uncertain and outside the scope of this Article. See Consolidated Appropriations Act, H.R.2055, 112th Cong. § Div. F, tit. V, SEC. 507 (d)(1) (2012).

³⁷⁷ Rosenbaum, *supra* note 342, at 1–2.

³⁷⁸ See Affordable Care Act § 1311, 42 U.S.C. § 13031 (2010).

³⁷⁹ Kay Lazar, *Health Law Adds Coverage Red Tape*, BOSTON GLOBE, Mar. 24, 2010, at B1. "Dr. JudyAnn Bigby, Massachusetts Health and Human Services secretary, said the system the state put in place appears to already meet that test [of ACA abortion requirements]. Jon Kingsdale, Executive Director of the Connector, said his agency had not begun sorting out how it might revamp its system to collect two monthly payments from each consumer," but that plans are in the works. *Id.* All plans that currently participate in the Massachusetts Connector are required to offer abortion coverage, and the Connector has a system in place to ensure federal funds are not used to reimburse for abortion services. *Id.* For Massachusetts Medicaid plans, an independent actuary determines the value of each health plan without the value of the abortion coverage and the patient copayments. *Id.* That amount is submitted to the federal government for partial reimbursement according to the state-federal Medicaid partnership rules. *Id.* The federal reimbursement is then placed in a general state fund. The Connector then reimburses insurers from the general account for all services except abortion, while reimbursing for the value of abortion services from a separate account, comprised of state and private moneys. *Id.*

H. Exempt Abortion Coverage from Requirements that Multi-State Plans Offer Uniform Benefit Packages

Large multi-state plans offer health insurance coverage across state lines.³⁸⁰ Abortion coverage may be banned in one but not other states included in a multi-state plan. To prevent an abortion coverage ban in one state from prevailing over states with no such ban, multi-state plans could be permitted to cover abortion even if the coverage is banned in one state where the multi-state plan is offered. This would best preserve sovereignty for the vast majority of states where abortion coverage is available.

I. Finance Exchange-Based Abortion Coverage

States could fund abortion coverage for exchange-based enrollees. Even if current fiscal crises make this option unlikely, it may be a possibility in the future. States could be billed by and reimburse providers through the exchange. This type of arrangement currently exists under Timothy's Law, which requires parity for mental health coverage for plans in New York State, but uses state funds to provide this coverage for small employers.³⁸¹ The state-as-purchaser creates leverage to negotiate best pricing because it would capture the entire market of abortions in the exchange. For example, for New York State to cover exchange-based abortions in full, it would cost approximately \$2,000,000 per year. This is based on data described below that applies the abortion rate in New York to the projected exchange population.³⁸²

J. Setting the Premium for Abortion Coverage: an Estimate for New York State

Pricing exchange-based abortion coverage in the face of uncertainty carries two risks. The primary risk of setting the per member per month (PMPM) price too low is that premium dollars in the pool might be insufficient to cover claims. The risks of setting the PMPM too high are the potential to either price consumers who cannot afford the premium out of the market or to lose enrollment from consumers who are not willing to pay an artificially high premium. Without consumers to purchase the benefit, insurers might raise the PMPM to ensure sufficient reserves in the pool or drop the coverage altogether due to lack of demand.

Regardless of the \$1 pricing floor established by the ACA, it is important to identify the actual cost of health insurance coverage for abortion. Over time, claims experience within exchanges may allow for more precise pricing. Even at this early stage of implementation, a

³⁸⁰ KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM: SUMMARY OF THE NEW HEALTH REFORM LAW (2011), available at <http://www.kff.org/healthreform/upload/8061.pdf>; Affordable Care Act § 1334(a)(6), 42 U.S.C. § 18054(a)(6) (2010) ("ASSURED AVAILABILITY OF VARIED COVERAGE.—In entering into contracts under this subsection, the Director shall ensure that with respect to multi-state qualified health plans offered in an exchange, there is at least one such plan that does not provide coverage of services described in section 1303(b)(1)(B)(i).").

³⁸¹ PETER NEWELL & BELA GORMAN, UNITED HOSPITAL FUND, TWO INTO ONE: MERGING MARKETS AND EXCHANGES UNDER THE AFFORDABLE CARE ACT 18 (2011), available at <http://www.uhfnyc.org/publications/880772>.

³⁸² Projection expects 650,000 individuals, projecting 3,981 abortions each year on the exchange. See N.Y. STATE HEALTH FOUND., IMPLEMENTING FEDERAL HEALTH CARE REFORM: A ROADMAP FOR NEW YORK STATE 4-5 (2010); see also *Table 19: Induced Abortion Summary by Woman's Race/Ethnicity — New York State 2008*, NEW YORK STATE DEPARTMENT OF HEALTH, http://www.nyhealth.gov/nysdoh/vital_statistics/2008/table19.htm (last visited Mar. 31, 2012). Multiplying the number of abortions by the projected average price of \$503 based on provider data, producing the estimated figure of \$2,000,000 dollars.

reference point for pricing is important to ensure solvency of segregated abortion insurance pools.

In addition, states that either now or in the future may be able to fund abortion coverage for exchange enrollees, may find it useful to demonstrate that relative to other health benefits, abortion coverage is inexpensive.³⁸³ In fact, the cost of an abortion benefit within a standard exchange-based health insurance benefit package appears *lower* than \$1 PMPM. To provide an example of a process used to price an abortion coverage benefit for an exchange-based state-wide pool, New York data was gathered and analyzed.³⁸⁴ The state of New York was selected for this exercise because it has readily available data on both occurrences and costs of abortion as well high rates of rigorous reporting.³⁸⁵ Given potentially divergent legislative interpretations,

³⁸³ Lazar, *supra* note 379, at 2.

Terry Dougherty, Medicaid director with the Executive Office of Health and Human Services, said an independent actuary calculates the value of every benefit in a consumer's health plan, minus the value of abortion services and patient co-payments. That amount is submitted for partial reimbursement from the federal government, and the federal money is put in the state general fund. The state, from a separate account, then pays the insurers—minus the value of abortion services—and the insurers then pay for abortions from this pool of money. An abortion, from an insurance perspective, is a low-cost item, typically valued at less than \$1, per enrollee, per month.

Id.

³⁸⁴ To yield an estimate relevant to the exchange, population parameters were altered to mimic the exchange population. The number of abortions and the number of people in the state of New York were adjusted to exclude subpopulations ineligible for enrollment in the exchange.

Adjusting Number of Abortions. The total frequency of abortions was taken from the induced abortion data reported in the 2008 NYS Department of Health Vital Statistics report. *Table 19: Induced Abortion Summary by Woman's Race/Ethnicity — New York State 2008*, N. Y. STATE DEP'T OF HEALTH, http://www.nyhealth.gov/nysdoh/vital_statistics/2008/table19.htm (last visited Mar. 31, 2012). Excluded were all abortions paid for by Medicaid (N=43,420). To mimic the population that will be privately insured in the exchanges the abortions paid for with the following payment methods were included: "HMO", "Other Insurance", "Self-Pay", "More Than One", and "Not Stated." The categories of "other insurance" as well as "not stated" were included as these values represent private and public insurance outside of the categories listed; however, the exact breakdown is unclear. "Self-pay" and "more than one" were included because they may represent a population that can potentially acquire insurance coverage in the exchange. Thus, the total number of abortions included in the calculation was 75,946. To adjust the NYS population, data projections from the 2000 Census were used. According to the Census Bureau, the projection for the NYS population in 2008 was 19,490,297. *Population - New York City Department of City Planning*, N. Y. CITY DEP'T OF CITY PLANNING, <http://www.nyc.gov/html/dcp/html/census/popcur.shtml> (last visited Mar. 31, 2012). Since Medicare (N=2,841,000) and Medicaid (N=4,147,000) enrollees would be ineligible for coverage in the exchange, they were subtracted from the total population. *Medicaid Managed Care Enrollment Report Medicaid Data Sources - General Information*, CTRS. FOR MEDICARE & MEDICAID SERVS., http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/04_MdManCrEnrllRep.asp (last visited Mar. 31, 2012). Other ineligible groups (SCHIP, enrollees of the FEHBP, and incarcerated individuals) were also subtracted. *Prison Count 2010: State Population Declines for the First Time in 38 Years*, PEW CTR. ON THE STATES, RESEARCH & STATE POLICY INITIATIVES, http://www.pewcenteronthestates.org/report_detail.aspx?id=57653 (last visited Apr. 12, 2012); RUPRI CTR. FOR RURAL HEALTH POL'Y ANALYSIS, NEW YORK, <http://www.unmc.edu/ruprihealth/FEHBP/part2/NewYork.htm> (last visited Apr. 11, 2012). The final population metric included in the calculation was 11,863,417. Although illegal immigrants will not be permitted to purchase products at the Health Benefits Exchanges, they were not excluded from the New York State population, since they are usually not counted in the census.

³⁸⁵ It should be noted that New York State is an outlier relative to other states in both the incidence and price of abortion services, yielding a comparatively high per member per month cost. To apply the below analysis to other states, two factors must be considered: (1) How frequent is the incidence of abortion relative to New York?; and (2) How divergent is the cost of the procedure compared to that in New York? The degree to which New York's per member per month cost is higher will depend on the difference in incidence and price of the procedure in the comparison state. It

forthcoming in regulation, different scenarios for calculating the benefit were devised.³⁸⁶ The scenarios modeled here suggest that the PMPM cost for abortion coverage is lower than the \$1 PMPM minimum plans are required to collect by law.³⁸⁷ Based on these calculations, insurers

appears reasonable to assume the cost of an abortion benefit in other states would be *lower* than in New York.

³⁸⁶ After starting with a baseline calculation using unadjusted NYS population data and Medicare cost data, the population and cost parameters were then incrementally changed to create four different scenarios. First, the unadjusted NYS population and the average cost of the termination procedure alone (i.e. costs associated with ancillary services such as for anesthesia or sonograms were not included) derived from Medicare reimbursement amounts by CPT Code [1] were used. Second, PMPM cost was calculated based on the adjusted New York State population that excludes Medicaid and other public insurance beneficiaries to more accurately reflect those entering the exchange. The cost variables were held constant (Medicare cost data solely for the termination procedure). Third, the population variables were maintained at the adjusted level (as in the second scenario), but the cost variable was varied using costs obtained from an academic hospital setting. Finally, holding the population parameter at adjusted levels (second scenario), cost level was adjusted to reflect private clinic rates. All the above-mentioned scenarios used NYS Vital statistics to derive the frequency variable.

1. American Medical Association. AMA Bookstore. Web. 22 Nov. 2010. < <https://ocm.ama-assn.org/OCM/CPTRelativeValueSearch.do>>.
2. Physician practice interviews conducted by the authors.

³⁸⁷ It is important to note that in performing the calculations, the following assumptions were made:

1. It is presumed that the segregation rules apply to costs attributable to only the abortion procedure itself and not to the costs of related non-abortion services such as ultrasound or office visits.
2. As the Affordable Care Act mandates that the actuarial value be estimated "as if such coverage were included for the entire population covered," this estimate spreads the risk to the entire projected Exchange population accordingly.
3. Although several projections exist for the number of people that will enroll in the exchange by 2014 (*see* NYS HEALTH FOUND., IMPLEMENTING FEDERAL HEALTH CARE REFORM: A ROADMAP FOR NEW YORK STATE (2010); UNITED HOSPITAL FUND, NEW YORK STATE AND THE EMERGING FEDERAL HEALTH CARE REFORM BLUEPRINT: TAKING STOCK AND MAKING PLANS (2010)), no projections exist for the expected number of abortions per enrollee in the exchange population. As such, we assume that the prevalence of abortions in the exchange is equal to the known prevalence of abortions in NYS.
4. The exchange population will be identical in risk profile to the general NYS population, with the exception of the excluded groups listed above. For example, the gender, age, race, and health status of the exchange and NYS population will be the same for this calculation. Risk profiles will also be similar across all Qualified Health Plans (QHPs).
5. The source of payment for abortion services in the exchange population will be similar to the current population (NYSDOH Vital Statistics) and Medicaid and Medicare will continue to pay for abortions. To account for this, abortions paid by Medicaid and Medicare were removed from the model.
6. Reporting is accurate by procedure, reimbursement, and number of abortions.
7. The reporting for D&C procedure is inaccurate. Providers are likely checking this box when manual aspiration is performed.
8. National rates of abortion by gestational age are similar to those in NYS.
9. Reimbursement rates for medical providers are the same regardless whether a specialist or generalist performs the service (e.g. an obstetrician versus a family practitioner).
10. The reimbursement procedures used apply to all provider-carrier relationships.
11. The frequency of abortions stays constant and will remain unchanged at the time the exchanges are operational.
12. The Medical Loss Ratio (MLR) for exchange plans will be eighty percent.
13. Cost data in 2014 will be similar to 2008 in that the estimates are not adjusted for future medical inflation.

operating within the exchange and choosing to offer abortion coverage are expected to price the abortion benefit premium between eleven and thirty-three cents on average.³⁸⁸ Because of the minimum pricing established by the ACA, the abortion benefit will likely be priced at \$1 PMPM. Over time, claims experience within exchanges will allow for more precise premiums notwithstanding the \$1 minimum established by the ACA.

In the successful challenge of a Rhode Island statute that barred coverage of abortion discussed above,³⁸⁹ the two major insurers in Rhode Island stipulated the costs of riders for excluded abortion coverage. The court noted, in relevant part:

Before the planned effective date of the prohibition, virtually all comprehensive health insurance policies in Rhode Island which covered pregnancy-related conditions also covered all induced abortions. Blue Cross and Blue Shield of

14. The separate price for abortion coverage for exchange plans will include *all* abortions, meaning it will also include abortions in cases of rape, incest, and life of the pregnant woman. This is done for administrative ease: it is unduly cumbersome to parse pricing of claims by the reason a woman is seeking an abortion.

³⁸⁸ This range was calculated by two sequential estimates: (1) the calculation of the cost of the benefit, which then provided the data for (2) the calculation of the actuarial value. The preliminary premium estimate is the dollar value that each participant pays into an insurance fund from which claims payments can be drawn. In its simplest scenario, such a calculation only takes into account the number of people paying into the pool, an estimated claims frequency, and the estimated cost of each claim. The calculation does not include a deductible, co-pay, co-insurance, or differentiations by age or gender.

A complete actuarial value calculation also considers other factors. *See* AMERICAN ACADEMY OF ACTUARIES, ISSUE BRIEF: ACTUARIAL VALUE UNDER THE AFFORDABLE CARE ACT 2–3, 8 (2011). Variations in benefits plan design involve the co-insurance, deductible, and co-payment amounts. A more in-depth risk-adjusted estimate takes into account the risk profile of the population, variation in use of the benefit by demographic or geographic groups, and the frequency of claims. *Id.* at 2–3. Although gender rating is prohibited in the individual and small group markets under the ACA, gender is a significant cost determinant in childbearing years. Administrative costs and profit at a combined rate of twenty percent, consistent with the ACA’s medical loss ratio, are also factored into pricing the benefit. *Id.* at 8; Affordable Care Act § 2718, 42 U.S.C. §300gg-18 (2010). All aforementioned variables figure into identifying the amount a subscriber should pay, so that the carrier is able to pay out claims, stay solvent, and make a profit in accordance with applicable law.

To calculate the actuarial value for different scenarios, the benefit amount was adjusted to include two important inputs: the administrative costs a carrier bears in complying with the “two-check requirement” (using an MLR of eighty percent), and the actuarial value for each QHP in the exchange. The ACA establishes different deductibles, co-payments, and co-insurance levels across the four levels of plans to be offered in exchanges (Bronze, Silver, Gold, Platinum). A Bronze plan will provide a level of coverage equivalent to sixty percent of the full actuarial value of the benefit provided under the plan. Silver plans will be seventy percent, Gold plans will cover eighty percent, and Platinum plans will cover ninety percent of the full actuarial value. The different levels of cost sharing will affect the PMPM prices. Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. (2010); Health Care and Education Reconciliation Act of 2010, H.R. 4872, 111th Cong. (2010).

A twenty percent medical loss ratio was assumed, meaning that insurers will spend eighty percent of their premium revenues (excluding federal and state taxes and licensing and regulatory fees) on health care and quality improvement activities). *See* John K. Iglehart, *Defining Medical Expenses: An Early Skirmish over Insurance Reforms*, 11 NEW ENG. J. MED. 999 (2010); *see also* Julie Appleby, *New Law’s Health Insurance Regulations Could Mean Rebates For Consumers*, KAISER HEALTH NEWS, Nov. 22, 2010, <http://www.kaiserhealthnews.org/Stories/2010/November/22/mlr-sebelius-medical-loss-ratio-insurance.aspx>. For each level of coverage, the PMPM costs were multiplied by the co-insurance percentage to obtain the true member contribution per month.

³⁸⁹ Under the Rhode Island Statute, coverage was barred for all induced abortion except in cases of rape, incest or to preserve the life of the pregnant woman. R. I. GEN. LAWS ANN. § 27-18-28 (West 1983).

Rhode Island (“Blue Cross”) and the Rhode Island Group Health Association (“RIGHA”), who between them provide the vast majority of health insurance policies in Rhode Island, have stated that but for the prohibition, they would not have deleted or segregated from their comprehensive policies the abortion coverage at issue here. . . . Those wishing the “abortion rider” would be required to pay an extra premium, calculated by the insurers to represent the incremental cost of abortion coverage.³⁹⁰

In stipulation, Blue Cross priced an abortion rider at fifty-six cents per month for family memberships and forty-one cents per month for individuals. RIGHA proposed pricing of fourteen cents per month for individuals and six cents per month for individuals. Although the Rhode Island statute was passed and the challenge upheld some thirty years ago, the price of abortion services has stayed relatively constant during that time.³⁹¹ The pricing suggested by the Rhode Island carriers, while not instructive, is potentially a useful reference point for pricing segregated abortion benefits under the ACA.

The level of discretion insurers will have over funds collected but not spent is unclear. Insurers could be required to rollover surplus abortion premium dollars within the segregated account from year to year. Rollover would provide an important cushion to ensure sufficient reserves for coverage over time given uncertainties of exchange enrollment and benefit utilization.

VIII. CONCLUSION

This Article explores payment mechanisms for abortion in the United States, reviews federal and state laws that limit insurance coverage of abortion, highlights unprecedented abortion coverage restrictions promulgated under the ACA, considers the potential impact of those restrictions, and identifies key options available to state regulators to promote access to abortion despite the limitations established by health reform.

Health insurance exchanges established by the Affordable Care Act (ACA) are expected to expand health coverage and create new regulatory environments for insurance nationwide. Federal abortion coverage financing restrictions in the ACA—although tailored to the exchanges—could effect markets outside of the exchange. As a result, health reform has the potential to diminish availability of abortion coverage in private insurance markets in the United States. Although the demand for abortion services could remain constant even as private

³⁹⁰ Nat’l Educ. Ass’n of Rhode Island v. Garrahy, 598 F. Supp 1374 (D.R.I. 1984) *aff’d* 779 F.2d 790 (1st Cir. 1986).

³⁹¹ Stanley Henshaw & Lawrence Finer, *The Accessibility of Abortion Services in the United States, 2001*, 35 PERSP. ON SEXUAL & REPROD. HEALTH 16, 19 (2003).

In current dollars (the amount paid at the time), the average self-paying client’s payment for an abortion at 10 weeks LMP has increased steadily over time—from \$200 in 1983 to \$319 in 1997, and to \$372 in 2001. . . . When inflation in the cost of living (as measured by the Consumer Price Index for all items) is taken into account, the amount changed little between 1983 and 1997, but increased by 9% (\$30) from 1997 to 2001. When compared with the amounts paid for other medical care, the amount paid for abortion services fell from 1983 to 1997, and then increased by 5% (\$17) between 1997 and 2001.

Id.

insurance coverage of abortion services decreases, the erosion of insurance coverage for abortion could create new burdens disproportionately borne by lower-income women.

Relative to other medical procedures, abortion received exceptional political and legal treatment in the passage and codification of health reform in the United States. Insurance carriers that provide coverage for abortion services in exchange-based plans must comply with administrative and accounting requirements as well as maintain a robust system of internal controls outlined in the ACA and subsequent regulations. To preserve insurance coverage of abortion services, states may consider: maintenance of the individual and small group health insurance markets outside exchanges; recognition of single payment instruments as a reasonable means to satisfy federal segregation requirements; review of abortion access protections to ensure compliance with state law; and access to confidential care and coverage consistent with state law. Additionally, regulators may provide guidance to industry to assist compliance with the new rules. States may also consider opportunities to mandate abortion coverage, structure exchanges to segregate funds for insurers, or provide state financing for exchange-based abortion coverage. Regulators might choose to exempt abortion coverage from requirements that multi-state plans offer uniform benefit package. Finally, state regulators can provide estimates of the cost of an abortion benefit to ensure fair pricing for consumers. Estimates performed in this analysis using New York data suggest the price of exchange-based abortion coverage will be approximately \$1 per member per month as required by the statutory minimum in the ACA.

As described herein, states serve pivotal roles in the regulation of commercial insurance, the implementation of health reform and the structure and enforcement of the new federal abortion coverage restrictions. Within this context, states have a number of options available should policymakers seek to ensure continued availability of insurance coverage for abortion.