
# Evaluation of HF XXXX – Coverage for Abortions and Abortion-Related Services

Report to the Minnesota Legislature Pursuant to Minn. Stat. § 62J.26

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## Executive Summary

This proposed mandate would require a health carrier to provide health insurance coverage for abortions and abortion-related services. This bill would prohibit cost-sharing (e.g., co-payment, deductible, or coinsurance) for abortions and abortion-related services except in the case of high-deductible health plans.

This proposed mandate would apply to all medication or procedural interventions intended to terminate a pregnancy. Abortion-related services are not defined in this proposed mandate, but pre-abortion or follow-up services may include evaluation of pre-procedural medical conditions, tests to confirm pregnancy status, emergency department visits, and contraceptive and family planning services.

Some public comments noted that providing comprehensive insurance coverage is critical to creating equitable access to abortions and abortion-related services. As the cost of an abortion may be a significant portion of monthly income for many individuals and families, lack of coverage for abortions may impact health outcomes and result in higher health care costs. Some public comments highlighted the operational challenges associated with the proposed mandate, such as the administrative burden for health plans to account for and report the separation of federal funds in abortion coverage.

As of November 2023, eleven other states require private and/or exchange-based plans to cover abortions. Medical Assistance and MinnesotaCare currently cover abortions and abortion-related services, but there are no Minnesota state laws requiring commercial carriers to cover abortions or specific abortion-related services. Federal laws currently prohibit the explicit use of federal funds for abortion in commercial or public health coverage and restrict states from including abortion as an essential health benefit.

According to the Minnesota Department of Health, 10,166 Minnesota residents had an induced abortion in 2022. Of these abortions, 48% were covered by state public insurance, 33.5% were self-pay, and 18.5% were covered by commercial plans. In addition, 91% of abortions performed in Minnesota occurred during the first trimester, 8.9% in the second, and 0.01% in the third. One study reported a median cost in the Midwest of $550 for first trimester medication abortions, $647 for first trimester procedural abortions, and $815 for second trimester procedural abortions. Delays in abortion are linked to financial and legal barriers.

Due to the broad scope of the mandate related to pre-abortion and follow-up services, along with limitations in the claims data for commercial coverage of abortions, an actuarial analysis could not be performed to estimate the potential economic impact of the mandate.

The potential state fiscal impact of this mandate is as follows:

- Minnesota Management and Budget estimates the cost of this legislation for the State Employee Group Insurance Program to be $27,300 for partial Fiscal Year 2025 (FY 2025) and $57,300 for FY 2026.
- Commerce has determined that this proposed mandate would likely require partial defrayal under the Affordable Care Act, with an estimated cost between $90,000 and $300,0000 in the first year.
- There is no estimated cost for Minnesota public health coverage programs, as the proposed health benefit mandate does not apply to these programs.

## Introduction

In accordance with Minn. Stat. § 62J.26, the Minnesota Department of Commerce (Commerce), in consultation with the Minnesota Department of Health (MDH) and Minnesota Management and Budget (MMB), performs a detailed evaluation of all relevant benefit mandate proposals. For evaluation criteria and required evaluation components, please review the Evaluation Report Methodology, available at https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/.

## Bill Requirements

This House bill is sponsored by Rep. Stephenson. At the time Commerce received the request for evaluation, the bill had not yet been introduced.

If enacted, this bill would require a health carrier to provide health insurance coverage for abortions and abortion-related services, including pre-abortion and follow-up services.

This proposed mandate would prohibit cost-sharing (e.g., co-payment, deductible, or coinsurance) for abortions and abortion-related services, except in the case of high-deductible health plans (HDHPs). For HDHPs with a health savings account, a health carrier may only apply cost-sharing at the minimum level necessary to preserve the enrollee's ability to maintain the health savings account, as outlined in section 223 of the Internal Revenue Code of 1986.

This proposed mandate would apply to fully insured small and large group commercial health plans, individual market plans, and the State Employee Group Insurance Program (SEGIP). It would not apply to self-insured employer plans, grandfathered plans, Medicare and Medicare supplemental policies, and Minnesota public health coverage programs.

## Related Health Conditions and Associated Services

In 2021, the fertility rate in Minnesota was 58.6 births per 1,000 women aged 15–44, with a total of 64,425 births.[1]

According to a report produced by MDH, 10,166 Minnesota residents had induced abortions in 2022.[2] Individuals may seek an abortion for various reasons, including but not limited to economic barriers and emotional or physical health risks.

An induced abortion refers to a medication or procedural[a] intervention to terminate a pregnancy.[3] Some health carriers use the term “elective” induced abortion to differentiate between reasons for abortion and associated coverage. While the American College of Obstetricians and Gynecologists has recommended excluding the use of “elective” to describe any abortion procedure, the term is used in this report to reflect the coverage exclusions defined by some health plans and state laws.[4]

This proposed mandate does not define what services may be considered pre-abortion or follow-up services. Pre-abortion services may include tests to confirm pregnancy status and evaluation of other medical conditions.

[a] Some literature and official reporting use the terms “medical” and “surgical” when differentiating between medication abortions and procedural abortions.

Follow-up services may include treatment for post-procedural health complications, emergency department visits, and contraceptive and family planning services. Currently, Minnesota Health Care Programs cover abortion-related services if they are directly related to an induced abortion. These services include but are not limited to hospitalization for abortions, counseling related to abortion, general anesthesia, prescription medications, and ultrasounds.[5]

## Related State and Federal Laws

This section provides an overview of state and federal laws related to the proposed mandate and any external factors that provide context on current policy trends related to this topic.

### Relevant Federal Laws

In 1977, the Hyde Amendment was passed, restricting state Medicaid programs from using federal funding to cover abortions except in the case of life endangerment of the mother, rape, or incest.[6] The amendment does not restrict the state's right to cover abortions in other circumstances, as long as only state funds are used. While the Hyde Amendment was initially intended to only restrict abortion coverage under Medicaid, it has been used to restrict abortion coverage for other federally funded plans (i.e., women covered under the Indian Health Service and federal employees).

The Pregnancy Discrimination Act of 1978 prevents employers from being required to pay for health insurance benefits for abortion unless the life of the mother would be endangered if the pregnancy was carried to full term or abortion-related medical complications occurred.[7]

The Patient Protection and Affordable Care Act (ACA) explicitly prohibits states from including abortion as an essential health benefit (EHB) and does not require Marketplace plans to offer abortion coverage. However, if Marketplace plans do cover abortion, the coverage must explicitly segregate and exclude federal funds.[6]

### Relevant Minnesota Laws

On January 1, 2023, Governor Walz signed the Protected Reproductive Options Act (House File [HF] 1) establishing that every Minnesotan has a fundamental right to make decisions about their own reproductive health, including the right to obtain an abortion.[8] This bill codifies protections for all reproductive health care and prohibits local units of government from regulating a person's ability to freely exercise their fundamental right to receive reproductive health care.

Medical Assistance and MinnesotaCare currently cover abortions and abortion-related services.[8] On May 24, 2023, HF 2930/Senate File (SF) 2995 was passed addressing health care affordability, delivery, disparities, and reproductive care protections.[9] Abortion-specific coverage updates from this revision include

- broadening coverage of abortions under MinnesotaCare by removing provisions that limited coverage of abortions to enrollees whose pregnancy resulted from rape or incest or who were in danger of death unless an abortion was performed,
- expanding coverage of abortion-related services under Medical Assistance to include all services determined to be medically necessary by the treating provider, and
- increasing payment rates by 20% for family planning and abortion services starting January 1, 2024.

There are several current Minnesota statutes that restrict coverage of abortions and abortion-related services. The latest version of this proposed health benefit mandate would repeal the abortion-specific subdivisions in the following statutes.[10,b]

- Minn. Stat. § 62A.041, subd. 3 states that maternity benefits shall not include elective induced abortion whether performed in a hospital, another abortion facility, or the office of a physician.[11]
- Minn. Stat. § 62D.02, subd. 7 states that coverage for elective induced abortion, except as medically necessary to prevent the death of the mother, whether performed in a hospital, an abortion facility, or the office of a physician, shall not be mandatory for any health maintenance organization.[12]
- Minn. Stat. § 62D.20, subd. 1 states that health maintenance organizations have the option of excluding or including elective induced abortions, except as medically necessary to prevent the death of the mother, as part of their comprehensive health maintenance services.[13]
- Minn. Stat. §62D.22, subd. 5 states that health maintenance organizations are not required to cover elective induced abortions, wherever performed, under health or maternity benefits.[14]
- Minn. Stat. § 62Q.14 states that health plan companies may restrict the choice of where an enrollee receives services related to abortion services.[15]

## State Comparison

Insurance coverage for abortion-related services is a key element of abortion access, even across states where abortion is legal, and there is significant variation in the extent to which states allow Medicaid, private, and exchange-based coverage of abortion.[16] As of November 2023, eleven states require private and/or exchange-based plans to cover abortions.[16]

- **California's** Knox-Keene Health Care Service Plan Act of 1975, in conjunction with the California Constitution, requires all health plans to cover abortion services.[17] Senate Bill (SB) 245 was enacted in 2022 and requires insurance plans that cover abortion to also cover abortion services with no cost-sharing.[18]
- **Colorado's** SB 189 was passed in 2023 and requires large employer health benefit plans renewed on or after January 1, 2025, to provide coverage for abortion care with no cost-sharing.[19]
- **Illinois's** Reproductive Health Act (SB 0025) was enacted in 2019. It requires private health insurance plans that cover pregnancy-related care to also cover abortions and allows cost-sharing to the same extent as other pregnancy-related care.[20]
- **Maine's** Act to Remove Barriers to Abortion Coverage in Private Insurance (Legislative Document 935) was enacted in 2023 and requires private insurance companies to cover abortion care without cost-sharing.[21]
- **Maryland** passed SB 786 in 2023. It requires insurers that provide labor and delivery coverage to also cover abortion services.[22] Maryland previously passed House Bill (HB) 937, which requires abortion coverage to be provided without cost-sharing.[23]
- **Massachusetts** Acts § Chapter 127 ensures insurance coverage of abortions and abortion-related health care services without cost-sharing for all health insurance plans delivered, issued, or renewed on or after January 1, 2023.[24]

[b] This evaluation report focuses on the proposed mandate language that was provided to Commerce in November 2023.

- **New Jersey's** Department of Banking and Insurance started requiring coverage for abortion services without exceptions beginning with the 2023 plan year.[25]
- **New York** enacted Assembly Bill 9007 in 2022. It requires all private insurance plans offering maternity coverage to also cover abortion.[26] Coverage for abortion services is required without cost-sharing, except in the case of HDHPs.
- **Oregon's** Reproductive Health Equity Act (HB 3391) requires private health insurance plans to cover abortion with no cost-sharing.[27]
- **Washington** passed SB 6219 in 2018. It requires health plans covering maternity care to also provide coverage for abortion.[28] In 2023, SB 5242 was enacted, prohibiting cost-sharing for abortion coverage.[29]
- **Vermont** passed SB 37 in 2023. It requires state-regulated health insurers to provide coverage for abortion-related care with no cost-sharing.[30]

## Public Comments Summary

Commerce solicited public input on the potential health benefit mandate through a request for information (RFI) posted to Commerce's website and the Minnesota State Register. The summary below represents only the opinions and input of the individuals and/or organizations who responded to the RFI.

### Key Stakeholder Comment Themes

For this proposed mandate, Commerce received RFI responses from six commercial health carriers, two health care provider organizations providing abortion care and family planning services, and one consumer advocacy organization.

Some respondents submitted comments that were neither for nor against the bill but raised considerations related to insurance coverage requirements. Below are key takeaways from these comments:

- Some respondents reported that it would be operationally challenging to identify any service as "abortion-related" in order to appropriately waive cost-sharing unless the associated health care claim includes a primary diagnosis code related to pregnancy or termination of pregnancy. This may result in misapplied cost-sharing for abortion-related services, add considerable administrative burden for health plans, and require enrollees to inform their health plan that a service they received was related to an abortion.
- The proposed mandate may place an additional administrative burden on health carriers to ensure alignment with federal guidance on the separation of funds used to cover the cost of abortion services. Qualified Health Plans (QHPs) offered through MNsure may be impacted most, as this proposed mandate would require QHPs to collect a separate monthly premium from each enrollee regardless of their age, gender, or family status or whether they received abortion services. Under Section 1303 of the ACA, this separate premium is required to be a minimum of $1 per member per month (PMPM) regardless of the actual PMPM cost to issuers.[31] The separate billing for these amounts must be itemized from the remaining premium, and QHP issuers must establish a separate allocation account exclusively for these funds and submit an annual attestation to the state that their "segregation plan" complies with federal requirements.
- Stakeholders expressed concern that the proposed mandate would result in an increase in monthly premiums for all enrollees, potentially causing some individuals to opt out of enrolling in health

insurance coverage altogether. They noted that this may disproportionately affect individuals who are receiving federal subsidies and would be required to pay out of pocket for this specific premium increase.

- The proposed mandate includes an exemption for HDHPs such that health carriers are only allowed to apply cost-sharing for abortions and abortion-related services at the "minimum level necessary" to preserve enrollees' ability to maintain their HDHP status. However, stakeholders have expressed uncertainty about how health carriers would implement a unique deductible for these specific benefits. Additionally, stakeholders highlighted that this approach does not follow the strategy of other mandates, where HDHPs are exempt from cost-sharing requirements for specific services.

Multiple respondents submitted comments voicing support for the bill. Below are key takeaways from these comments:

- Stakeholders stressed the importance of the proposed mandate for aligning private and public health care coverage for all types of abortions (i.e., medication abortions and procedural abortions). They also noted that comprehensive coverage for abortion services should prioritize patient preferences and clinical indicators, recognizing that each individual and pregnancy are unique and may require a treatment plan tailored to the individual's specific needs.
- Stakeholders defined pre-abortion services as evaluation, procedures, and treatment that include but are not limited to confirming pregnancy, reviewing medical history, performing ultrasounds and lab work, and providing education on procedures, particularly for medical abortions. They defined follow-up services to include the prescription of antibiotics, ibuprofen, and anti-nausea medication as well as psychosocial counseling and support and discussing birth control options. However, stakeholders emphasized the importance of deferring to "the judgment of providers about what should be considered pre-abortion care and follow-up services," given that providers are medical experts and aware of current best practices.
- Providing comprehensive insurance coverage is critical to creating equitable access to abortion and abortion-related services. Two stakeholders emphasized that the proposed mandate is key to ensuring that abortion and abortion-related services are accessible to all Minnesotans regardless of their insurance type or the financial barriers they may face. Removing cost-sharing is crucial to ensure affordable access to abortion, as out-of-pocket costs could be considered catastrophic expenditures for many individuals and cause them to delay care, leading to more complex and costly health care needs.
- Three stakeholders voiced the opinion that health plans should not be allowed to implement prior authorization under this coverage requirement and that prior authorization could potentially lead to delays in care and an unnecessary administrative burden for providers. Additionally, one stakeholder highlighted that allowing individuals to access abortion care and related services as needed is not only better for health outcomes but also minimizes burden and stress on the health care system.

# Evaluation of Proposed Health Benefit Mandate

## Methodology

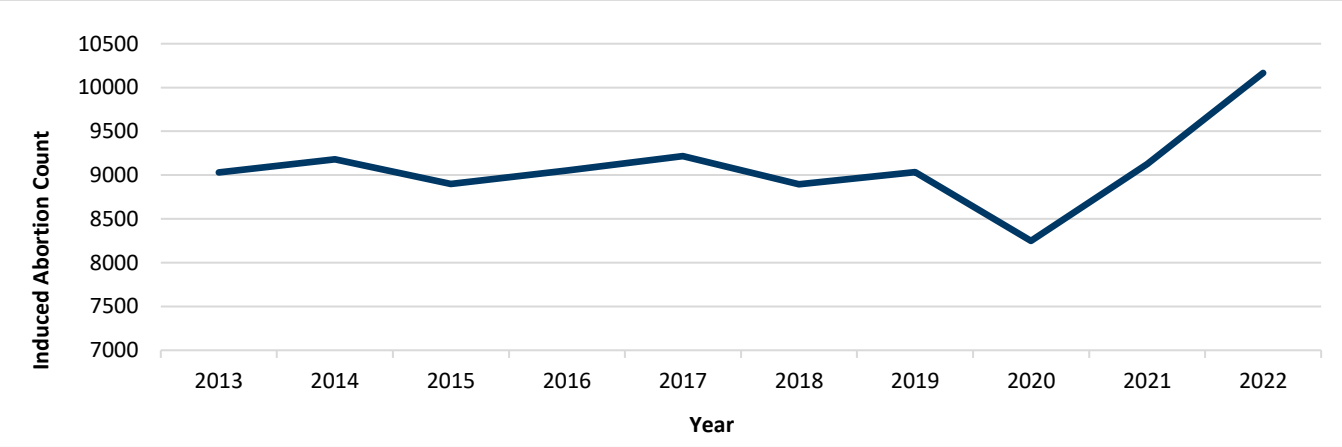
The following section summarizes key findings related to the proposed mandate's potential public health and economic impact from current (under 10 years old) national and in-state resources related to utilization of and coverage for abortion services. To assess the potential cost associated with the mandate, as well as potential

forgone costs for enrollees of these plans if the proposed mandate was enacted, the evaluation sought peer-reviewed literature from the last 10 years from within the United States to address the average cost of abortions and related procedures. Costs are not currently included in Minnesota's state-required reporting on abortions. For further information on the methodology for including literature related to cost, please reference https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/.

## Public Health Impact

**Utilization Rates for Abortion.** In 2022, there were 10,166 abortions reported for Minnesota residents, representing 0.17% of Minnesota residents.[2,32] There is no consistent trend in the number of abortions among Minnesota residents in the last 10 years, with 10-, 5-, and 1-year percent change estimates of 13%, 14%, and 11%, respectively (see Figure 1), and both periods of increase and periods of decrease occurred between the reference years.[2,33–41]

**Figure 1. Annual Number of Induced Abortions for Minnesota Residents (2013–2022)**




Of the 10,166 induced abortions in 2022, 3% were for individuals under the age of 18, 35% for individuals between the ages of 18 and 24, 48% for individuals between the ages of 25 and 34, and 15% for individuals 35 and over.[2]

**Current Coverage for Abortions and Abortion-Related Services.** Of the abortions performed in 2022 reported for Minnesota residents, 48% were covered by public insurance, 33.5% were self-pay, and 18.5% were covered by commercial plans. Between 2013 and 2022, the percentage of Minnesotans using private insurance to pay for abortions dropped from 22.9% to 18.5%.[2,33] It is unclear whether this represents a reduction in commercial coverage for abortions. In addition, while current rates of self-pay versus use of private coverage for abortion services are available in each year's legislative report from MDH, it is unclear what percentage of individuals choose to self-pay despite having insurance coverage and what percentage would continue to do so if the mandate was enacted.

According to publicly available information on benefits, many large health plans in Minnesota cover induced abortions for life-threatening circumstances, rape, or incest but do not cover elective induced abortions[c] (see

[c] As broadly considered by health plans, an elective abortion is any abortion performed for a reason other than life-threatening circumstances, rape, or incest.

Table 1 for reason-specific prevalence rates for abortions performed). According to 2021 estimates, 57% of Minnesota residents have private insurance, and of those residents, 36.1% are fully insured.[42]

**Clinical Considerations.** Minnesota residents mention various reasons for seeking an abortion.[2] Table 1 summarizes the reasons for abortion among Minnesota residents receiving an abortion in 2022. Of the stated reasons, 7.4% of respondents cited emotional or physical health concerns, 1.2% of respondents indicated that fetal abnormalities were identified, and 0.2% of respondents reported that continued pregnancy would result in bodily harm. Note that those who sought but did not receive an abortion due to coverage and/or cost restraints are not included in the data used to assess unmet need or projected impact on utilization from the proposed mandate.

**Table 1. Reasons for Seeking Abortion in 2022[2]**

| Provided reason for abortion | Percentage of responses[d] |
|---|---|
| Does not want children at this time | 52.6% |
| Financial/economic concerns | 10.2% |
| Emotional or physical health is at stake | 7.4% |
| Fetal abnormalities in pregnancy were identified | 1.2% |
| Pregnancy was a result of rape or incest | 0.3% |
| Continued pregnancy will result in bodily harm | 0.2% |
| Unknown, refused to answer, or other stated reason | 28.0% |

In 2022, 91% of Minnesota abortions occurred during the first trimester, 8.9% in the second, and 0.01% in the third.[2] This represents a 12.4% decrease in second trimester abortions from 2013 to 2022.[33,40]

The most commonly occurring abortion complications are typically considered clinically minor, such as pain and bleeding, while less common but major complications include cervical laceration and septic abortion, and these may be specific to gestational age at the time of abortion (i.e., first or second trimester abortion) or type of abortion (i.e., medication or procedural).[43,44] Nationally, risks of complications are lowest in the first trimester.[45] The rates of intraoperative and postoperative complications for abortions among Minnesota residents are not currently available, as state-required reports indicate abortion complications that may be co-occurring but do not separate out discrete types. One study based on a California Medicaid population found complication rates of 0.23% for first trimester medication abortion, 0.16% for first trimester aspiration (procedural) abortion, and 0.41% for abortions occurring in the second trimester or beyond.

**Access to Abortion and Health Equity.** Black, Indigenous, and other people of color (BIPOC) are disproportionately represented in the demographic statistics for those receiving an abortion compared to their White counterparts.[2] Based on the 2017–2018 Center for Health Equity report on maternal mortality statistics in Minnesota, BIPOC individuals have a higher risk of pregnancy-associated death and infant mortality than their White counterparts.[46,47] As barriers to abortion access[e] may be associated with higher rates of maternal morbidity and mortality and with more complex second trimester abortions (in cases where coverage is delayed), the expansion of coverage and removal of cost-sharing may have broad health equity consequences.[46]

[d] Respondents could cite more than one reason for seeking abortion, so indicated responses do not add up to 100%.
[e] Barriers to access may include restrictive state laws, geographic availability and proximity of abortion services, and financial barriers.

## Economic Impact

**Cost Data for Abortions.** Cost for abortions varies by factors related to facility type, pregnancy trimester, and type of abortion (i.e., medication or procedural).[48,49]

While Minnesota-specific costs for abortions and abortion-related services are not available across facilities, one nationally based study found that in 2017 the average cost of first trimester surgical abortions was $549 ($534 at specialized clinics and $578 at nonspecialized clinics) and that for first trimester medication abortions the average cost was $551 ($541 at specialized clinics and $568 at nonspecialized clinics).[48] The average cost for abortions in the second trimester[f] ranged between $410 and $5,386, and the average for abortions in this trimester requiring emergency and inpatient services was $1,670. Another study found a median cost of $550 in the Midwest for first trimester medication abortions, $647 for first trimester procedural abortions, and $815 for second trimester procedural abortions.[50] Costs for abortions and out-of-pocket spending for patients were found to be higher in areas with relatively higher overall cost of living.[49]

Of abortions for Minnesota residents, 62% were medication abortions, which represents a 25% reduction in procedural abortions since 2018. Most abortions in Minnesota occurred at abortion clinics, and only 1.34% of abortions occurred as inpatient or emergency admissions.

While follow-up services are not defined in the proposed mandate, these would include all types of post-procedural evaluation and treatment related to the abortion itself, such as interventions for post-abortion complications. As noted previously, complications are most common for later stage abortions.[51] Because the cost of abortion procedures and associated travel was cited as a primary reason for delaying abortion, reduced economic burden could also reduce complications associated with abortion.[49,52] Minnesota claims data do not indicate what abortions were delayed and why delays occurred. Therefore, it is unclear whether the percentage of the abortion-related complications resulting from delays would be decreased by reducing economic barriers to abortion.

**Other Cost Considerations.** One study found that from 2017 to 2020 there was a national decline in the number of facilities accepting insurance for abortion.[49] Over this period, the Midwest experienced a decline from 88% to 75%. Reimbursement rates may play the largest role in determining whether more facilities will accept insurance in the future and whether the national and regional decline observed in 2017–2020 will continue.

The number of facilities currently accepting insurance for abortion in Minnesota is unknown. It is unclear whether the recent coverage expansion under Minnesota public health programs or the potential commercial coverage expansion under this proposed mandate would result in more facilities accepting insurance for abortion procedures and services.

## Limitations

**Existing Data Limitations.** There is limited literature addressing expansion of abortion coverage in commercial insurance specifically or the impact of cost-sharing on abortion access. Due to privacy concerns, wide variations in commercial coverage of abortions and related services, and limited claims data for abortions and related services, there is limited information to further evaluate the impact of this proposed mandate.

[f] Data cited in study were specific to 20 weeks gestation.

**Actuarial Analysis Limitations.** A reliable actuarial analysis is not feasible for this evaluation given the data challenges for this proposed mandate. Specifically, the Minnesota All Payer Claims Database contains a low percentage of commercial claims for abortions and related services because many abortions are self-paid and coverage for abortions is inconsistent across plans. Furthermore, the procedure codes associated with abortion may correspond with procedure codes for other purposes, which may skew the rate of utilization. Finally, as a result of the broad language of the proposed mandate related to pre-abortion and follow-up services, it is unclear what treatments and services would be included in the analysis for this component of the evaluation.

## State Fiscal Impact

The potential state fiscal impact of this legislation includes the estimated cost to SEGIP as assessed by MMB in consultation with health plan administrators, the cost of defrayal of benefit mandates as understood under the ACA, and the estimated cost to public programs.

- MMB estimates the cost of this legislation for the state plan to be $27,300 for partial Fiscal Year 2025 (FY 2025) and $57,300 for FY 2026.
- Commerce has determined that this proposed mandate would likely require partial defrayal under the ACA, with an estimated cost between $90,000 and $300,000 in the first year.
- There is no estimated cost to state public programs.

### *Fiscal Impact Estimate for SEGIP*

MMB reports that SEGIP plans cover abortions and abortion-related services, with members paying cost-sharing in the form of copayments, coinsurance, or deductibles depending on the place of service. MMB provided SEGIP's fiscal impact analysis, which uses claims for abortions as well as abortion services occurring before and after the procedure, to estimate the total claims cost to the plan if member cost-sharing was removed. MMB's analysis predicted a PMPM fiscal impact ranging from $0.02 to $0.05 PMPM. MMB noted the impact range is due to the lack of specificity in the proposed mandate's language, as the bill does not explicitly indicate the applicable diagnoses and procedure codes. The partial fiscal year impact of the proposed legislation on SEGIP is estimated to be $27,300 for partial FY 2025 ($0.035 average PMPM medical cost × 130,000 members × 6 months). The estimated impact for FY 2026 equals $57,330, due in part to a predicted 5% rate of inflation. MMB notes that that the language of the bill does appear to conflict with SEGIP's Advantage HDHP, which would continue to apply cost-sharing. As SEGIP's costs are funded by state and quasi-state employer contributions, MMB's fiscal analysis assumes that 86.6% of added costs will be paid by state agencies and that 13.4% will be paid by state employees and quasi-state agencies.

### *Affordable Care Act Mandate Impact and Analysis*

States may require qualified health plan issuers to cover benefits in addition to the 10 EHBs defined by the ACA but must defray the costs, either through payments to individual enrollees or directly to issuers, and can partially defray the costs of proposed mandates if some of the care, treatment, or services are already covered in the state's benchmark plan or mandated by federal law, pursuant to section 1311(d)(3)(b) of the ACA.[53,54] For further defrayal requirements and methodology, please visit https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/.

If enacted, this bill would likely create a partial state benefit mandate beyond the 10 EHBs defined under the ACA, as it relates to new coverage requirements that are not already described in Minnesota's benchmark plan.

The state's benchmark plan includes coverage for maternity benefits and prenatal care as well as coverage for abortion in life-threatening circumstances.[1] Some pre-abortion services (e.g., evaluation of medical conditions and laboratory tests and services to confirm pregnancy status, intrauterine location, and gestational duration)[3] and some follow-up services (e.g., post-procedure emergency department services to treat health complications and contraceptive and family planning services)[4] may be classified under maternity benefits, prenatal care, or other health services required by the state's benchmark plan.

The cost of defrayal associated with this bill is estimated to be between $90,000 and $300,000 in the first year. In developing this estimate, Commerce assumed that the state would be required to defray the cost of elective medication and procedural abortions as well as certain related services not already covered under the state's benchmark plan. Commerce also considered abortion prevalence rates, average distributions by reason for abortion, average distributions by type of abortion (e.g., medication, first trimester procedural, second trimester procedural, and third trimester procedural), average abortion costs by type, average costs of related services not already covered by the benchmark plan, and projected QHP enrollment. Estimating the specific defrayal costs associated with certain related services is challenging because the bill language does not clearly identify what treatments and services would be required that are not already covered under the benchmark plan.

### *Fiscal Impact for State Public Programs*

There is no estimated cost to Minnesota public health coverage programs, as the proposed health benefit mandate does not apply to these programs.

# Appendix A. Bill Text

A bill for an act relating to insurance; requiring coverage of abortions and abortion-related services; proposing coding for new law in Minnesota Statutes, chapter 62Q.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

**[62Q.524] COVERAGE OF ABORTIONS AND ABORTION-RELATED SERVICES.**

Subdivision 1. **Definition.** For purposes of this section, "abortion" means any medical treatment intended to induce the termination of a pregnancy with a purpose other than producing a live birth.

Subd. 2.**Required coverage; cost-sharing.** (a) A health plan must provide coverage for abortions and abortion-related services, including preabortion services and follow-up services.

(b) Except as provided in paragraph (c), cost-sharing requirements, including co-payments, coinsurance, and deductibles, must not apply for abortions and abortion-related services.

(c) A health plan that is a high-deductible health plan in conjunction with a health savings account must include cost-sharing for abortions and abortion-related services at the minimum level necessary to preserve the enrollee's ability to make tax-exempt contributions and withdrawals from the health savings account as provided in section 223 of the Internal Revenue Code of 1986, as amended.

**EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health plans offered, sold, issued, or renewed on or after that date.

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