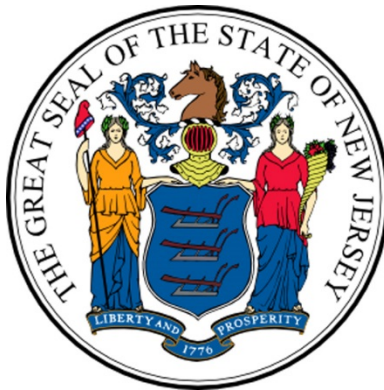


New Jersey Department of Banking and Insurance

FREEDOM OF REPRODUCTIVE CHOICE ACT

Report to the Governor and Legislature



November 23, 2022



State of New Jersey
DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF THE COMMISSIONER
PO Box 325
TRENTON, NJ 08625-0325
TEL (609) 633-7667

PHIL MURPHY
Governor

SHEILA OLIVER
Lt. Governor

MARLENE CARIDE
Commissioner

November 23, 2022

The Honorable Philip D. Murphy
Governor of New Jersey

The Honorable Nicholas P. Scutari
President of the Senate

The Honorable Craig J. Coughlin
Speaker of the General Assembly

RE: Freedom of Reproductive Choice Act Report

Dear Governor Murphy, Senate President Scutari and Speaker Coughlin:

The Department of Banking and Insurance submits the attached report pursuant to section 3 of P.L. 2021, c. 375 (C.26:2S-39), which was approved January 13, 2022.

The report demonstrates that a regulation is necessary to provide that health benefit plans available to employers and residents in the State-regulated markets, consisting of the individual, small employer, and large employer markets, provide comprehensive coverage for abortion.

Accordingly, the Department will be proposing such a regulation consistent with the Act.

Respectfully submitted,

A handwritten signature in blue ink, appearing to read "M. Caride".

Marlene Caride
Commissioner

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Introduction

On January 13, 2022, Governor Phil Murphy signed P.L. 2021, c. 375 (“the Act”). The Act codifies an individual’s right to make their own decisions concerning reproduction, including the right to contraception, the right to terminate a pregnancy, and the right to carry a pregnancy to term, without government interference or fear of prosecution in the State of New Jersey. With regard to health insurance coverage, the Act contemplates that the Department of Banking and Insurance, after conducting a study and issuing a report, may direct health benefit plans to provide coverage for abortion services. If such a regulation is adopted, it must include certain exceptions for religious employers.

The recent Supreme Court of the United States decision in *Dobbs v. Jackson Women’s Health Organization* overturned decades of national precedent and upended well-established constitutional rights under the United States Constitution. The decision was issued on June 24, 2022 and overturned the landmark decisions in *Roe v. Wade* and *Planned Parenthood v. Casey*. While there has been an abrupt shift and uncertainty created by the United States Supreme Court, P.L.2021, c.375 and New Jersey Supreme Court precedent make clear that, in New Jersey, an individual continues to have a right to abortion as part of their reproductive care. However, for a variety of reasons, the availability of insurance coverage for such services is inconsistent.

As part of the study provided for under the Act, on April 26, 2022, the Department solicited feedback from the public pursuant to section 3 of the Act to determine whether regulations are necessary to secure comprehensive insurance coverage for reproductive care and enable the citizens of New Jersey to fully exercise their freedom of reproductive choice. In response, hundreds of comments were submitted and reviewed by the Department.

In addition to reviewing and considering the public comments received the Department reviewed the medical evidence that points to access to the full range of safe reproductive health care services, particularly the range of recommended contraceptive methods, as central to healthy outcomes. The

Department also reviewed available data on the cost of coverage for abortion services and found the cost to be de minimus.

Additionally, the Department reviewed and considered the relevant regulatory landscape in New Jersey. By way of background, the Department notes that the New Jersey Supreme Court, in *Choose v. Byrne*, 91 N.J. 287 (1982) and *Planned Parenthood of Cent. N.J. v. Farmer*, 165 N.J. 609 (2000), recognized that the right to reproductive choice is a fundamental right enshrined in the State Constitution and that the right to reproductive choice includes the right to determine whether and when to bear children. In addition, the New Jersey Legislature has expressed its commitment to, “ensuring that no barriers to reproductive freedom exist in the State.”¹ To achieve those ends, the Legislature, in the Act, declared it the policy of this State to, among other things, advance comprehensive insurance coverage for reproductive care, including services to terminate a pregnancy that enables the citizens of New Jersey to fully exercise their freedom of reproductive choice while recognizing the rights of certain religious employers to request an exemption from such coverage. Finally, under the Act, the Legislature expressed an intent to ensure that all laws and regulations that are currently in force or enacted in the future conform to the provisions and the express or implied purposes of the act.

The Department submits this report to the Governor and Legislature to demonstrate the need for greater transparency and consistency regarding health coverage for abortion. Accordingly, there is a need for a clear regulation to provide for abortion coverage under state-regulated health benefits plans consistent with state policy and the rights promulgated in the Act.

Health Insurance Coverage

While many commercial health benefits plans in New Jersey, as well as Medicaid, cover the cost of abortion services, neither federal nor State law mandate all health benefits plans provide such coverage. This fact alone has been cited as a source of confusion and a potential obstacle to accessing the full range of reproductive health care services for many individuals.

The state of New Jersey has regulatory authority over certain health insurance markets. Specifically, the Department, regulates the individual, small employer and the fully-insured large employer health insurance markets, often referred to as the “regulated markets.” The New Jersey Department of Human Services oversees the Medicaid program, with substantial federal funding provided for the program. The State Health Benefits Commission and the School Employees’ Health Benefits Commission oversees the State and School Employees Health Benefits Programs respectively (SHBP and SEHBP). Federally-regulated markets include the self-insured employer market and Medicare.

While not the focus of this report, it is important to point out that the New Jersey Medicaid market, which currently covers approximately 2,182,660 individuals², provides coverage for abortion services. Although Medicaid is largely federally funded, the abortion services are paid for with state funds.³ With regard to

¹ Subsection g. of section 1 of P.L. 2021, c. 375.

² https://www.state.nj.us/humanservices/dmahs/news/reports/enrollment_2022_09.pdf

³ The federal Hyde Amendment, passed in 1977, bans state use of federal Medicaid dollars to pay for abortions unless the pregnancy is the result of rape or incest, or the abortion is “necessary to save the life of the woman.” States can use their own funds to cover other medically necessary abortions - usually defined by states as those to protect the physical or mental health of the woman - for Medicaid beneficiaries. Overall, 34 states and DC follow the Hyde amendment standards, 1 state, South Dakota, does not follow Hyde standards and only pays for

the SHBP and SEHBP, abortion coverage is also provided in those markets. For the purposes of this report, section 3 of P.L. 2021, c.375 provides that the Department may, after a study and issuing this report, provide that health benefit plans provide coverage for abortion, with exceptions available for religious employers. Section 3 of the Act, as well as the scope of this report, pertains to the “regulated” markets, which include the individual, small employer and fully-insured large employer markets.

Currently, health insurance coverage for abortion services in the regulated markets is neither explicitly prohibited nor required by state or federal law. However, in the most regulated markets, the individual and small employer markets, all carriers currently provide coverage for abortion. While the default policy language is for coverage to include all abortions, carriers in these markets may opt to limit such coverage to cases of rape, incest or the life of the mother.⁴ Therefore, consumers in these markets may review the Summary of Benefits and Coverage for plans offered to determine the extent to which abortion is covered under their plan. Currently, policies are available with either abortion coverage for all abortions or only for cases of rape, incest and the life of the mother. In the large employer market, in which policy language is less directly regulated by the Department, abortion coverage may be offered on a case-by-case basis.

Marketplace Plans

Currently, plans offered through New Jersey's Official Health Insurance Marketplace, Get Covered New Jersey, offer abortion coverage; however, like in many states that do not mandate such coverage, the coverage is not consistently available. Carriers have the option to cover all abortions or to restrict such coverage to cases of rape, incest or the life of the mother. While information regarding this coverage is included in the Summary of Benefits and Coverage (SBC) it may not always be clear to consumers what coverage is included in each health benefits plan.

All plans offered on the Affordable Care Act (ACA) Marketplaces, including New Jersey's official Marketplace Get Covered New Jersey, provide coverage for 10 Essential Health Benefits (EHB). EHBs include, among other benefits, preventative services, maternity and newborn care, mental health and substance use disorder services including behavioral health treatment, and prescription drugs. However, federal law explicitly excluded abortion from the list of EHBs that all plans are required to offer. Therefore, federal law does not require abortion coverage. On the other hand, states were permitted to include additional benefits as EHBs if those benefits were in the state's “benchmark plan.”⁵ Currently, New Jersey's benchmark plan⁶ includes coverage for “medically necessary” abortion, including abortions for which public funding is not available.

abortions when necessary to protect a woman's life, while 15 states pay for all or other medically necessary abortions.

⁴ Individual standard forms: https://www.nj.gov/dobi/division_insurance/ihcseh/ihcforms.html. The language for this exception is based on the federal Hyde amendment, which states that the exception for the life of the mother applies “where the life of the mother would be endangered if the fetus were carried to term.” See, e.g., Pub.L. No. 101-166, § 204, 103 Stat. 1159, 1177 (1989).

Small Employer standard forms: https://www.nj.gov/dobi/division_insurance/ihcseh/sehforms.html

⁵ 45 CFR §156.100

⁶ EHBs in addition to the 10 required by the ACA, are determined by each state's benchmark plan. The New Jersey benchmark plan, including the plan in effect prior to December 31, 2011, the Horizon HMO Access HSA Compatible, included coverage for medically necessary abortions. Thus, if an abortion regulation pursuant to the Act were adopted, defrayal under 45 CFR §155.170 is not triggered.

The Affordable Care Act created tax credits to assist consumers in purchasing individual coverage on the Marketplace. These tax credits, or “subsidies,” were recently expanded under the American Rescue Plan and again extended under the Inflation Reduction Act.⁷ However, Under federal law, federal funding is prohibited from paying for the portion of premium attributed to coverage for abortion. The ACA requires plans that offer coverage for abortion beyond Hyde limitations (rape, incest and life of the mother) to segregate the federal funds used to subsidize premium costs for the EHBs from the premiums costs that pay for that coverage. Carriers are required to collect a separate payment for abortion coverage and notify consumers regarding the inclusion or exclusion of abortion in the Summary of Benefits and Coverage at enrollment. Any plan that includes coverage of abortions beyond Hyde limitations must estimate the cost of the abortion benefit, but it must be valued at least \$1 per enrollee per month.⁸

Beginning in plan year 2021, New Jersey further increased affordability in the individual market by creating a state the New Jersey Health Plan Savings (NJHPS), a state subsidy that is in addition to the federal ACA subsidies.⁹ The NJHPS is not subject to the limits under the ACA regarding abortion coverage.

Other States

As part of the study conducted pursuant to section 3 of the Act, the Department considered the range of applicable policies across other states. The Department has found that seven states require abortion coverage in private health insurance plans, five of which require abortion coverage with no copayments.¹⁰ Notably, both New York and Maine require all major medical plans to cover abortion services, including through telehealth and mail order services related to abortion. Several other states restrict coverage to cases of rape, incest, substantial and irreversible impairment of a major bodily function, or to protect the life of the patient.

In 2019, eight states that do not have laws restricting abortion coverage (Delaware, Iowa, Illinois, Minnesota, New Mexico, Nevada, West Virginia, and Wyoming), had no Marketplace plans that offered abortion coverage.¹¹ In the five states (Connecticut, Hawaii, Maryland, New Hampshire, and Vermont) and the District of Columbia that have no laws banning on requiring abortion coverage, all of the 2019 Marketplace plans include abortion coverage. Four states (California, New York, Oregon, and Washington) require abortion coverage from plans on the marketplace. As of January 1, 2020, abortion coverage is required on the Marketplace in Maine. There are seven states (Alaska, Colorado, Maine, Massachusetts, Montana, New Jersey, and Rhode Island) that do not require abortion coverage and offer at least one plan on the Marketplace that includes abortion coverage. For women in these seven states, the actual availability of coverage depends on whether there is a plan offered in their area that includes abortion services. As a combined result of the state laws and insurance company choices, women in 34 states currently do not have access to insurance coverage for abortions through a Marketplace plan.

⁷ <https://www.kff.org/policy-watch/five-things-to-know-about-renewal-of-extra-affordable-care-act-subsidies-in-inflation-reduction-act/>

⁸ The Patient Protection and Affordable Care Act, Section 1303 Special Rules - 42 U.S. Code § 18023

⁹ <https://nj.gov/getcoverednj/financialhelp/premiums/>

¹⁰ California, Illinois, Maine, Maryland, New York, Oregon, Washington. See the following:
<https://www.guttmacher.org/state-policy/explore/regulating-insurance-coverage-abortion>

¹¹ <https://files.kff.org/attachment/issue-brief-coverage-for-abortion-services-in-medicaid-marketplace-plans-and-private-plans>

Social Impact

Abortions in the United States

The Center for Disease Control and Prevention (CDC) broadly divides abortions into two categories: surgical abortions and medication abortions. In 2019, 56% of legal abortions in clinical settings occurred via some form of surgery, while 44% were medication abortions, according to the CDC. Since the Food and Drug Administration first approved medication abortion in 2000, their use has increased over time as a share of abortions nationally. Guttmacher Institute's¹² preliminary data from its forthcoming study says that 2020 was the first time that more than half of all abortions in clinical settings in the U.S. were medication abortions.¹³

Each year, almost one million women in the U.S. have an abortion.¹⁴ The last year for which the CDC reported a yearly national total for abortions is 2019. The agency says there were 629,898 abortions nationally that year, slightly up from 619,591 in 2018.¹⁵ Guttmacher's latest available figures are from 2020, when it says there were 930,160 abortions nationwide, up from 916,460 in 2019.¹⁶

In 2017, there were 1,587 facilities providing abortion in the United States, representing a 5% decrease from the 1,671 facilities in 2014.¹⁷ Sixty percent of all abortions were provided at abortion clinics, 35% at nonspecialized clinics, 3% at hospitals and 1% at physicians' offices.¹⁸

In 2017, 89% of U.S. counties had no clinics providing abortions.¹⁹ Some 38% of reproductive-age women lived in those counties and would have had to travel elsewhere to obtain an abortion.²⁰ Of patients who had an abortion in 2014, one-third had to travel more than 25 miles one way to reach a facility.²¹

Abortion in New Jersey

According to the Guttmacher Institute, in 2017, 48,110 abortions were provided in New Jersey.²² Note that not all abortions that occurred in New Jersey were provided to state residents. Some patients may have traveled from other states, and some New Jersey residents may have traveled to another state for an abortion. There was a 9% increase in the abortion rate in New Jersey between 2014 and 2017, from 25.8 to 28.0 abortions per 1,000 women of reproductive age.²³ Abortions in New Jersey represent 5.6% of all abortions in the United States.²⁴ Approximately 862,320 abortions occurred in the United States in

¹² The Guttmacher Institute describes itself as "a leading research and policy organization committed to advancing sexual and reproductive health and rights (SRHR) worldwide." While the organization is a nonprofit and nonpartisan, it is also an advocate for reproductive rights. Regardless, the organization provides research and statistics on abortion that are widely cited.

¹³ <https://www.guttmacher.org/article/2022/02/medication-abortion-now-accounts-more-half-all-us-abortions>

¹⁴ <https://www.pewresearch.org/fact-tank/2022/06/24/what-the-data-says-about-abortion-in-the-u-s-2/>

¹⁵ https://www.cdc.gov/reproductivehealth/data_stats/index.htm

¹⁶ <https://www.guttmacher.org/article/2022/06/long-term-decline-us-abortions-reverses-showing-rising-need-abortion-supreme-court>

¹⁷ <https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017>

¹⁸ <https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017>

¹⁹ <https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017>

²⁰ <https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017>

²¹ <https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017>

²² <https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-new-jersey>

²³ <https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-new-jersey>

²⁴ <https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-new-jersey>

2017.²⁵ The resulting abortion rate of 13.5 abortions per 1,000 women of reproductive age (15–44) represents an 8% decrease from the 2014 rate of 14.6.²⁶ The Department notes that abortions may occur in a variety of clinical settings, such as facilities or clinics, but also by prescription medication. In New Jersey, there were 76 facilities providing abortion in New Jersey in 2017, and 41 of those were clinics. However, by recently clearing the path for certain healthcare providers other than physicians to perform a termination of pregnancy, New Jersey has likely significantly expanded access to reproductive care in New Jersey.²⁷ Currently, there are approximately 11,956 Advanced Practice Nurses, 4,495 Physician Assistants, 393 Certified Nurse Midwives, and 18 Certified Midwives in the State who could become authorized to perform the procedure once new regulations take effect.²⁸

Medical Evidence

The medical community generally supports unfettered access to abortion as part of reproductive health care, including such recommendations by the World Health Organization (WHO)²⁹, the American Medical Association and the American College of Obstetricians and Gynecologists (ACOG)³⁰. As the major medical organization dedicated to the health of individuals in need of gynecologic and obstetric care, ACOG has found that “Abortion is an essential component of comprehensive, evidence-based health care.”³¹

The Department notes that the medical evidence points to access to the full range of safe reproductive health care services, particularly the range of recommended contraceptive methods, as central to healthy outcomes, and notably leads to fewer unintended pregnancies.³² However, access to such services are often not available due to systemic, patient and provider barriers.³³

Comprehensive abortion care is included in the list of essential health care services published by WHO in 2020.³⁴ When carried out using a method recommended by WHO appropriate to the pregnancy duration, and by someone with the necessary skills, abortion is a safe health care intervention.³⁵ However, when people with unintended pregnancies face barriers to attaining safe, timely, affordable, geographically reachable, respectful and non-discriminatory abortion, they often resort to unsafe abortion.³⁶

According to a study performed by researchers from The University of California San Francisco, when compared with women who were able to obtain a wanted abortion, women denied a wanted abortion who went on to give birth were more likely to experience:

²⁵ <https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-new-jersey>

²⁶ <https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-new-jersey>

²⁷ <https://www.njconsumeraffairs.gov/News/Pages/10132021.aspx>

²⁸ <https://www.njconsumeraffairs.gov/News/Pages/10132021.aspx>

³⁰ <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/abortion-policy>

³¹ <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/abortion-policy>

³² <https://www.njhqcqi.org/wp-content/uploads/2020/05/NJRHAP-Full-Toolkit.pdf>

³³ Power to Decide: Contraceptive Access in New Jersey, March 2020. https://powertodecide.org/sites/default/files/2020-04/State%20Factsheet_New%20Jersey.pdf

³⁴ <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/related-health-issues>

³⁵ <https://www.who.int/news-room/fact-sheets/detail/abortion>

³⁶ <https://www.who.int/news-room/fact-sheets/detail/abortion>

- Gestational hypertension.
- Joint pain and headaches or migraines.
- Fair or poor health.
- Death. Two women in the study died of maternal causes.

According to the study, women denied abortions also had large and significant differences in their economic trajectories, facing more hardships than women receiving wanted abortions.

The women denied abortions were more likely to:

- Raise children alone, not with family or a male partner.
- Live in households that drop below the poverty level, with 72% of households where a mother was denied an abortion living below the federal poverty level, compared with 55% of those who received the abortion.
- Lack enough money to pay for food, housing and transportation, with 87% of those who were denied abortions reporting that problem, compared with 70% of those who received an abortion.³⁷

The National Academy of Sciences, Engineering, and Medicine (NASEM) NASEM completed an exhaustive review on the safety and effectiveness of abortion care and concluded that complications from abortion are rare and occur far less frequently than during childbirth.³⁸ The review also concluded that safety is enhanced when the abortion is performed earlier in the pregnancy. State level restrictions such as waiting periods, ultrasound requirements, and gestational limits that impede access and delay abortion provision likely make abortions less safe.³⁹ Financial burdens and difficulty obtaining insurance are frequently cited by women as reasons for delay in obtaining an abortion.

When medication abortion, which account for the majority of abortions, are administered at 9 weeks' gestation or less, the pregnancy is terminated successfully 99.6% of the time, with a 0.4% risk of major complications, and an associated mortality rate of less than 0.001 percent (0.00064%).⁴⁰

Medication abortion can be provided in a clinical setting or via telehealth (without an in person visit). Research has found that the provision of medication abortion via telehealth is as safe and effective as the provision of the medication abortion at an in person visit.⁴¹ Studies on procedural abortions, which include aspiration and D&E, have also found that they are very safe. Research on aspiration abortions, the most common procedural method, have found the rate of major complications of less than 1%.⁴²

³⁷ <https://www.ama-assn.org/delivering-care/population-care/access-abortion-and-women-s-health-what-research-shows> citing the Turnway Study: <https://www.ansirh.org/research/ongoing/turnaway-study>

³⁸ National Academies of Sciences, Engineering, and Medicine. 2018. The Safety and Quality of Abortion Care in the United States. Washington, DC: The National Academies Press. <https://doi.org/10.17226/24950>.

³⁹ Id. at page 77

⁴⁰ [https://www.kff.org/womens-health-policy/fact-sheet/the-availability-and-use-of-medication-abortion/#:~:text=Medication%20abortion%20is%20a%20safe,than%200.001%20percent%20\(0.00064%25\).](https://www.kff.org/womens-health-policy/fact-sheet/the-availability-and-use-of-medication-abortion/#:~:text=Medication%20abortion%20is%20a%20safe,than%200.001%20percent%20(0.00064%25).)

⁴¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5847856/>

⁴² <https://www.kff.org/womens-health-policy/report/key-facts-on-abortion-in-the-united-states/>

It is also worth noting that the Emergency Medical Treatment and Labor Act (EMTALA), along with N.J.A.C. 8:43G-12 et seq., requires that patients who present at an emergency department of a hospital who request examination or treatment shall receive an appropriate medical screening examination, stabilizing treatment, and transfer if necessary. Emergency medical conditions involving pregnant patients may include but are not limited to ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as severe preeclampsia. Thus, if a physician believes that a pregnant patient presenting at an emergency department, including certain labor and delivery departments, is experiencing an emergency medical condition as defined by EMTALA, and that abortion is the stabilizing treatment necessary to resolve the emergency medical condition, the physician must ensure that the patient receives that treatment.

Financial Impacts And Out of Pocket Costs

The cost of an abortion varies depending on many factors. The cost can vary based on the location, facility, timing and type of procedure. The cost of medication abortion is slightly lower than the cost of procedural abortions, however, the cost increases the later in pregnancy the procedure is performed.

In 2020, the median patient charge for the cost of a medication abortion was \$560, and \$575 for a first-trimester procedural abortion.⁴³ The cost for a third-trimester procedural abortion was \$895.⁴⁴ Though the vast majority (~90%) of abortions are performed in the first trimester of pregnancy, the costs are challenging for many low-income women.⁴⁵ The Federal Reserve estimates that only 76% of adults in the United States would be able to fund a \$400 emergency expense.⁴⁶ Thus, one quarter of adults may not be able to afford an abortion without some assistance. In fact, since three-quarters of abortion patients are poor or low income,⁴⁷ it may be that the relevant populations are not able to afford abortions in even larger numbers. While most abortions occur earlier in pregnancy, approximately 5% of abortions are performed at 16 weeks or later in the pregnancy.⁴⁸ Therefore, for women with medically complicated health situations or who need a second-trimester abortion, the costs could be prohibitive. To the extent that patients find they have to delay their abortion while they take time to raise funds,⁴⁹ or patients first learn of a fetal anomaly in the second trimester, then the costs increase.⁵⁰

⁴³ <https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01528>

⁴⁴ [https://www.healthaffairs.org/doi/Bhutta N, Dettling L. Money in the bank? Assessing families' liquid savings using the Survey of Consumer Finances \[Internet\]. Washington \(DC\): Board of Governors of the Federal Reserve System; 2018 Nov 19 \[cited 2022 Feb 15\]. Available from: https://www.federalreserve.gov/econres/notes/feds-notes/assessing-families-liquid-savings-using-the-survey-of-consumer-finances-20181119.htm](https://www.healthaffairs.org/doi/Bhutta N, Dettling L. Money in the bank? Assessing families' liquid savings using the Survey of Consumer Finances [Internet]. Washington (DC): Board of Governors of the Federal Reserve System; 2018 Nov 19 [cited 2022 Feb 15]. Available from: https://www.federalreserve.gov/econres/notes/feds-notes/assessing-families-liquid-savings-using-the-survey-of-consumer-finances-20181119.htm) Google Scholar10.1377/hlthaff.2021.01528

⁴⁵ <https://www.guttmacher.org/state-policy/explore/overview-abortion-laws>
<https://www.guttmacher.org/fact-sheet/induced-abortion-united-states>

⁴⁷ Jerman J, Jones RK, Onda T. Characteristics of U.S. abortion patients in 2014 and changes since 2008 [Internet]. New York (NY): Guttmacher Institute; 2016 May [cited 2022 Feb 15]. Available from: https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf Google Scholar

⁴⁸ *ibid*

⁴⁹ <https://www.guttmacher.org/gpr/2016/07/abortion-lives-women-struggling-financially-why-insurance-coverage-matters>

⁵⁰ <https://www.nationaljournal.com/s/627985/should-mothers-be-forced-bear-disabled-children-against-their-will/>

The extent to which individuals must bear the costs of abortion services depends on many factors. Federal and state laws, as well as insurers' coverage policies, shape the extent to which women can have coverage for abortion services under both publicly funded programs and private plans. Women who seek an abortion, but do not have coverage for the service, shoulder the out-of-pocket costs of the services. There is research indicating that the proportion of facilities that accept any insurance declined between 2017 and 2020.⁵¹ While there are multiple barriers for facilities in accepting private insurance, facilities have reported that the largest difficulty in accepting private insurance was determining whether insurers would pay for the abortion care their clients received.⁵²

Whether health insurance covers abortion has direct financial implications for patients, particularly those with lower incomes. Approximately four in 10 privately insured abortion patients use their insurance to pay for the procedure. There may be many reasons why insurance is not used when seeking an abortion. It may be that some patients may have health insurance plans that do not cover abortion, or they may not know whether their plan covers the procedure. Others have deductibles that must be met before their plan covers any expenses. In some cases, a patient's health plan may not include the patient's abortion provider in its network. Stigma around abortion may also play a role and patients may be concerned about privacy if they use their insurance coverage.

As part of its study pursuant to the Act, the Department requested specific information and conducted an analysis of available data on the cost and possible impacts to insurance coverage if coverage for abortion were required in the regulated markets. Carriers in the individual and small employer markets in New Jersey were asked to provide the impact of covering all abortions as part of their 2023 rate filings. Carriers estimated a range of zero impact to .1% of premium. Based on the responses provided, the Department finds that the costs of administering an abortion coverage requirement pursuant to the Act to be de minimis. Thus, enacting an abortion coverage requirement would not be expected to materially impact insurance rates in the regulated markets.⁵³ The Department also recognizes that any costs associated with abortion coverage would be offset, to an unspecified degree, by savings achieved as a result of the abortions, such as the savings of not paying claims for prenatal care, delivery or postnatal care.

Transparency

One of the concerns with coverage for abortion is, to the extent a particular plan covers abortion, the way that coverage is communicated to covered persons. The ACA requires plans covering abortion beyond cases of rape, incest or life endangerment to inform individuals of this coverage "as part of the summary of benefits and coverage explanation, at the time of enrollment." The Government Accountability Office and the Guttmacher Institute have found continuing problems with individuals' ability to readily and easily determine whether and to what extent plans cover abortion.

The GAO examined the extent to which 2014 marketplace plans covered abortion services beyond cases of rape, incest and life endangerment.² According to the GAO's report, issued in September 2014, the vast majority of issuers did not offer clear information to individuals shopping for plans on the marketplace about whether abortion care is covered. Concerns regarding transparency were also raised by a

⁵¹ <https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01528>

⁵² Kimport K, Rowland B. Taking insurance in abortion care: policy, practices, and the role of poverty. In: Kronenfeld JJ, editor. Health and health care concerns among women and racial and ethnic minorities. Vol. 35. Somerville (MA): Emerald Publishing; 2017. p. 39–57. Crossref, Google Scholar

Guttmacher Institute analysis published earlier in 2014 and a more recent Guttmacher review of 2015 marketplace plans.⁵⁴ Increasingly SBCs, including those available in New Jersey, do address abortion coverage. However, even among the SBCs that do address abortion coverage, the way the information is provided varies considerably and can be difficult to understand.

Importantly, when issuers do mention coverage or exclusion of abortion services in SBCs, this information may be presented in different ways and make it difficult to find and compare across plans. And the language used to describe abortion coverage or exclusions varies among carriers. In trying to comply with the ACA and state law, some issuers use language that may be confusing for consumers. For example, one carrier states their plan "Includes voluntary abortion services rendered by a licensed and certified professional provider, including those for which federal funding is prohibited." The consumer shopping for health insurance may not fully understand this language.

An additional consideration is the interaction of commercial individual health coverage with the Medicaid program. One of the guiding principles of Get Covered New Jersey is to work with the Medicaid program to achieve the "no wrong door" eligibility process that the ACA envisions. The goal is for consumers to submit one application and then easily enroll in the health program for which they are eligible: an exchange plan, Medicaid, or CHIP. The "no wrong door" concept applies to all health insurance marketplaces, meaning they must provide at least minimal coordination across programs. Particularly for low-income individuals, income volatility causes a high degree of "churn" between Medicaid and Marketplace coverage. Tracking the nuances between Marketplace and Medicaid coverages is extremely challenging for consumers experience such churn. Therefore, to the extent similarities in these coverages exist and consumers are not surprised by services that might be covered under one program, but not the other, it benefits consumers.

Discussion

The above summarizes the results of the study undertaken by the Department. There are a variety of considerations that the Department has taken into account, such as the medical evidence, cost impacts, practices in other states, the social impacts, and the regulatory environment. What this information shows is that requiring comprehensive insurance coverage for abortion will not increase premiums in any material way, contributes to access to the full range of reproductive healthcare, increases transparency, and would be consistent with actions taken in other states.

A regulation to require uniform comprehensive abortion coverage that includes coverage for all abortions across the regulated markets is consistent with state policy and the rights promulgated in the Act. State law protects the right to terminate a pregnancy without government interference. Therefore, abortion is part of comprehensive insurance coverage for reproductive care and should reasonably be included in the range of services coverage by health insurance. The Act also recognizes the right of religious employers to request an exclusion under a health insurance contract if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. Therefore, the regulation proposed by the Department would incorporate such an exception.

⁵⁴ https://www.guttmacher.org/sites/default/files/article_files/gpr170115.pdf
<https://www.guttmacher.org/gpr/2015/04/abortion-coverage-under-affordable-care-act-advancing-transparency-ensuring-choice-and>

Additionally, the medical evidence points to access to the full range of safe reproductive health care services, including contraceptive methods, as central to healthy outcomes. Since insurance coverage for abortion contributes to accessing the range of reproductive health care services, it will likely lead to overall better health outcomes. The major medical societies support the principle that access to abortion is an important factor in healthcare and including such coverage in health benefits plans is consistent with this medical advice.

Furthermore, the cost of requiring abortion coverage in health benefits plans is de minimis. In the individual market, those costs would not be covered by premium tax credits and are already separately accounted for in the cost of these plans. On the other hand, the benefit to individuals seeking abortion could be significant, particularly low-income individuals. To the extent that the cost of abortion causes delayed abortion care or unwanted pregnancy, the impacts on individuals are significant. For example, the population that qualify for Marketplace coverage who may have been covered by Medicaid previously and benefit from significant tax subsidies would be well served by clear and consistent coverage for abortion care.

This same population who experiences “churn” between Medicaid and Marketplace coverage would be particularly susceptible to confusion regarding abortion coverage. Under Medicaid these individuals would have had coverage for abortion, but they may not be aware that Marketplace coverage currently could have certain limitations on abortion coverage. Therefore, providing consistency across these markets creates greater certainty and improves transparency.

Conclusion

This study demonstrates the need for a regulation to provide that health benefit plans delivered, issued, executed, or renewed in this State, provide comprehensive coverage for abortion. Specifically, with respect to health benefits plans regulated by the Department, there is a need for a regulation to ensure coverage for abortion services without exceptions that limit such coverage to cases of rape, incest or the life of the mother. This report identifies the reasons such a regulation is necessary including the need for greater transparency, consistency with the Medicaid market, the de minimis cost of such coverage, and the role coverage plays in creating better social and medical outcomes.