



Evaluation of Proposed Mandated Health Insurance Benefits

Evaluation of House Bill 1174:

Mandated Offer of Insurance Plans Not Covering Induced Abortions Outside of Certain Exceptions



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JLARC provides evaluations of proposed health insurance mandates in accordance with Sections 2.2-2503 and 30-58.1 of the *Code of Virginia*.

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Evaluation of House Bill 1174: Mandated Offer of Insurance Plans Not Covering Induced Abortions Outside of Certain Exceptions

JLARC SUMMARY

House Bill (HB) 1174 of the 2012 General Assembly Session would mandate health insurers to offer policies that do not provide coverage for abortion services outside of certain required exceptions. In particular, the bill would require that insurers that provide coverage for abortion services must also offer substantively identical policies that do not provide coverage for abortion services. The bill stipulates that any policy not covering abortion services must provide coverage for medical costs incurred in preserving the life of a pregnant woman as long as every possible measure is taken to save the life of the unborn child. It further requires that a policy that does not cover abortion services must reimburse the medical costs of treating previous fetal demise or intrauterine fetal death. In addition, an existing mandate may still require coverage of abortion services in cases of rape or incest.

MEDICAL EFFICACY AND EFFECTIVENESS

Medical and surgical abortions are the standard medical practices for terminating pregnancies, and the medical efficacy and effectiveness of these methods are well established. Clinical trials show that medical and surgical abortions achieve their intended outcome of terminating pregnancy with a high rate of success overall (approaching 100 percent). However, the efficacy and effectiveness of medical and surgical abortions vary by gestational age and, to some extent, the medication regimen and surgical method.

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SOCIAL IMPACT

Approximately 25,000 women in Virginia received induced abortions in 2010. Of those, it is estimated that one to two percent of the abortions were performed in cases of rape, incest, fetal anomaly, or to preserve the life of the pregnant woman. Up to three-fourths of women nationwide who receive induced abortions in outpatient settings are estimated to pay for their abortions out of pocket (some may be reimbursed later by insurance). Because so many women pay out of pocket, not providing coverage outside of the exceptions listed above would not appear to cause a financial hardship for many. However, lack of coverage would cause more of a hardship for women receiving more costly second term abortions.

Based on a Bureau of Insurance survey, approximately 37 percent of insurers' standard plans do not cover induced abortions outside of rape, incest, or to preserve the life of the pregnant woman. This option may become more widely available depending on Virginia's implementation of the health insurance exchanges required by the federal Affordable Care Act (ACA). Legislation passed during 2011 indicated the General Assembly's intent that plans sold through the exchanges not provide abortion coverage, and in February 2013, the Governor's Office also indicated its interest in excluding abortion coverage from the exchanges.

FINANCIAL IMPACT

HB 1174 is not expected to significantly impact the cost or utilization of abortions, or the availability of abortion providers. As a result, HB 1174 is unlikely to have a direct measurable impact on premiums. The take-up rate for HB 1174 is not expected to be high and most women pay out of pocket for abortions. However, the mandate could result in more women carrying their pregnancies to term if their insurance does not cover induced abortions, which could lead to higher overall health care costs and higher insurance premiums.

BALANCING MEDICAL, SOCIAL, AND FINANCIAL CONSIDERATIONS

HB 1174 is not expected to be a costly health insurance mandate, but it does not appear needed. Although there is some documented unmet demand for health insurance policies in Virginia that do not include coverage for induced abortions (outside of the required exceptions), health insurers indicate that there are few requests for such policies. Further, plans exist in the current individual, small group, and large group markets that indicate they will provide these policies. An option may be for BOI to make available a list of plans that are willing to offer policies not covering abortion.

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BACKGROUND

HB 1174 would require health insurance providers to offer policies that do not cover induced abortions, except for in certain required circumstances. (An existing Virginia mandate requires the coverage of abortion services in the cases of rape and incest.) Induced abortions are used to terminate viable pregnancies and remove the products of conception, as opposed to spontaneous abortions which occur because the pregnancy is not viable. Physicians perform two different types of induced abortions, medical and surgical, and decide which method to use based on a combination of the woman's preference, the physician's training, and gestational age.

a. Description of Medical Condition and Proposed Treatment

According to § 18.2-72 and § 18.2-73 of the *Code of Virginia*, a woman who is pregnant may legally elect to have a physician licensed by the Virginia Board of Medicine to practice medicine and surgery terminate the pregnancy through an induced abortion within the first or second trimester of gestation. The *Code* defines an induced termination of pregnancy as “the intentional interruption of pregnancy with the intention to produce other than a live-born infant or to remove a dead fetus and which does not result in a live birth (§ 32.1-249-2a).” This definition includes induced abortions that terminate and remove the embryo or fetus, as well as procedures that are limited to removing an embryo or fetus that has died spontaneously. Women having an induced abortion in Virginia, except in cases of rape and incest, must receive counseling, undergo an abdominal ultrasound, and wait 24 hours after the counseling and ultrasound before the procedure may be performed (§ 18.2-76). Parental consent is also required for induced abortions performed on minors in Virginia (§ 16.1-241).

The most commonly used medication regimen to induce abortions is mifepristone (RU-486) followed by misoprostol.

There are two broad categories of induced abortions – medical and surgical. Medical abortions induce abortion with medication and are typically used in the first trimester. The most commonly used medication regimen is mifepristone (RU-486) followed by misoprostol. Mifepristone blocks the uptake of the hormone progesterone, which is essential for gestation. Misoprostol, which is also used to induce labor, is then administered 24 to 72 hours after the mifepristone to expel the uterine contents. The U.S. Food and Drug Administration (FDA) has approved this regimen as safe and effective for induced abortions through 49 days of gestation. A follow-up is conducted 14 days after administration of the mifepristone, and if the abortion is determined to be incomplete, a surgical abortion is performed.

Surgical abortions involve dilating the cervix and removing the uterine contents. Suction curettage (also known as dilation and curettage or D&C) is the primary surgical abortion method used during the first trimester. Suction curettage uses a vacuum device to remove the uterine contents. Surgical abortions performed in the second trimester are typically performed using dilation and evacuation (D&E), which is similar to D&C but more complex due to the gestational age of the fetus (Table 1).

Whereas an induced abortion is intended to terminate a pregnancy, abortions can also occur when an embryo or fetus dies spontaneously. The *Code of Virginia* (§ 32.1-249-2b) defines spontaneous fetal death as “the expulsion or extraction of an embryo or fetus that does not result in a live birth and which is not an induced termination of pregnancy.” The term miscarriage is often used to

Table 1: Method of Induced Abortion Depends on Prenatal Development

Trimester:	First	Second	Third
Commonly used induced abortion procedure(s)	Medical, D&C	D&E	

Source: JLARC staff analysis of interviews with medical experts and research literature.

refer to spontaneous abortions early in pregnancy, and stillbirth is used to refer to intrauterine fetal death later in pregnancy. If a spontaneous abortion is incomplete, missed, or septic, a D&C or D&E may be necessary to remove any tissue that was not expelled because these conditions pose significant health risks to the woman, such as severe infection.

It appears that coverage for services related to spontaneous abortions would still be required under HB 1174. HB 1174 specifically directs that the costs of abortion services necessary to treat previous fetal demise or intrauterine fetal death be reimbursed by a plan not covering abortion services. (Medical experts indicate that “fetal demise” and “fetal death” are equivalent terms.) The *Code of Virginia* defines fetal death as “death prior to the complete expulsion or extraction from its mother...regardless of the duration of pregnancy (§ 32.1-249-2).” This definition implies that reimbursement would be provided for abortion services provided at any gestational age if the embryo or fetus has died spontaneously.

Medical loss ratio must be kept below certain thresholds

The medical loss ratio is the ratio of the premium revenue attributable to profits and administrative costs relative to total premium revenue. Under current law, if the medical loss ratio exceeds 15 percent for plans in the large group market or 20 percent in the individual and small group markets, insurers must refund a portion of the premiums to policy holders. Insurance companies refunded \$43.1 million to 687,000 Virginia residents in 2012.

b. History of Proposed Mandate

HB 1174 was introduced in the 2012 General Assembly Session on behalf of businesses that want to provide their employees with health insurance plans that do not cover abortion services except to save the life of the pregnant mother. Although insurance providers routinely customize plans in the large group market (100 or more employees), exceptions are not routinely made in the small group market because of the administrative costs involved in customizing plans. The concern for keeping administrative costs low is compounded by the new federal requirement that health insurance plans must refund a portion of policy holders’ premiums if the insurers do not spend a given percentage of the premium revenue on medical care (medical loss ratio). The impetus for this mandate appears to be to provide businesses in the small group market that are morally opposed to induced abortions the option to purchase health insurance without coverage for abortion services.

HB 1174 Does Not Address Existing Mandate Requiring Coverage of Abortion Services in the Cases of Rape or Incest.

In 1981, the General Assembly enacted a mandated health benefit requiring all health insurance plans to cover pregnancy services in the case of

rape and incest, which includes abortion. HB 1174 does not address abortions in the cases of rape or incest and does not amend the existing mandate covering those cases. This could leave room for legal interpretation as to whether policies purchased in accordance with HB 1174 would be required to cover abortions in the cases of rape and incest.

New Health Exchange Expected to Cover Abortion Services but Could Be Modified in the Future. Governor McDonnell announced on December 14, 2012, that Virginia will use the federal exchange option to comply with the federal Affordable Care Act (ACA), reserving the option to develop a State exchange at a later date. This contrasts with Chapter 823 of the 2011 Acts of Assembly, which expressed the General Assembly's intent to develop a State health exchange in accordance with the ACA. Chapter 823 also prohibited any plan offered through the Virginia exchange from providing coverage for abortion services except in the cases of rape, incest, or when necessary to save the life of the pregnant woman.

The largest small group plan in the State is the default essential health benefit plan for the federal exchange option, and this plan currently covers abortion services in Virginia. However, the ACA indicates that a state may prohibit abortion coverage in the exchange if it enacts a law providing such a prohibition. In February 2013, the Governor's Office indicated its interest in potentially excluding abortion coverage from plans sold through the federally-run exchange. Also, if Virginia were to adopt a State-based health benefits exchange in the future, the coverage in HB 1174 could be more widely available given the General Assembly's previously stated intent.

c. Proponents and Opponents of Proposed Mandate

Proponents and opponents of HB 1174 will have the opportunity to officially express their view at the public hearing conducted by the Special Advisory Commission on Mandated Health Insurance Benefits. Proponents of the bill appear to be pro-life advocates, including representatives of the Susan B. Anthony List. Proponents indicate that employers in every market should have access to health insurance plans that do not provide coverage for abortion services.

The main opposition to the proposed mandate appears to be from pro-choice organizations and the health insurance industry. Pro-choice organizations, such as Planned Parenthood and the National Association for the Repeal of Abortion Laws (NARAL Pro-Choice America), contend that this mandate could reduce the availability of abortion services and impose financial hardship on pregnant women. These organizations have also expressed concern that insurance companies could respond to this mandate by eliminating

coverage for induced abortions under their standard plans rather than offering separate plans that do not cover these services. Several groups raised further concerns about specific language used in the proposed mandate. They contend that § 38.2-3407.2:1C could be read to limit coverage of services to preserve the life of the mother “or” to treat previous fetal demise or intrauterine fetal death, not both. Moreover, the use of the term “reimburse” in § 38.2-3407.2:1C(ii), as opposed to the phrase “provide coverage” used in § 38.2-3407.2:1C(i), has been highlighted as potentially placing additional financial hardship on women if they are required to first pay out of pocket and then be reimbursed for these services.

Health insurance industry representatives oppose the bill because they indicate that substantial administrative costs could be incurred in developing an alternative plan for every plan they currently offer, which could increase premiums and potentially make insurance less affordable.

MEDICAL EFFICACY AND EFFECTIVENESS

Medical and surgical abortions are the standard medical practices for terminating pregnancies, and the medical efficacy and effectiveness of these methods are well established. Clinical trials show that medical and surgical abortions achieve their intended outcome of terminating pregnancy with a high rate of success overall (approaching 100 percent). However, the efficacy and effectiveness of different types of medical and surgical abortions vary by gestational age and, to some extent, with medication regimen and surgical method.

a. Medical Efficacy of Abortions

Clinical trials for abortions have focused on the efficacy of medical regimens and surgical techniques to induce abortions at different gestational ages. Medical abortions have been shown to be most successful in terminating pregnancies at less than seven weeks’ gestation, whereas surgical abortions are most effective after six weeks.

Medical abortions vary according to the types of drugs, dosage, timing, and route of administration (Table 2). All regimens have high overall success rates (over 88 percent), with the rate of complete abortion declining as gestational age increases for a given drug regimen. However, medical experts indicate that a surgical evacuation is performed in cases where a medical abortion does not result in the pregnancy being expelled, and the efficacy of this sequence of procedures approaches 100 percent. The U.S Food and Drug Administration (FDA) has approved the use of 600 mg of mifepristone administered orally followed 48 hours later by 400 µg

Medical Efficacy

Assessments of medical efficacy are typically based on clinical research, particularly randomized clinical trials, demonstrating the efficacy of a particular treatment compared to alternative treatments or no treatment.

of misoprostol administered orally as safe and effective for medical abortion through 49 days of gestation. Efficacy with this regimen averages 92 percent up to 49 days; however, complete abortion rates are higher (96 to 98 percent) prior to 42 days. The efficacy of this regimen decreases with gestational age and is less than 85 percent after 49 days' gestation.

Alternative medical regimens may have greater efficacy than the one approved by the FDA, but some may have disadvantages such as greater time to expulsion and increased side effects. The regimen with the greatest efficacy (95 to 99 percent) is an adaptation of the FDA-approved regimen, using one-third the mifepristone and twice the misoprostol. This regimen also calls for the misoprostol to be administered vaginally instead of orally, which has been shown to decrease the amount of time to expulsion and adverse side effects, as well as increase the rate of complete abortion. While concerns have been raised about women administering the misoprostol vaginally themselves, multiple studies have found that women can safely and effectively administer the drug at home.

Table 2: Typical Medical Abortion Regimens

Common Regimens	Success Rate (%) ^a	Advantages	Disadvantages	Gestational Age
Mifepristone, 600 mg orally + misoprostol, 400 µg orally 48 hours later (FDA approved)	92		Patient must remain in office or clinic 4 hours after administration	Up to 49 days
Mifepristone, 200 mg orally + misoprostol, 800 µg vaginally 24 - 72 hours later	95 - 99	<i>Compared with FDA-approved regimen</i> <ul style="list-style-type: none"> • More effective • Less time to expulsion • Fewer side effects 	<ul style="list-style-type: none"> • Requires vaginal administration 	Up to 63 days
Methotrexate, 50 mg/m ² IM or 50 mg vaginally + misoprostol, 800 µg vaginally 3 - 7 days later	92 - 96	<i>Compared with mifepristone-misoprostol regimen</i> <ul style="list-style-type: none"> • Readily available medications • Low drug cost 	<ul style="list-style-type: none"> • Takes longer for expulsion in 20 - 30% of women 	Up to 49 days
Misoprostol only, 800 µg Vaginally, repeated for up to three doses	88	<i>Compared with mifepristone-misoprostol regimen</i> <ul style="list-style-type: none"> • Low drug cost 	<ul style="list-style-type: none"> • Requires complicated dosing regimen • Significantly higher incidence of side effects 	Up to 56 days

^a A surgical evacuation is performed in cases where a medical abortion does not result in the pregnancy being expelled, and the efficacy of this sequence of procedures approaches 100 percent.

Source: Table 1 from ACOG Practice Bulletin. Clinical Management Guidelines for Obstetrician-Gynecologists. Number 67, October 2005.

Surgical abortion after six weeks of gestation is a highly safe and efficacious procedure with complete abortion occurring in 99.95 percent of cases. Failed surgical abortions are rare and largely occur in procedures performed before six weeks' gestation. The high success rate of surgical abortions is attributable to the efficacy of the D&C and D&E procedures and the immediate verifiability of the outcome. Success can be verified in the clinic by examining the removed tissue or by performing a transvaginal ultrasound in very early pregnancies. Unsuccessful surgical abortions are most typically followed by repeated aspiration or evacuation to complete the procedure.

b. Medical Effectiveness of Benefit

Medical Effectiveness

Medical effectiveness refers to the effectiveness of a particular treatment in a normal clinical setting as opposed to ideal or laboratory conditions.

Experts at two Virginia medical schools were consulted on a number of issues for this evaluation, including the effectiveness of medical and surgical abortions in terminating pregnancies. The experts indicated that abortions are highly effective. However, the effectiveness of medical and surgical abortions varies with gestational age and technique. Clinicians follow up with patients to confirm that the pregnancy was completely expelled. In cases where the induced abortion was incomplete, surgical evacuation is performed.

For example, medical abortions which require women to orally ingest or vaginally administer one or more doses of medications at home have been shown to be safe and effective. In cases where the medical abortion was not successful, surgical techniques are typically used to complete the abortion upon follow-up.

Complications arising from medical abortions occur in approximately 0.5 percent of cases in the first trimester and one percent in the second trimester. Incomplete evacuation of uterine contents is the most common complication and can lead to cramping and continued vaginal bleeding or hematometra, which occurs when blood collects in the uterus. Immediate D&C is recommended to remove the remaining uterine contents, relieve symptoms, and decrease the potential for infection.

SOCIAL IMPACT

Approximately 25,000 patients in Virginia received induced abortions in 2010. Of those, it is estimated that one to two percent of the abortions were performed in cases of rape, incest, fetal anomaly, or to preserve the life of the pregnant woman. Nearly three-fourths of women who receive induced abortions in outpatient settings are estimated to pay for their abortions out of pocket (some may be reimbursed later by insurance). Therefore, it appears that some women with health insurance coverage are paying out of pocket.

Based on a Bureau of Insurance survey, approximately 37 percent of insurers' standard plans do not cover induced abortions outside of rape, incest, or to preserve the life of the pregnant woman. Because so many women pay out of pocket, limiting coverage to these situations does not appear to cause a financial hardship for many. However, lack of coverage would cause more of a hardship for women receiving second term abortions, which are more costly. This option may become more widely available depending on Virginia's implementation of the health insurance exchanges required by the ACA given that both the General Assembly and the Governor's Office have separately indicated their intent that plans sold through the exchanges not provide abortion coverage.

a. Utilization of Treatment

In 2010, 24,892 Virginia residents underwent induced abortions in Virginia, based on data from the Virginia Department of Health (VDH). The most common procedure used was suction curettage, followed by medical abortion (Table 3). An additional 1,048 non-residents had induced abortions performed by Virginia abortion providers; however, VDH does not report the types of procedures used for non-residents.

Table 3: Vast Majority of Induced Abortions Performed on Virginia Residents Are D&Cs

Procedure Terminating Pregnancy	Number of Virginia Residents	Percent of Total
Suction curettage (D&C)	20,078	80.7%
Medical	3,576	14.4
Sharp curettage	634	2.5
Dilation and evacuation (D&E)	505	2.0
Unknown	70	0.3
Other	23	0.1
Intra-uterine instillation	6	0.02
Total	24,892	100.0%

Source: JLARC staff analysis of Virginia Department of Health data on induced terminations of pregnancy undergone by Virginia residents by procedure, 2010.

It appears that nearly all (98 percent or more) induced abortions are performed for reasons other than rape, incest, fetal anomaly, or to save the life of the pregnant woman. Based on abortion data from the State employee health plan and the Virginia Medicaid program, JLARC staff estimated that between 84 and 576 of the total induced abortions performed in 2010 were performed for one of these four reasons. This represents 0.3 to 2.3 percent of total induced abortions statewide.

b. Availability of Coverage

The availability of insurance plans that do not cover induced abortions varies for the individual, small, and large group markets. According to insurance providers that responded to the Bureau of Insurance's survey, 64 percent of standard plans in the individual market do not cover induced abortions in instances other than rape, incest, or to save the life of the pregnant woman.

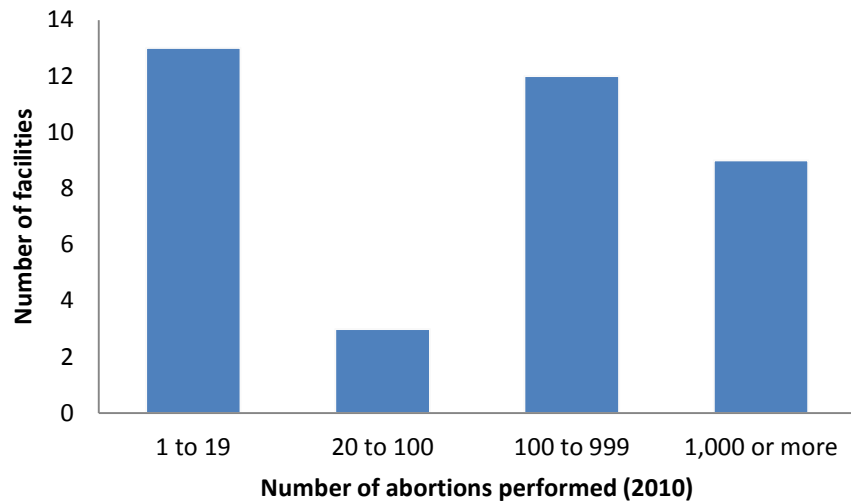
Whereas the majority of individual plans do not cover induced abortions for cases other than rape, incest, or to save the life of the pregnant woman, most (78 percent) plans in the small and large group markets provide coverage for all first and second trimester abortions. However, the willingness of insurance providers to remove coverage for induced abortions varies substantially between the two markets. Insurance providers typically limit customization of plans in the small group market in order to minimize administrative costs. Only 20 percent of insurance providers in Virginia reported offering the option to remove coverage for induced abortions in the small group market. One of the companies explained that the option not to have coverage for induced abortions is administered as a rider, not as an entirely separate plan. Customization of plans is more common in the large group market, with 64 percent of insurance providers reporting that they will remove coverage for induced abortions if requested.

As previously indicated, this coverage option may become more widely available depending on Virginia's implementation of the health insurance exchanges required by the ACA given that both the General Assembly and the Governor's Office have separately indicated their intent that plans sold through the exchanges not provide abortion coverage.

c. Availability of Treatment / Benefit

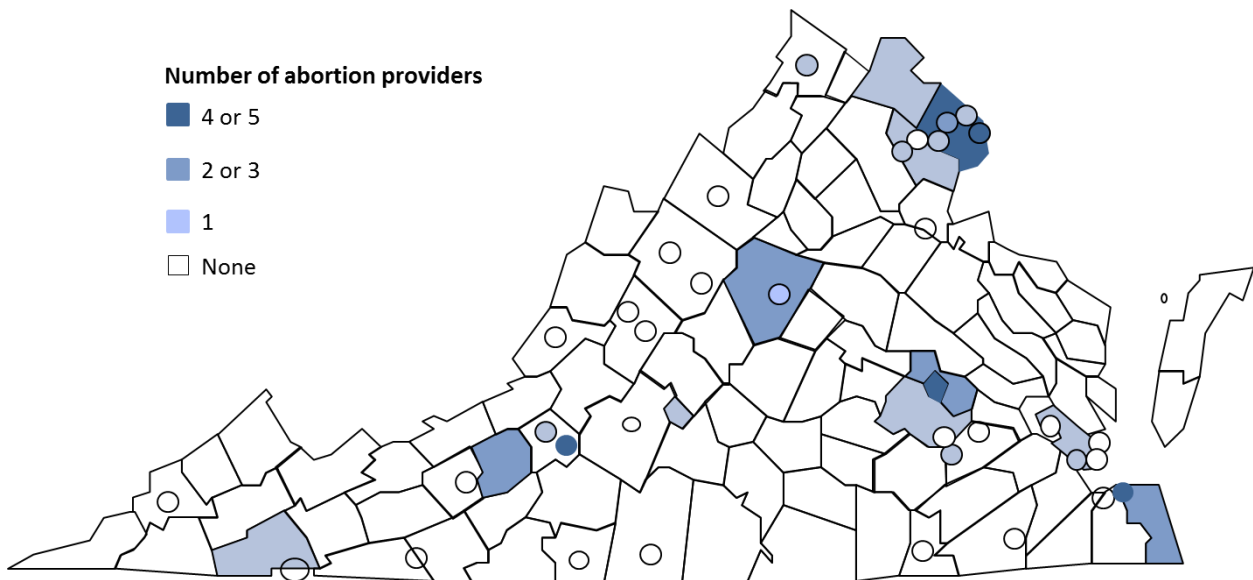
Between 2009 and 2011, physicians at 48 different facilities in Virginia induced at least one abortion, with an average of 39 different facilities inducing abortions per year. In 2010, 22 of the 37 facilities providing abortions in that year induced more than 100 abortions (Figure 1). Access to abortion services is more widely available in the more populous regions of the State (Figure 2). Of Virginia's 134 cities and counties, only 24 localities have had facilities provide this service in the last three years, with facilities being concentrated in the northern, central, and Tidewater regions.

Figure 1: Majority (57 Percent) of Abortion Facilities Performed More Than 100 Abortions (2010)



Source: JLARC staff analysis of Virginia Department of Health data, 2010.

Figure 2: Abortion Facilities Are Located in More Populous Regions of State (2010)



Source: JLARC staff analysis of Virginia Department of Health data, 2010.

Recent legislation may affect the availability of abortion services. The types of facilities in which abortions have been provided have traditionally varied by the gestational age, but legislation passed by the 2011 General Assembly and subsequent regulations will require all abortions to be performed in a licensed hospital. Since 1975, the *Code of Virginia* (§ 18.2-73) has required all abortions in

the second trimester of pregnancy to be performed in a hospital. However, most induced abortions are performed in the first trimester and have been legally performed in outpatient clinics specializing in abortion services. Senate Bill 924 of the 2011 General Assembly mandates that all “facilities in which 5 or more first trimester abortions per month are performed shall be classified as a category of ‘hospital.’” Although some abortion providers currently operate in facilities that are certified as hospitals, others do not. Those facilities that are not certified as hospitals will either be required to make the improvements necessary to be certified as a hospital or stop providing abortion services.

d. Availability of Treatment Without Coverage

Many women, including some with health insurance for abortion services, currently pay for induced abortions out of pocket. According to the Guttmacher Institute, up to 74 percent of women nationwide who receive induced abortions in outpatient offices pay for their abortions out of pocket. However, this figure may be overstated because some women are reimbursed by health insurance after the procedure is performed.

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Many of the facilities that provide abortions, especially clinics primarily intended to handle women’s reproductive health issues, routinely provide abortion services to women without health insurance coverage for the procedure. Moreover, the Guttmacher Institute reports that approximately 12 percent of induced abortions are billed at reduced or no charge through financial assistance from abortion providers.

e. Financial Hardship

The out-of-pocket cost of induced abortions may be substantial for some women without health insurance coverage. This is especially true for women who undergo the procedure in the second trimester when an induced abortion is approximately four times more expensive.

A review of the largest abortion facilities in Virginia shows that the average out-of-pocket cost for a medical abortion in the first trimester, including an initial pregnancy consultation, is \$395 (Table 4). Surgical abortions in the first trimester cost on average \$450, including an initial pregnancy consultation and light intravenous sedation. Median household income in Virginia was \$61,882 in 2011, which means medical and surgical abortions could cost 0.6 and 0.7 percent of an average Virginia household’s income, respectively.

Induced abortions in the second trimester are more complex procedures and are required by Virginia law to be performed in a li-

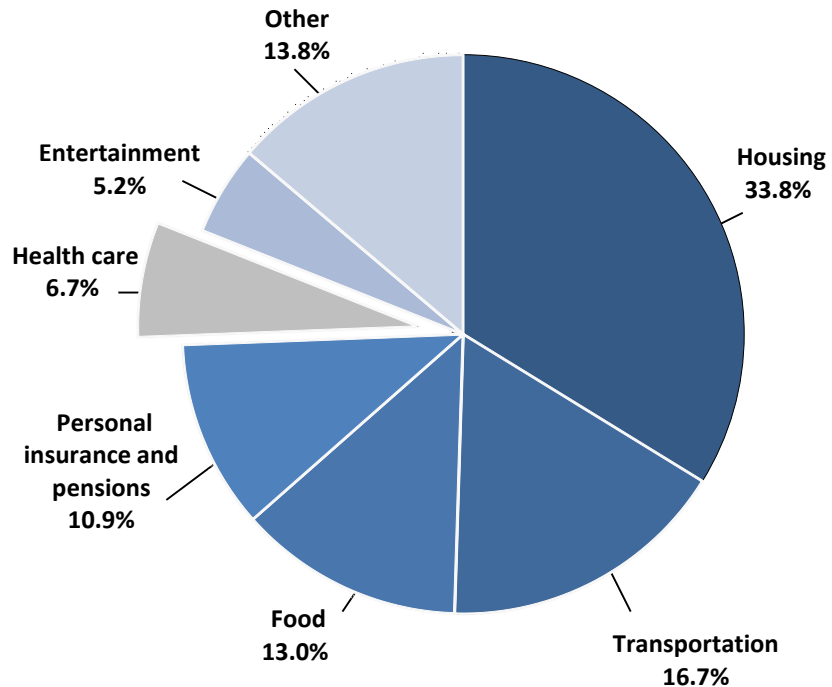
censed hospital (§ 18.2-73). As a result, abortions in the second trimester are more expensive costing nearly \$1,800, which would represent about three percent of an average household's income in Virginia. Figure 3 shows that 6.7 percent of all U.S. household expenses were dedicated to health care in 2011. Therefore, a second term abortion in Virginia would represent nearly half the typical \$4,150 household allocation for health care expenditures (based on 2011 median household income).

Table 4: Average Cost of Abortion Procedures

Procedure	Average Cost	Percent of Median Household Income
<i>First Trimester</i>		
Medical	\$395	0.6%
Surgical	450	0.7
<i>Second Trimester</i>		
Surgical	1,800	2.9

Source: JLARC staff analysis of Virginia abortion providers' posted costs for abortion services.

Figure 3: Health Care Costs Accounted for 6.7 Percent of Total Annual Household Expenditures (2011)

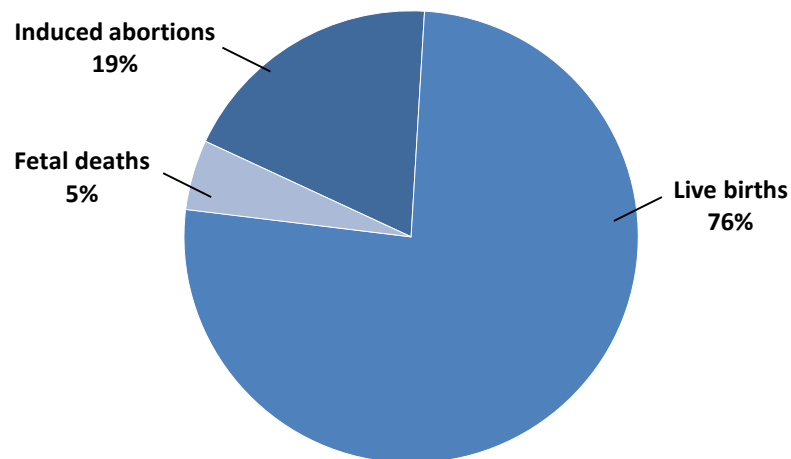


Source: 2011 Consumer Expenditure Survey, U.S. Bureau of Labor Statistics (2012).

f. Prevalence / Incidence of Condition

The vast majority of all pregnancies in Virginia result in live births (Figure 4). Among female Virginia residents ages 15 to 44, there were 102,934 live births in 2010. This figure equates to 62.3 live births per 1,000 women of child-bearing age and represents 77 percent of all pregnancy outcomes. Approximately 18 percent of pregnancies (24,892) were terminated through an induced abortion. On average, 1.5 percent of female Virginia residents had an induced abortion in 2010. There were also 6,590 natural fetal deaths in 2010, corresponding to five percent of all pregnancies or 4.0 per 1,000 female Virginia residents ages 15 to 44.

Figure 4: Over Three-Quarters of Pregnancies in Virginia Result in Live Births



Source: JLARC staff analysis of Virginia Department of Health data, 2010.

g. Demand for Proposed Coverage

Unlike a typical proposed mandate, HB 1174 would require insurers to offer the option not to have coverage for a service. The demand for health insurance coverage that does not include abortion services is likely limited to employers and individuals who are morally opposed to abortions or who believe that they will never need the service. As previously mentioned, the majority of insurance providers do not offer coverage for induced abortions outside of those cases for which it is mandated as a part of their standard plans in the individual market and readily offer customization to not cover induced abortions in the large group market. Therefore, it appears that the largest source of unmet demand may be from employers in the small group market that would like to offer their employees health insurance that does not cover induced abortions but cannot find an insurance company willing to customize a plan for them.

It appears that the largest source of unmet demand may be from employers in the small group market.

The number of small Virginia businesses that would like to offer policies that do not cover abortion services is unknown; however, there is at least one company that has sought out this type of coverage and could not find it. Still, at least four health insurance providers report that they will remove coverage of abortion services at the request of the employers in the small group market.

h. Labor Union Coverage

Unions do not appear to have advocated specifically for the inclusion or exclusion of abortion services in their health benefit packages. Typically, unions advocate for broader benefits rather than benefits as specific as coverage for induced abortions.

i. State Agency Findings

In 1994, the Virginia Maternal and Child Health Council released the report *Ways to Create and Maintain Effective Maternal Health Services for Pregnant Women in Crisis*. This report reviewed abortions as one of the services that may be required by pregnant women in crisis. It found that induced abortions are safer the earlier the procedure is performed in the pregnancy. It also found that most abortion providers will not perform an abortion late in the second trimester unless it is recommended for serious medical reasons. According to the report, in 1991 there were 31,578 abortions, which is 27 percent more than in 2010. The report concluded that “although many insurance companies cover abortions, many women choose to pay from private funds.”

In 1969, the Virginia Advisory Legislative Council published the report *Virginia’s Abortion Laws*. This report reviewed the existing statutes at the time, which only allowed for abortions in the case of saving the life of the mother. The report found that public opinion towards induced abortions was evolving and that as many as 17,108 abortions were being performed illegally each year in Virginia. As a result, the report recommended that abortions should also be legal when the pregnancy threatens the mental or physical health of the mother as well as in cases of rape and incest.

j. Public Payer Coverage

Medicare and Medicaid in Virginia provide coverage for induced abortions only in certain situations. The federal Hyde Amendment prohibits federal funds from being used to fund or subsidize abortions, except where necessary to save the life of the pregnant woman or the pregnancy is the result of rape or incest. Coverage under Medicare is limited to cases of rape, incest, or where necessary to save the life of the pregnant woman. In Virginia, Medicaid only covers abortions when necessary to save the life of the pregnant woman; however, the Virginia Department of Health (VDH)

does offer financial assistance for abortions in the cases of rape, incest, or severe fetal anomaly.

Medicare. Medicare coverage for induced abortions is strictly limited to cases of rape, incest, or when necessary to save the life of the pregnant woman. Most women who benefit from Medicare are over the age of 65 and are unlikely to become pregnant. However, there are Medicare beneficiaries that are of childbearing age, including individuals who have a permanent disability, end stage renal disease, or amyotrophic lateral sclerosis (ALS) who could possibly become pregnant. These individuals could potentially meet Medicare's criteria for coverage of induced abortions.

Medicaid. Medicaid coverage for induced abortions in Virginia is limited to situations where an abortion is necessary to save the life of the pregnant woman. Prior to July 1, 2010, Virginia Medicaid also covered induced abortions when the physician certified that the health of the mother was in jeopardy. Although Virginia Medicaid does not provide coverage for induced abortions in the cases of rape, incest, or fetal anomaly, VDH provides financial assistance for induced abortions in these cases. Eligibility for the VDH funding of induced abortions is based on meeting the eligibility criteria for Virginia Medicaid, but the coverage is provided outside of the Medicaid program.

k. Public Health Impact

Public Health

The role of public health is to protect and improve the health of a community through preventative medicine, health education, and control of communicable diseases.

Medical experts consulted for this review stated that there could be some negative public health impacts associated with the proposed mandate. Experts expressed concern over women potentially delaying abortions to later gestational ages, which can make the procedure more complicated and less safe. Physicians also expressed some concern that this mandate could lead to more self-inflicted abortions or abortions performed below the standard of care; however, they suggested this was unlikely to occur on a widespread basis. Ultimately, the negative public health impact of HB 1174 would be proportional to the take-up rate by employers wishing their health insurance plans not to cover induced abortions.

FINANCIAL IMPACT

HB 1174 is not expected to significantly impact the cost or utilization of abortions, or the availability of abortion providers. As a result, HB 1174 is unlikely to have a direct measurable impact on premiums. The take-up rate for HB 1174 is not expected to be high, and as previously mentioned, most women pay out of pocket for abortions. (If the take-up rate is significant, there could be a greater impact on abortion providers.) However, the mandate could result in more women carrying their pregnancies to term if

their insurance does not cover induced abortions, which could lead to higher overall health care costs and higher insurance premiums.

a. Effect on Cost of Treatment

The average cost of providing an induced abortion is unlikely to be impacted by the proposed mandate. According to health insurance representatives, market demand for plans that do not cover abortion services has been minimal, and as a result the take-up rate for HB 1174 is not expected to be high. For example, the Virginia Association of Health Plans (VAHP) indicates that one of its members reports that over the last 11 years they have only received one request for a plan that does not cover abortion services. Moreover, since most women (up to 74 percent) already pay for abortion services out of pocket, there is not expected to be a substantial impact on the cost of the procedure. However, for those women who would otherwise have utilized their insurance coverage, the cost for induced abortions would be higher. Therefore, rather than having a substantial impact on the costs of providing induced abortions, the primary impact of HB 1174 would be to shift the burden of the costs in some cases from the insurance companies directly to the insured.

b. Change in Utilization

Reducing the number of women who have health insurance coverage for induced abortions could decrease the number of abortions performed in Virginia and potentially increase the number of births. Research literature demonstrates that as the cost of abortions increases, the rate of abortions decreases. A large decrease in utilization is not expected as a result of HB 1174 because most women pay out of pocket and the take-up rate of HB 1174 is expected to be low, but there could more of a decrease for second term abortions, which are more costly. If, however, insurance plans change their base coverage such that induced abortion is not covered but is available for purchase through a rider, more insured women may end up without abortion coverage. This, coupled with the legislative changes in 2011 which may reduce the number of providers, could decrease utilization because the costs associated with an abortion can be both monetary and non-monetary, such as travel time.

c. Serves as an Alternative

The alternative to undergoing an induced abortion would be to carry the pregnancy to term. Induced abortions cost less than full-term, uncomplicated deliveries, which cost on average \$9,705 in 2009. However, not all deliveries are uncomplicated, and the costs of delivering and hospitalizing a newborn are substantially higher

if the child is preterm or suffers from significant birth defects or anomalies (for example, spina bifida).

d. Effect on Providers

HB 1174 is not expected to substantially reduce the number of abortion providers. As previously mentioned, from 2009 to 2011, an average of 39 facilities induced abortions in Virginia. A large subset of these facilities specializes in women's reproductive care, including abortions, and representatives of these facilities indicate they would not stop offering abortion services because of this mandate. However, 13 of the 37 facilities providing abortion services in 2010 performed less than 20 each, and some of these may reconsider their decision to provide abortion services. Although HB 1174 is unlikely to significantly impact the overall number of abortion providers, even a small reduction in the number of abortion providers in the less populous regions of the State could significantly reduce access for women who live in those regions.

Although not expected to have a significant impact on the number of abortion providers in Virginia, medical experts expressed concern that the language in HB 1174 requiring that "every possible measure shall be taken to preserve the life of the unborn child," is overly broad and could expose abortion providers to substantial liability. The experts also stated that this could place a greater burden on safety-net hospitals, which may become the abortion providers of choice for women who do not have health insurance coverage and the ability to pay out of pocket for an abortion.

e. Administrative and Premium Costs

Mandating insurance companies to offer plans that do not cover induced abortions outside of rape, incest, or to save the life of the pregnant woman is expected to have a minimal effect on both insurance company administrative expenses and health insurance premium costs. Unlike with previous health mandates where costs were incurred by insurers and passed on to some extent to their policyholders, federal health care reform under the ACA requires all mandates adopted after December 31, 2011, to be paid for by states. Actuarial analyses will need to be conducted to determine the exact impact of HB 1174, and any additional cost resulting from HB 1174 would need to be paid by the State.

Administrative Expenses of Insurance Companies. Although insurance companies do not provide the estimated impact of proposed mandates on administrative expenses in their responses to the BOI survey, several insurance companies indicated that they do not currently offer customization of small group and individual plans because of the administrative costs. However, one insurance

company that offers the option to not provide coverage for induced abortions characterized the expenses related to HB 1174 as “relatively low.”

Premium and Administrative Expenses of Policyholders. In response to BOI’s survey, insurance companies provided estimates of the monthly premium impact of HB 1174 (Table 5). The estimates suggest the impact of HB 1174 on premiums is likely to be minimal and mixed. This is consistent with the experience of the insurance company that currently offers plans consistent with HB 1174 for the same price as plans that cover induced abortions outside of rape, incest, or to save the life of the pregnant woman. The estimates are also consistent with the perspective of representatives of the VAHP, who noted that they expect that HB 1174 would not result in a measurable impact on premiums.

**Table 5: Estimated Monthly Premium Impact of HB 1174
(Per Policyholder Per Month)**

Plan	Number of Responses ^a	Lowest Estimate	Highest Estimate
Individual (standard)	7	-\$0.38	\$0.25
Individual (optional)	7	-\$0.05	\$0.25
Group (standard)	19	-\$0.65	\$0.41
Group (optional)	17	-\$0.05	\$0.47

^a n=30

Note: Due to inconsistencies in how insurers reported premium impact estimates, where necessary, JLARC staff converted estimates from a per member per month basis to a per policyholder per month basis by assuming the average members per policyholder was 2.4. In addition, one insurer estimated that removing coverage for abortion services as an optional benefit as part of individual contracts or group certificates would reduce premiums by \$147 per policyholder per month. This was excluded from the table because it was 2,490 times larger than the next lowest premium impact estimate, making it a significant outlier.

Source: Bureau of Insurance Survey of Insurance Providers, 2012.

For individual plans, premium estimates ranged from a decrease of \$0.38 to an increase of \$0.25 per policyholder per month as part of a standard benefit package. Similarly, if offered as part of an optional benefit, per policyholder per month premium estimates ranged from a decrease of \$0.05 to an increase of \$0.25. Offered as a part of a standard benefit through a group plan, premium estimates ranged from a reduction of \$0.65 to an increase of \$0.41 per policyholder per month. If purchased as an optional benefit as part of a group plan, the change in premiums ranged from a decrease of \$0.05 to an increase of \$0.47 per policyholder per month.

Average Individual Insurance Premiums

In October 2012, the Virginia Bureau of Insurance reported an average annual health insurance premium (with current mandated benefits) for an individual contract, single coverage, of \$3,335 or approximately \$278 per month.

A premium increase of \$0.25 for individual standard optional coverage would result in a monthly premium increase of 0.09 percent. This impact is consistent with the premium impact of the existing mandate to provide coverage for induced abortions in the cases of rape or incest. As reported in the State Corporation Commission's 2012 *Report on the Financial Impact of Mandated Health Insurance Benefits*, providing coverage for induced abortions in the cases of rape or incest represent between 0.00 and 0.11 percent of overall average premium costs for single coverage through both individual contracts and group certificates. However, it is also the case that a number of insurers indicated that the proposed mandate would lead to a reduction in premium costs.

One group of companies did not provide a specific premium amount, but responded that HB 1174 could raise premiums by 1 percent across all types of plans listed in Table 5 as a result of members deciding not to end pregnancies due to lack of coverage for abortion services. This estimate is significantly higher than the impacts estimated by plans providing a specific dollar amount.

f. Total Cost of Health Care

The proposed mandate is not expected to have a substantial impact on overall healthcare costs in Virginia. As indicated previously, because as many as three-quarters of women already pay out of pocket, there are not expected to be large changes in utilization of abortion procedures. However, as described above, HB 1174 could result in some pregnancies being carried to term rather than being aborted. Full term pregnancies and the future healthcare costs associated with a live birth are much more costly than an abortion. For those infants with developmental anomalies, costs could be significant. For example, children with survivable defects, such as spina bifida or Down syndrome, which each occur in approximately 1 in 1,000 live births, can live many years while requiring ongoing care above and beyond the typical medical standard.

BALANCING MEDICAL, SOCIAL, AND FINANCIAL CONSIDERATIONS

HB 1174 is not expected to be a costly health insurance mandate, but it does not appear necessary. Although there is some documented unmet demand for health insurance policies in Virginia that do not include coverage for induced abortions, there are plans in the current individual, small group, and large group markets that indicate they will provide such policies without being mandated to do so. Rather than require the State to bear the potential costs of an unnecessary mandate, an option may be for BOI to maintain and disseminate a list of those insurers that are willing to remove coverage for abortion services (outside of required excep-

tions) so that this information is more easily accessible to interested parties.

a. Social Need / Consistent With Role of Insurance

Based on the premise that the role of health insurance is to promote public health, encourage the use of preventive care, and to provide protection from catastrophic financial expenses for unexpected illness or injury, HB 1174 does not seem to be consistent with the role of health insurance because it would remove coverage for a safe, effective, and legal medical treatment. However, there appears to be some unmet demand to purchase policies that do not include abortion coverage outside of instances of rape, incest, or to save the life of the pregnant woman. Mandating that insurance plans offer policies without this coverage would meet this demand, but it would also have the effect of transferring the cost of abortions from insurance companies directly to their policyholders. For first term abortions, this may not result in a significant shift because an estimated 74 percent of women receiving abortions in outpatient offices already pay for their abortions out of pocket. However, it could have a greater impact on women seeking more costly second term abortions who may no longer have coverage. In addition, there may be some women for whom lack of coverage would provide a financial hardship for a first term abortion.

b. Need Versus Cost

There are expected to be minimal, if any, premium and administrative costs associated with HB 1174. However, despite the potentially small cost, it is not clear that the proposed mandate is needed. Based on the BOI survey, there are insurance companies currently serving the individual, small group, and large group markets that offer policies without coverage for induced abortions, even if not all insurance companies provide this option. Health insurance representatives also indicate that market demand for plans that do not cover abortion services has been minimal.

An additional consideration is that the ACA requires states pay for the costs of any mandate proposed after December 31, 2011. As a result, to the extent that there are increased premium costs related to HB 1174, the State would need to reimburse insurers or enrollees for these costs. Instead of having the State subsidize the costs of HB 1174, BOI could maintain and disseminate a list of those insurers that are willing to remove coverage for abortion services. Further, this option may become more widely available depending on Virginia's implementation of the health insurance exchanges in response to the ACA. Legislation passed during 2011 indicated the General Assembly's intent that plans sold through the exchanges not provide abortion coverage, and in February

2013, the Governor's Office also indicated its interest in excluding abortion coverage from the exchanges.

c. Mandated Offer

Mandated Offer

A mandated offer requires health insurers to offer for purchase the coverage described in the mandate for an additional fee.

As currently written, HB 1174 is a mandated offer. The mandate would require that all health insurance companies offer policies that do not cover abortion services except to save the life of the mother. Plans offered in compliance with HB 1174 would also be required to cover abortions in the cases of previous fetal demise, intrauterine fetal death, and, presumably, cases of rape and incest.

ACKNOWLEDGMENTS

JLARC staff would like to acknowledge the expertise, assistance, and information provided by staff at Virginia Commonwealth University and the University of Virginia Health System. In addition, JLARC staff would like to thank the Virginia State Corporation Commission Bureau of Insurance, the Virginia Association of Health Plans, the Department of Medical Assistance Services, the Department of Human Resource Management, and the Virginia Department of Health.

Statutory Authority for JLARC Evaluation of Proposed Mandated Health Insurance Benefits

§ 2.2-2503. Special Advisory Commission on Mandated Health Insurance Benefits; membership; terms; meetings; compensation and expenses; staff; chairman's executive summary.

A. The Special Advisory Commission on Mandated Health Insurance Benefits (the Commission) is established as an advisory commission within the meaning of § 2.2-2100, in the executive branch of state government. The purpose of the Commission shall be to advise the Governor and the General Assembly on the social and financial impact of current and proposed mandated benefits and providers, in the manner set forth in this article.

B. The Commission shall consist of 18 members that include six legislative members, 10 nonlegislative citizen members, and two ex officio members as follows: one member of the Senate Committee on Education and Health and one member of the Senate Committee on Commerce and Labor appointed by the Senate Committee on Rules; two members of the House Committee on Health, Welfare and Institutions and two members of the House Committee on Commerce and Labor appointed by the Speaker of the House of Delegates in accordance with the principles of proportional representation contained in the Rules of the House of Delegates; 10 nonlegislative citizen members appointed by the Governor that include one physician, one chief executive officer of a general acute care hospital, one allied health professional, one representative of small business, one representative of a major industry, one expert in the field of medical ethics, two representatives of the accident and health insurance industry, and two nonlegislative citizen members; and the State Commissioner of Health and the State Commissioner of Insurance, or their designees, who shall serve as ex officio nonvoting members.

C. All nonlegislative citizen members shall be appointed for terms of four years. Legislative and ex officio members shall serve terms coincident with their terms of office. All members may be reappointed. However, no House member shall serve more than four consecutive two-year terms, no Senate member shall serve more than two consecutive four-year terms, and no nonlegislative citizen member shall serve more than two consecutive four-year terms. Vacancies occurring other than by expiration of a term shall be filled for the unexpired term. Vacancies shall be filled in the manner as the original appointments. The remainder of any term to which a member is appointed to fill a vacancy shall not constitute a term in determining the member's eligibility for reappointment.

D. The Commission shall meet at the request of the chairman, the majority of the voting members or the Governor. The Commission shall elect a chairman and a vice-chairman, as determined by the membership. A majority of the members of the Commission shall constitute a quorum.

E. Legislative members of the Commission shall receive such compensation as provided in § 30-19.12, and nonlegislative citizen members shall receive such compensation for the performance of their duties as provided in § 2.2-2813. All members shall be reimbursed for all reasonable and necessary expenses incurred in the performance of their duties as provided in §§ 2.2-2813 and 2.2-2825.

Funding for the compensation and costs of expenses of the members shall be provided by the State Corporation Commission.

F. The Bureau of Insurance, the State Health Department, and the Joint Legislative Audit and Review Commission and such other state agencies as may be considered appropriate by the Commission shall provide staff assistance to the Commission. The Joint Legislative Audit and Review Commission shall conduct assessments, analyses, and evaluations of proposed mandated health insurance benefits and mandated providers as provided in subsection D of § 30-58.1, and report its findings with respect to the proposed mandates to the Commission.

G. The chairman of the Commission shall submit to the Governor and the General Assembly an annual executive summary of the interim activity and work of the Commission no later than the first day of each regular session of the General Assembly. The executive summary shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

§ 30-58.1. Powers and duties of Commission.

The Commission shall have the following powers and duties:

A. Make performance reviews of operations of state agencies to ascertain that sums appropriated have been, or are being expended for the purposes for which such appropriations were made and to evaluate the effectiveness of programs in accomplishing legislative intent;

B. Study on a continuing basis the operations, practices and duties of state agencies, as they relate to efficiency in the utilization of space, personnel, equipment and facilities;

C. Make such special studies and reports of the operations and functions of state agencies as it deems appropriate and as may be requested by the General Assembly;

D. Assess, analyze, and evaluate the social and economic costs and benefits of any proposed mandated health insurance benefit or mandated provider, including, but not limited to, the mandate's predicted effect on health care coverage premiums and related costs, net costs or savings to the health care system, and other relevant issues, and report its findings with respect to the proposed mandate to the Special Advisory Commission on Mandated Health Insurance Benefits; and

E. Make such reports on its findings and recommendations at such time and in such manner as the Commission deems proper submitting same to the agencies concerned, to the Governor and to the General Assembly. Such reports as are submitted shall relate to the following matters:

1. Ways in which the agencies may operate more economically and efficiently;
2. Ways in which agencies can provide better services to the Commonwealth and to the people; and
3. Areas in which functions of state agencies are duplicative, overlapping, or failing to accomplish legislative objectives or for any other reason should be redefined or redistributed.

Proposed Mandated Offer of Insurance Plans Not Covering Abortion Services

HOUSE BILL NO. 1174

Offered January 17, 2012

A BILL to amend and reenact § 38.2-4300 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3407.2:1, relating to health insurers; offering health insurance policies that do not provide coverage for abortion services.

Patron-- Marshall, R.G.

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4300 of the Code of Virginia is amended and reenacted and the Code of Virginia is amended by adding a section numbered 38.2-3407.2:1 as follows:

§ 38.2-3407.2:1. Requirement to offer plans that do not provide abortion coverage.

A. As used in this section:

"Health insurance coverage" means benefits consisting of coverage for costs of medical care, whether directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care under a group policy of accident and sickness insurance, a hospital or medical service policy or certificate, a hospital or medical service plan contract, or a health maintenance organization contract, which coverage is subject to this title or is provided under a plan regulated under the Employee Retirement Income Security Act of 1974.

"Health insurance policy" means an individual or group accident and sickness insurance policy providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; an accident and sickness subscription contract providing health insurance coverage for eligible individuals; or a health care plan that provides, arranges for, pays for, or reimburses any part of the cost of any health care services.

"Health insurer" means any insurance company that issues accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; a corporation that provides accident and sickness subscription contracts; or any health maintenance organization that provides a health care plan that provides, arranges for, pays for, or reimburses any part of the cost of any health care services, that is licensed to engage

in such business in the Commonwealth, and that is subject to the laws of the Commonwealth that regulate insurance within the meaning of § 514(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1144(b)(2)).

B. A health insurer that offers, sells, or issues a health insurance policy in the Commonwealth that provides coverage for abortion services shall also offer for sale in the Commonwealth a health insurance policy with substantively identical terms and conditions except that it does not provide coverage for abortion services.

C. A health insurance policy that does not provide coverage for abortion services shall (i) provide coverage for the costs of services of a physician and other services incurred in providing medical assistance to preserve the life of a pregnant woman provided every possible measure shall be taken to preserve the life of the unborn child of the pregnant woman or (ii) reimburse the costs of services incurred in providing medical treatment to address previous fetal demise or intrauterine fetal death.

D. The Commission shall adopt any regulations necessary to implement this section.

§ 38.2-4300. Definitions.

As used in this chapter:

"Acceptable securities" means securities that (i) are legal investments under the laws of the Commonwealth for public sinking funds or for other public funds, (ii) are not in default as to principal or interest, (iii) have a current market value of not less than \$50,000 nor more than \$500,000, and (iv) are issued pursuant to a system of book-entry evidencing ownership interests of the securities with transfers of ownership effected on the records of the depository and its participants pursuant to rules and procedures established by the depository.

"Basic health care services" means in and out-of-area emergency services, inpatient hospital and physician care, outpatient medical services, laboratory and radiologic services, and preventive health services. "Basic health care services" shall also mean limited treatment of mental illness and substance abuse in accordance with such minimum standards as may be prescribed by the Commission which shall not exceed the level of services mandated for insurance carriers pursuant to Chapter 34 (§ 38.2-3400 et seq.) ~~of this title~~. In the case of a health maintenance organization that has contracted with the Commonwealth to furnish basic health services to recipients of medical assistance under Title XIX of the United States Social Security Act pursuant to § 38.2-4320, the basic health services to be provided by the health maintenance organization to program recipients may differ from the basic health services required by this section to the extent necessary to meet the benefit standards prescribed by the state plan for medical assistance services authorized pursuant to § 32.1-325. *"Basic health care services" may, but shall not be required to, provide coverage for abortion services; however, plans that do not provide coverage for abortion services shall (i) provide coverage for the costs of services of a physician and other services incurred in providing medical assistance to preserve the life of a pregnant woman provided every possible measure shall be taken to preserve the life of the unborn child of the pregnant woman*

or (ii) reimburse the costs of services incurred in providing medical treatment to address previous fetal demise or intrauterine fetal death.

"Copayment" means an amount an enrollee is required to pay in order to receive a specific health care service.

"Deductible" means an amount an enrollee is required to pay out-of-pocket before the health care plan begins to pay the costs associated with health care services.

"Emergency services" means those health care services that are rendered by affiliated or nonaffiliated providers after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment of the individual's bodily functions, (iii) serious dysfunction of any of the individual's bodily organs, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Emergency services provided within the plan's service area shall include covered health care services from nonaffiliated providers only when delay in receiving care from a provider affiliated with the health maintenance organization could reasonably be expected to cause the enrollee's condition to worsen if left unattended.

"Enrollee" or "member" means an individual who is enrolled in a health care plan.

"Evidence of coverage" means any certificate or individual or group agreement or contract issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which an enrollee is entitled.

"Excess insurance" or "stop loss insurance" means insurance issued to a health maintenance organization by an insurer licensed in the Commonwealth, on a form approved by the Commission, or a risk assumption transaction acceptable to the Commission, providing indemnity or reimbursement against the cost of health care services provided by the health maintenance organization.

"Health care plan" means any arrangement in which any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services. A significant part of the arrangement shall consist of arranging for or providing health care services, including emergency services and services rendered by nonparticipating referral providers, as distinguished from mere indemnification against the cost of the services, on a prepaid basis. For purposes of this section, a significant part shall mean at least 90 percent of total costs of health care services.

"Health care services" means the furnishing of services to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

"Health maintenance organization" means any person who undertakes to provide or arrange for one or more health care plans.

"Limited health care services" means dental care services, vision care services, mental health services, substance abuse services, pharmaceutical services, and such other services as may be determined by the Commission to be limited health care services. Limited health care services shall not include hospital, medical, surgical, or emergency services except as such services are provided incident to the limited health care services set forth in the preceding sentence.

"Net worth" or "capital and surplus" means the excess of total admitted assets over the total liabilities of the health maintenance organization, provided that surplus notes shall be reported and accounted for in accordance with guidance set forth in the National Association of Insurance Commissioners (NAIC) accounting practice and procedures manuals.

"Nonparticipating referral provider" means a provider who is not a participating provider but with whom a health maintenance organization has arranged, through referral by its participating providers, to provide health care services to enrollees. Payment or reimbursement by a health maintenance organization for health care services provided by nonparticipating referral providers may exceed five percent of total costs of health care services, only to the extent that any such excess payment or reimbursement over five percent shall be combined with the costs for services which represent mere indemnification, with the combined amount subject to the combination of limitations set forth in this definition and in this section's definition of health care plan.

"Participating provider" means a provider who has agreed to provide health care services to enrollees and to hold those enrollees harmless from payment with an expectation of receiving payment, other than copayments or deductibles, directly or indirectly from the health maintenance organization.

"Provider" or "health care provider" means any physician, hospital, or other person that is licensed or otherwise authorized in the Commonwealth to furnish health care services.

"Subscriber" means a contract holder, an individual enrollee, or the enrollee in an enrolled family who is responsible for payment to the health maintenance organization or on whose behalf such payment is made.

Evaluation Topic Areas and Criteria for Assessing Proposed Mandated Health Insurance Benefits

Topic Area	Criteria
1. Medical Efficacy	
a. Medical Efficacy of Benefit	The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any clinical research, especially randomized clinical trials, demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service.
b. Medical Effectiveness of Benefit <i>JLARC Criteria*</i>	The contribution of the benefit to patient health based on how well the intervention works under the usual conditions of clinical practice. Medical effectiveness is not based on testing in a rigid, optimal protocol, but rather a more flexible intervention that is often used in broader populations.
c. Medical Efficacy of Provider	If the legislation seeks to mandate coverage of an additional class of practitioners: <ul style="list-style-type: none"> 1) The results of any professionally acceptable research, especially randomized clinical trials, demonstrating the medical results achieved by the additional class of practitioners relative to those already covered. 2) The methods of the appropriate professional organization to assure clinical proficiency.
d. Medical Effectiveness of Provider <i>JLARC Criteria*</i>	The contribution of the practitioner to patient health based on how well the practitioner's interventions work under the usual conditions of clinical practice. Medical effectiveness is not based on testing in a rigid, optimal protocol, but rather more flexible interventions that are often used in broader populations.
2. Social Impact	
a. Utilization of Treatment	The extent to which the treatment or service is generally utilized by a significant portion of the population.
b. Availability of Coverage	The extent to which insurance coverage for the treatment or service is already generally available.
c. Availability of Treatment <i>JLARC Criteria*</i>	The extent to which the treatment or service is generally available to residents throughout the state.
d. Availability of Treatment Without Coverage	If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatments.
e. Financial Hardship	If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment.
f. Prevalence/Incidence of Condition	The level of public demand for the treatment or service.
g. Demand for Coverage	The level of public demand and the level of demand from providers for individual or group insurance coverage of the treatment or service.

h. Labor Union Coverage	The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts.
i. State Agency Findings	Any relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.
j. Public Payer Coverage <i>JLARC Criteria*</i>	The extent to which the benefit is covered by public payers, in particular Medicaid and Medicare.
k. Public Health Impact <i>JLARC Criteria*</i>	Potential public health impacts of mandating the benefit.
3. Financial Impact	
a. Effect on Cost of Treatment	The extent to which the proposed insurance coverage would increase or decrease the cost of treatment of service over the next five years.
b. Change in Utilization	The extent to which the proposed insurance coverage might increase the appropriate or inappropriate use of the treatment or service.
c. Serves as an Alternative	The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.
d. Impact on Providers	The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next five years.
e. Administrative and Premium Costs	The extent to which insurance coverage might be expected to increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.
f. Total Cost of Health Care	The impact of coverage on the total cost of health care.
4. Effects of Balancing Medical, Social, and Financial Considerations	
a. Social Need/Consistent With Role of Insurance	The extent to which the benefit addresses a medical or a broader social need and whether it is consistent with the role of health insurance.
b. Need Versus Cost	The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders.
c. Mandated Option	The extent to which the need for coverage may be solved by mandating the availability of the coverage as an option for policy holders.

*Denotes additional criteria added by JLARC staff to criteria adopted by the Special Advisory Commission on Mandated Health Insurance Benefits.

Source: Special Advisory Commission on Mandated Health Insurance Benefits and JLARC staff analysis.

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