The Affordable Care Act and abortion
Comparing the U.S. and Western Europe

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ABSTRACT. **The 2010 Affordable Health Care Act (ACA) treats abortion differently than any other health service, precluding public funding for abortion and imposing other restrictions on American states. To determine whether the ACA's abortion restrictions are uniquely American or have counterparts in other national health systems, this study employs a cross-sectional design comparing abortion restrictions in the ACA with those in 17 Western European countries. Using a six-item scale, the intensity of abortion restrictions is compared across Western European nations. A similar scale is employed for a five-state sample of state-level abortion restrictions. Although the United States is not alone in having abortion restrictions, how abortion is proscribed in the ACA has no counterpart in Western Europe. Unlike many Western European countries, the ACA's restrictions focus on abortion funding, not the length of gestation or the health of the pregnant woman.**

Key words: Affordable Care Act, abortion, health policy, comparative health policy, European Union

The 2010 Affordable Care Act (ACA) extended the right to health care to millions of Americans. By mandating health insurance for most of its citizens, the United States made a major stride toward universal health coverage and moved closer to the health care policies of other wealthy industrialized countries. At the same time, the ACA precluded abortion, one of the most common surgical procedures in the United States, from receiving public funding.[1,2]

Passage of the ACA was a difficult and uncertain proposition. For a century, repeated attempts to enact universal health insurance in the United States had failed.[3,4] Determined not to repeat the Clinton health care debacle, President Obama supported a congressionally centered process instead of a bill dictated by the White House.[5] Within the 111th Congress, however, health care legislation faced substantial barriers, including "internecine warfare" among Democrats and "steadfast GOP [Republican Party] opposition."[6]

In the end, the abortion issue nearly derailed the ACA. The GOP remained unyielding; not a single Republican in either chamber voted in support of the final health reform bills. Passage of the final House bill required solid Democratic support, a formidable undertaking within such a diverse political party. The party platform had a "pro-choice" position, but Democratic members of Congress reflected the full spectrum of abortion opinion.[7]

In order to garner enough votes, the Democratic House leadership had to make concessions to pro-life Democrats who refused to commit their votes until there was a pledge not to use tax dollars to fund abortions.[8,9] The resultant intraparty compromise reinforced, and even extended, the existing federal Hyde amendment that prohibits the expenditure of any federal dollars for abortion, except in the rare cases of rape, incest, or life endangerment of the pregnant woman.[10] To seal this endgame compromise, President Obama promised to issue a specific executive order, following the House vote, to reinforce bans on public abortion funding already in the pending legislation."[11] Consequently, the day after signing the ACA with great fanfare, the president quietly penned Executive Order 13535, "Ensuring Enforcement and Implementation of Abortion Restrictions in the Patient Protection and Affordable Care Act," doubly assuring that the new law would prohibit federally funded abortions.[12,13]

The purpose of this article is to compare the ACA's treatment of abortion with how national health systems

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in other wealthy countries address pregnancy terminations. Did contentious American abortion politics produce distinctive policy actions or are the ACA abortion restrictions similar to those found in other countries? Western Europe was selected as the comparator because of its cultural and economic similarities to the United States. The first section reviews comparative literature addressing abortion laws and restrictions. Next, the Methods section describes the implementation of ACA's abortion restrictions, scores the intensity of abortion restrictions in a sample of American states, and scores the intensity of abortion restrictions in 17 Western European countries. Third, the Findings section compares the intensity of abortion restrictions in the United States with those in Western Europe. The article concludes with a discussion of the significance of these findings and what they portend.

Background and research approach

Abortion laws and restrictions vary throughout the world, and they determine both the availability of abortion services and their safety."[14] Among these policies, the most important distinction is whether most induced abortions in a country take place legally. Over a quarter of the world's women live in countries where highly restrictive laws make most induced abortions illegal. However, more than 60 percent of the world's population lives in countries with liberalized abortion laws, where at least early abortion is legally available on broad grounds.[15]

"One of the many controversies surrounding abortion is whether restrictive abortion laws prevent women from obtaining abortions."[16] The most recent global evidence shows that highly restrictive national laws, which make most induced abortions illegal, are directly related to high abortion rates.[17] This relationship is due to the fact that countries with highly restrictive laws tend to be developing nations where modern contraceptive prevalence is low.[18] Worldwide, women living in countries with liberal abortion laws have lower abortion rates.[19]

Eastern Europe, with the world's highest regional abortion rate, provides a stark exception to this generalization.[20] Most countries in this region do have liberalized abortion laws, but abortion rates are high because of low contraceptive prevalence.[21] "Family planning services have been severely lacking in these societies, whereas abortion has long been readily available because it was legalized in the Soviet Union and its allies well ahead of other countries."[22]

Most countries with liberalized abortion laws also have abortion restrictions that specify the conditions under which legal abortion can occur. The ACA's funding proscriptions are examples of such restrictions. Thus far, scant research has compared abortion restrictions across countries with liberalized laws.

Comparing policy sectors between North American and Western European countries is a common practice in comparative health policy analysis;[23,24,25] abortion policy is no exception. A series of case studies covering changes in abortion policy—from formulation to implementation—in the United States, Western and Eastern Europe, and Japan was published two decades ago.[26] Another compilation of country studies from roughly the same time period examined the relationship between the women's movement and abortion policy.[27] Neither of these edited volumes quantified or analyzed specific abortion restrictions cross-nationally. A more recent Western European study reviewed legal developments from 1960 to 2010, showing the enactment of national restrictions over time,[28] but this study did not quantify the total bundle or intensity of abortion restrictions, making cross-national comparisons difficult.

My study compares the intensity of American restrictions under the ACA with those in Western Europe. The goal here is to "clarify and illuminate" the ACA restrictions by contrasting them with other national arrangements.[29] In this policy arena, Western Europe is a good comparator for the United States because of similar social norms and behaviors surrounding reproduction.

In any country or society, abortion demand is predicated upon two antecedent events: levels of sexual activity and use of contraception. Where sexual abstinence is not practiced consistently, effective contraception is needed for those not trying to become pregnant. When sexually active women not wanting to become pregnant do not use contraception, the demand for induced abortion increases.[30]

A common measure of sexual activity is age at sexual initiation, the age at which sexual intercourse first occurs.[31] Table 1 shows sexual initiation rates across the United States and five Western European countries, for which data are available. Little variation exists, even across gender. In general, most American and Western European youth initiate sexual activity before age 20. British men have the youngest age at initiation (16.5 years), while several countries report 18.5 years for both men and women. Swiss and American youth show the smallest gender gap in the age of initiation.[32]

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Table 1. Median age of sexual initiation by selected countries.

Country	Men	Women
UK	16.5	17.5
France	17.5	18.5
Italy	17.5	18.5
Norway	18.5	17.5
Switzerland	18.5	18.5
US	17.3	17.5

Source: Wellings *et al.* 2006.

Table 2. Contraceptive prevalence by country (median estimates for 2015).

Country	Any method	Any modern method
Austria	67.5	65.2
Belgium	68.5	67.0
Denmark	70.8	65.8
Finland	74.6	72.3
France	74.3	72.3
Germany	66.8	62.1
Greece	68.7	45.9
Ireland	67.2	62.4
Italy	65.3	48.9
Netherlands	67.6	65.0
Norway	78.6	71.5
Portugal	76.6	69.9
Spain	66.8	63.3
Sweden	70.4	61.6
Switzerland	76.6	72.2
UK	81.3	80.0
US	75.1	69.2

Source: United Nations Population Division, 2015.

Table 2 shows both the prevalence of any contraceptive method (including traditional methods, including rhythm, withdrawal, and other traditional methods) and the prevalence of modern contraceptive methods (oral contraception, injections, intrauterine devices, barrier methods, and sterilization).[33] "The contraceptive prevalence rate is the number of women of reproductive age who are using contraception per 100 women of reproductive age."[34] Missing from this table is Luxembourg because it did not report its contraceptive prevalence.[35]

Across Western European countries, contraceptive use varies greatly. Overall contraceptive prevalence varies from 65.3 percent in Austria to 81.3 percent in the United Kingdom. For the more effective modern methods, prevalence ranges from 45.9 percent in Greece to 80.0 percent in the United Kingdom. Of note is that U.S. modern contraceptive prevalence lags behind the rates of six Western European countries.[36]

Abortion rates in Europe vary as well. Table 3 shows the wide range in Western European abortion rates (the number of abortions per 1000 women aged 15–44).[37,38,39] Unfortunately, these country abortion data are reported for different years. Given that caveat, the American abortion rate is higher than that of most Western European countries, except for France and Sweden.[40,41]

Table 3. Abortion rates by country.

Country	Abortion rate	Year
Austria	1.4	2000
Belgium	9.2	2009
Denmark	15.2	2010
Finland	10.4	2010
France	17.4	2009
Germany	6.1	2010
Greece	7.2	2007
Iceland	14.1	2004
Ireland	4.5	2010
Italy	10.0	2010
Netherlands	9.7	2010
Norway	16.2	2010
Portugal	9.0	2010
Spain	11.7	2010
Sweden	20.8	2010
Switzerland	7.1	2010
United Kingdom	14.2	2010
United States	16.9	2011

Sources: United Nations, 2013; Guttmacher Institute, 2014.

Methods

Abortion policies and restrictions shape the delivery of abortion services in every country. American restrictions under the ACA are analyzed first, followed by Western European abortion restrictions.

Abortion restrictions and the ACA

Abortion became legal across the United States in 1973 when the U.S. Supreme Court handed down *Roe v. Wade*. The Court held that a woman's right to choose abortion was constitutionally protected as part of her right to privacy.[42] This decision prohibited any level of government from interfering with abortion during the first trimester of pregnancy, "except to insist that it be performed by a licensed physician."[43] During the second trimester, the state had only the power to regulate abortion in ways designed to preserve and protect the woman's health. In the third trimester, protection of fetal life became a compelling reason sufficient under *Roe* to justify interference with the exercise of the right to choose abortion.[44]

By permitting state discretion, *Roe v. Wade* federalized, rather than nationalized, abortion policy. States

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Table 4. Abortion provisions in 2010 health reform law.

Provision	Year to be implemented
Abortion prohibited from being considered an essential medical service.	2014
With state health insurance exchanges, payments for abortion coverage must be segregated from other funds.	2014
For insurance plans offering abortion coverage, the actuarial value must be calculated without including the savings in the calculation.	2014
Insurance plans that offer abortion coverage cannot discriminate against providers who do not provide abortions.	2014

Source: Kaiser Family Foundation, 2010.

thus became key players in developing abortion policies.[45] Given this structure, it is not surprising that there have been multiple challenges to *Roe* (more than 35 U.S. Supreme Court decisions).[46] These judicial decisions have established more parameters for American abortion policies, including changes in public funding, parental consent, and Roe's original trimester framework.

Public funding of abortion was effectively precluded in 1980 when the Hyde amendment was upheld by the U.S. Supreme Court in *Harris v. McRae*. This decision prohibited the use of federal money to fund abortions, except where the life of the pregnant woman would be endangered if the fetus were carried to term. Although the Hyde amendment applied to all federal funding, its major effect was to curtail federal Medicaid funding for poor women. In 1993, Congress expanded the Hyde amendment to include cases where the pregnancy was the result of incest or rape.[47]

Parental consent for abortions for unemancipated minors was upheld in 1981 in *H.L. v. Matheson* and reaffirmed in 1983 in *City of Akron v. Akron Center for Reproductive Health* as long as the state provided an alternate method of approval for a minor who had a good reason for not seeking parental consent and could demonstrate that an abortion would be in her best interest. Currently, 44 states have parental consent or notification measures that restrict young women's access to abortion.[48]

The trimester framework presented in *Roe v. Wade* was replaced in the 1992 *Planned Parenthood of Southeastern Pennsylvania v. Casey* decision. Here the majority of the Court discarded this framework, replacing it with whether or not a restriction posed an *undue burden* to the woman. The undue burden standard provided more leniency for analyzing the constitutionality of abortion restrictions.[49]

Since at least the 1980s, the abortion issue has been mostly partisan in American politics.[50] At the national platform level, Democrats support a "pro-choice" position, and Republicans support a "pro-life" position. However, the near defection of former Representative Bart Stupak (D-MI) and other Democrats from the coalition to support the ACA demonstrates that party members are not always like-minded.[51]

The ACA abortion restrictions

The ACA abortion restrictions affect key provisions of the legislation: state Medicaid expansions, essential health benefits (EHB), and options offered by state health insurance exchanges. Overall, the ACA restrictions reinforce and even broaden the 1977 Hyde amendment banning the use of any federal funds for abortion, unless the pregnancy is the result of rape, incest, or if it physically endangers the woman's life (as opposed to a woman's health). Initially, the Hyde amendment affected only funding for Medicaid abortions, but over the years Congress extended its reach to both federal employees and women served by the Indian Health Service.[52] The Hyde amendment now looms over each of the ACA's abortion restrictions, as shown in Table 4 and discussed below.

State Medicaid expansions. Originally, the ACA mandated health care coverage for the poorest uninsured through the expansion of Medicaid eligibility to all qualifying individuals with incomes up to 138 percent of the federal poverty level. However, the 2012 U.S. Supreme Court ruling, *National Federation of Independent Business (NFIB) v. Sebelius*, made this expansion optional for the state Medicaid programs rather than mandated.[53] Not surprisingly, the 50 states have made different decisions about this option. As of October 2015, 31 states and the District of Columbia had expanded their respective Medicaid eligibility criteria.[54]

These expansions are important for women's health in general and the demand for abortion, in particular. Two-thirds of adult women on Medicaid are of reproductive age,[55] and many of them receive family planning services subsidized by Medicaid. The relationship between Medicaid and family planning is important

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from a policy perspective; publicly funded contraceptive services have been shown to reduce the demand for abortion.[56]

Under the ACA, Medicaid coverage of abortion services remains highly restricted. The federal Hyde amendment prohibits state Medicaid programs from using federal funds to cover most abortions for low-income women. States can fund abortions with their own funds, but currently only seventeen states do.[57] Moreover, Medicaid funding prohibitions are not the only abortion restrictions that the ACA and Executive Order 13535 promulgate. The law explicitly does not preempt other state abortion restrictions, including parental consent or notification, waiting periods, and other state abortion limits or coverage requirements.[58]

Essential health benefits (EHBs). The ACA endeavors to make health insurance more affordable and accessible to those living above the federal poverty level, defined in 2015 as $24,250 for a family of four living in the 48 contiguous states.[59] Individuals with incomes above this threshold can obtain insurance through state health care marketplaces, also known as exchanges. These marketplaces offer a variety of health insurance plans. To help residents with low and moderate incomes with the cost of insurance, the federal government provides subsidies to eligible individuals and families with incomes between 100 percent and 400 percent of poverty ($24,250 to $97,000 for a family of four in the 48 contiguous states).[60,61] All plans offered in these marketplaces must provide coverage for 10 EHBs.[62] From the ACA's inception, abortion services have been explicitly excluded from the list of EHBs that all plans are required to offer.[63]

State health exchanges or marketplaces. By early 2014, U.S. citizens and legal residents were required to have qualifying health care coverage or face a penalty.[64] With the extensions provided by the Obama Administration, employers with 100 or more employees had to offer health insurance coverage to 70 percent of their employees by 2015, 95 percent by 2016, or pay an additional tax.[65] Employers with 50–90 employees had until 2016 to offer health insurance to their employees.[66]

The ACA created state-based health benefit exchanges where individuals and employers could purchase qualified coverage.[67] Not surprisingly, state health exchanges also have abortion restrictions.[68] "As of January 2015, 24 states had enacted laws banning health insurance plans available through their marketplaces from including abortion coverage to varying degrees."[69]

At the most extreme, states can prohibit insurance plans that participate in their health exchanges from providing *any* coverage for abortions.[70] By 2014, 11 states had outright bans on abortion coverage in all private insurance plans.[71] In states not proscribing abortion coverage beyond Hyde amendment exceptions, marketplace insurance plans offering abortion coverage must create separate accounts for abortion coverage premiums and premium payments for coverage of all other health services. Women who opt for abortion insurance have to write a separate check for that coverage.[72] The ACA requires that at least one plan within each state insurance exchange must not offer abortion coverage beyond narrow exceptions of the Hyde amendment.[73]

Marketplace health insurance plans covering abortion face other requirements. Within the state exchanges, companies offering abortion coverage must estimate the actuarial value of abortion coverage by accounting for the cost of the abortion benefit (valued at no less than $1 per enrollee per month). Moreover, they are disallowed from calculating any savings that may occur as a result of an abortion (e.g., savings from not paying for prenatal services and childbirth). Finally, insurance plans that participate in the exchanges are prohibited from discriminating against any provider unwilling "to provide, pay for, or refer for abortions."[74]

Under the ACA, states have the choice of setting up their own state health insurance exchanges or having the federal government perform that function for them. By October 2015, 17 states and the District of Columbia had established their own state health insurance exchanges. Twenty-seven states defaulted to a federally facilitated marketplace structure, and seven more elected a partnership-based exchange, a joint venture of the state and federal government.[75]

Regardless of the insurance mechanism employed, health insurance exchanges are subject to state law. Some states follow the same abortion parameters as the federal Hyde amendment for their private plans; others are even more restrictive. For example, Idaho permits funding abortion for cases of rape, incest, or to save the woman's life for plans sold on its state-based marketplace, but it limits abortion coverage to cases of women's life endangerment for all other private plans issued in the state. Utah limits abortion funding to saving the pregnant women's life or averting serious risk of loss of a major bodily function, the presence of

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Table 5. State abortion bans and state marketplace abortion coverage.

State bans on abortion coverage in marketplace	Insurance plans offering abortion coverage (beyond Hyde restrictions)		
	All plans	Some plans	No plans
No ban (26 states)	4 states	15 states	7 states
Various bans (24 states)	0 states	6 states	18 states

Sources: U.S. Government Accountability Office, 2014; Salganicoff and Sobel, 2015.

Table 6. Abortion restrictions for selected American states.

State	Reproductive rights grade	Public funding	Waiting period	Parental consent	TRAP regulations	Mandate counseling	Total
Washington	A+	0	0	0	0	0	0
Illinois	B	1	0	1	1	0	3
Colorado	C+	1	0	1	1	0	3
Rhode Island	D+	1	0	1	1	1	4
Louisiana	F	1	1	1	1	2	6

Sources: NARAL, 2015; Kaiser, 2014.

a lethal fetal defect documented by a physician, and in cases where pregnancy resulted from rape or incest. For private health insurance outside the marketplace, Utah prohibits any separate riders for abortion coverage. Six states (Kansas, Kentucky, Missouri, Nebraska, North Dakota, and Oklahoma) forbid abortion coverage in all private plans, with the single exception of saving the pregnant woman's life.[76]

In sum, the ACA proscribes health insurance coverage of abortion in a variety of ways, giving individual states wide leeway to restrict abortions. The implementation of these restrictions is complicated and partisan, recently leading eight Republican members of Congress to request a Government Accountability Office (GAO) study about coverage of nonexcepted abortion services in the state health insurance exchanges.[77] Table 5 summarizes and updates[70] the 2014 GAO findings. Among the 26 states without bans on abortion coverage in the health insurance marketplaces, 15 states offer some plans that provide abortion coverage beyond the Hyde amendment exemptions. However, seven states without such bans offer no plans with abortion coverage, and in four states, all plans in the marketplaces offer abortion coverage. The latter, of course, violates the ACA abortion compromise.[78,79]

Not all state abortion coverage bans are the same. Within the 24 states that do have bans, 75 percent of qualified marketplace plans offer no abortion coverage beyond Hyde amendment exceptions. Six states with some type of abortion coverage ban do offer abortion coverage in some of their plans.[80,81]

A representative sample of states' abortion restrictions

The implementation of the ACA abortion compromise occurs within individual states, where great differences exist in abortion restrictions. A sample of the diversity in state abortion policies is shown in Table 6. Here five representative states are profiled, selected on the basis of their respective grades on the *Report Card On Reproductive Rights*. One state was selected from each grade, ranging from F to A+. Specifically, Washington State received an A+ for access to reproductive health services, Illinois received a B−, Colorado received a C+, Rhode Island received a D+, and Louisiana received an F.[82] These grades are shown in column 2 of Table 6 along with five dimensions of state abortion policy: public funding, waiting period, parental consent, TRAP (Targeted Regulation of Abortion Providers) regulations, and mandated counseling. The total intensity of restrictiveness scores is shown in the last column.

Funding. Each state in the sample was scored on the basis of its abortion restrictions: the higher the total score, the more restrictive the state's policies. States not providing funding for low-income abortions received a "1" for this measure (Illinois, Colorado, Rhode Island, Louisiana), while the state that does provide funding (Washington State) was scored "0."

Waiting periods. The second scored dimension of state abortion policy is a state-mandated waiting period between the time a woman requests an abortion and when she is able to have the procedure. Only one state

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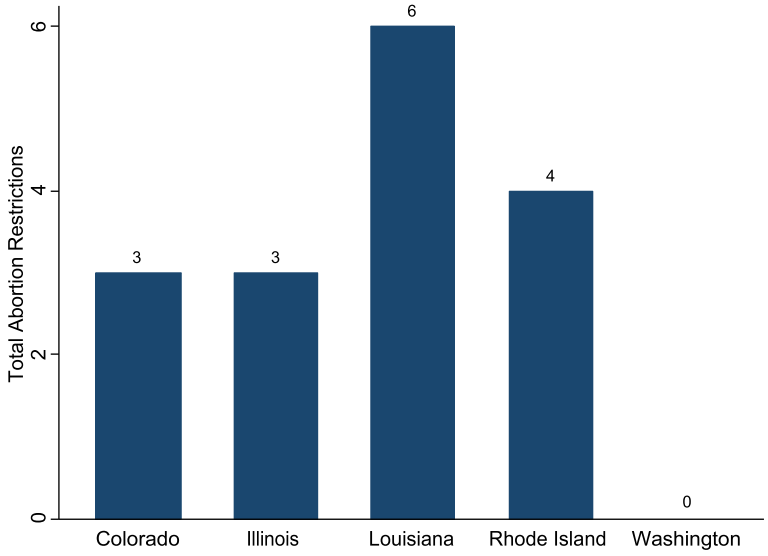

Figure 1. Total abortion restrictions for five American states.

in this sample, Louisiana, requires a waiting period and was scored "1"; each of the others was scored "0."

Parental consent. The third dimension scored was parental consent. States requiring parental permission in order for a minor to obtain abortion were scored "1." Washington, the only state in this sample without a parental consent requirement, scored "0."

Abortion clinic regulations. State TRAP regulations impose burdensome regulations on abortion providers that are not required for other medical procedures.[83] States with TRAP regulations were scored "1." Washington, the single state in the sample that does not impose TRAP regulations received a "0" here.

Mandated counseling. The final dimension of state abortion policy that was scored was mandated counseling, referring to various state requirements that women seeking abortion first must receive specific counseling, often with biased and medically inaccurate content.[84] For example, clinic personnel may be required to tell patients that abortion causes breast cancer, "a medically disproven claim."[85] Fulfilling state mandated counseling usually requires women to make an extra trip to the clinic, thereby increasing the cost of the abortion procedure, a disproportionate hardship on poor and rural women.[86] States (Washington, Illinois, Colorado) without this counseling requirement were scored "0." States mandating this counseling (Rhode Island and Louisiana) were scored "1." Louisiana earned another point for restrictiveness because it officially refers women to crisis pregnancy centers, which provide biased counseling and are dedicated to persuading women not to have abortions.[87]

In terms of restrictiveness scores, the five sample states showed an array of scores from 0 to 6. These scores correspond to the letter grades in column 2 in Table 6; they are displayed graphically in Figure 1. Access to abortion in the United States clearly depends on the state in which a woman lives.

Contraceptive coverage and the ACA

While access to abortion varies by state, contraceptive practices largely determine abortion demand (see Figure 1). In the United States, about half of all pregnancies are unintended,[88] and contraceptive prevalence varies by age, income, race and ethnicity, residential location, and health insurance coverage.[89] Even before the enactment of the ACA, most American women with health insurance were covered through private plans. Within that private insurance market, most large employers offered plans that covered contraceptive services.[90] Nevertheless, many women remained uninsured, without access to prescription birth control. The resulting disparities in contraceptive prevalence have driven the significantly higher abortion rates

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of poor and minority women, particularly African American women.[91]

The ACA requires health plans sold after March 23, 2010, to cover women's preventive care without cost sharing, including copayments or deductibles. Following the ACA's enactment, the U.S. Department of Health and Human Services (DHHS) charged the Institute of Medicine (IOM) with the task of recommending which women's preventive health services should be included in their comprehensive guidelines. Issuing its report in July 2011,[92] the Institute recommended eight services, including provision of "the full range of all Food and Drug Administration [FDA] approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity."[93] The DHHS officially adopted these recommendations in 2012 for all plans issued after that time, but allowed some exemptions for religious organizations.[93]

A review of 20 health insurance plans in five populous states, published in 2015, showed that the interpretation and implementation of the ACA's contraceptive coverage requirements varied.[94] Most insurance carriers were complying with the "spirit" of the ACA's requirements, but there were exceptions. Because of cost-sharing requirements for specific contraceptives, some women did not have access to their method of choice. The methods most likely to not be covered were certain types of vaginal rings, contraceptive implants, IUDs, and emergency contraception.[95,96] These exceptions persisted despite the federal contraceptive coverage rule under the ACA "that insurers must cover the full range of FDA-approved contraceptive methods without cost sharing."[97]

Religious exemptions for contraceptive coverage under the ACA appear to be infrequent. In the five-state review discussed above, insurers reported receiving few notifications from employers qualifying for the accommodation. Moreover, insurers had little difficulty accommodating those exemptions.[98]

While encouraging, these findings should be considered in temporal context. Data for the five-state report were gathered in October 2014, only three to four months after the 2014 U.S. Supreme Court ruled in *Burwell v. Hobby Lobby*.[99] This decision allowed the owners of a for-profit corporation to drop contraceptive coverage for their employees because birth control violated the owners' religious beliefs.[100] In an August 2015 decision, a federal district judge ruled that employers may deny contraceptive coverage to their employees if the employers have moral objections to birth control.[101] If this ruling stands, the grounds for exemption to the ACA's contraceptive mandate will have been broadened considerably.

Thus far, the implementation of the ACA has fallen short of providing American women access to all types of modern contraception without out-of-pocket payments.[102] In spite of this gap and other implementation problems, the ACA has increased women's access to contraception through both private insurance and through Medicaid. This situation mimics the implementation of the 2006 Massachusetts health reform that did increase that state's contraception coverage, albeit with gaps.[103] In sum, the ACA's expanded access to prescription birth control should decrease unintended pregnancy rates in the states and thus reduce the demand for abortion services. Given the dynamics of current policy making, it is premature to estimate the magnitude of that change.

Abortion policies in Western Europe

After a wave of abortion liberalization or reform from 1960 to 1980,[104] Western European abortion laws have been mostly stable. By and large, abortion "cuts across the dominant cleavage of Western European party systems, which are based on the socioeconomic cleavages of these societies. This means that political parties will not easily take a stand on abortion, which touches on the secular/religious divide."[105] Unlike American politicians, Western European party elites try to prevent the issue from gaining agenda status because they know that abortion has the potential to divide electoral party politics.[106]

As a result of these political forces, there have been stable abortion compromises for decades in most Western European countries.[107] Three exceptions are Germany, Spain, and Ireland. In the first case, the reunification of Germany required the conciliation of West and East German abortion laws.[108,109] Spain's abortion law was liberalized in 2010 by the then socialist government. Abortion was allowed without restriction (except that minors were supposed to tell one parent) up to the fourteenth week of pregnancy. The subsequent conservative government planned to tighten Spain's liberal abortion law until eventually backing down in the face of significant domestic and international opposition.[110,111]

In Ireland, the politics surrounding abortion may be in flux. More than 6,000 Irish women travel abroad for

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Table 7. Abortion restrictions (≤13 weeks gestation) by country.

Country	Public funding	Waiting period	Parental consent	Hospital only	Consent of 2 MDs	Mandate counseling	Total
Austria	0	1	0	0	0	0	1
Belgium	0	1	0	0	0	1	2
Denmark	0	1	1	1	0	1	4
Finland	0.1	0	0	1	1	0	2.1
France	0.2	1	1	0	0	1	3.2
Germany	0.8	1	0	0	0	1	2.8
Greece	0	0	1	0	1	0	2
Iceland	0	0	0.5	1	1	0	2.5
Italy	0	1	1	0	0	1	3
Luxembourg	0.5	1	1	0	1	1	4.5
Netherlands	0	1	0.5	0	0	0	1.5
Norway	0	0	0.5	0	0	1	1.5
Portugal	0	1	0.5	0	0	1	2.5
Spain	0	0	1	0	0	0	1
Sweden	0.1	0	0	0	0	0	0.1
Switzerland	0	0	0	0	0	0	0
United Kingdom	0.1	0	0.5	0	0	0	0.6

Source: IPPF, 2009; IPPF, 2012.

abortions,[112] a situation that has persisted for decades, but the Catholic Church's resolve to oppose liberalizing the abortion law has held firm. The Church, however, is increasingly in disrepute, particularly regarding gender issues. Both the laundry scandal revelations, which showed the collusion of the Church and the state in keeping thousands of women in slavery,[113,114] and the 2012 death of Dr. Savita Halappanavar, who would have survived had abortion been legal in Ireland,[115] have damaged the Church's reputation. The laundry scandal revealed the Church's callous disregard for the plight of thousands of women confined to servitude for over a half century.[116] Because of the Irish abortion law strongly supported by the Catholic Church, Dr. Halappanavar was initially denied an abortion while miscarrying a nonviable fetus and later, despite a hysterotomy, died in septic shock.[117]

Another indicator of waning Catholic influence is 2015 Irish referendum on gay marriage. "Sweeping aside the opposition of the Roman Catholic Church," Ireland became the first country in the world to approve gay marriage by referendum with 62 percent of the voters supporting it.[118] It is too early to tell, however, whether this development foretells a change in Irish abortion policy.

Western European abortion restrictions

Currently, abortion is legal in every Western European country except for Ireland and Northern Ireland.[119,120] Officially, Ireland allows abortion in cases where continuing the pregnancy would threaten the life of the pregnant woman. However, no guidelines about that determination have been issued—a critical factor in Dr. Halappanavar's 2012 death.[121] Had she received a pregnancy termination during the first three days of her week-long hospital stay, Savita Halappanavar probably would have survived, but under Irish law an abortion would have been illegal because there was "not a real and substantial risk to her life at that stage … And by the time her life was at risk, it was too late to save her with a termination."[122] Abortion is criminalized in most circumstances in Northern Ireland and, therefore, in-country procedures are rare.[123] The United Kingdom's 1967 Abortion Act was not extended to Northern Ireland "and only applies to England, Wales, and Scotland."[124]

While pregnancy termination is legal in most Western European nations, restrictions vary considerably. Individual countries often have different restrictions for abortions performed in roughly the first trimester of pregnancy (before the thirteenth week of gestation)[125] and abortions that take place after that time. Here, first-trimester abortions are called early abortions, and abortions occurring after the first trimester are termed later abortions.

Early abortions

Funding. Where abortion is legal, nearly all countries fund abortion, at least in part, for their residents through the first three months or thirteen weeks of pregnancy. In Table 7, national health systems that fully fund early abortions are coded "0." Countries that do not fully fund early abortions were scored according to the stringency of their funding restrictions. The German

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system is the least generous in this respect, usually covering only the initial visit but not the procedure itself. However, for women whose incomes are below a certain level, the state does cover the cost of the procedure.[126] For that reason, Germany is coded 0.8 for public funding. In Luxembourg, women undergoing procedures at less than 12 weeks are reimbursed by national health insurance. However, the conditions for obtaining an abortion are so onerous that most women travel abroad for the procedure and therefore must pay for both the procedure and the trip itself. For these reasons, Luxembourg is coded 0.5 for public funding.[127]

In Belgium, first-trimester abortions are fully funded by the government if performed in a clinic that has signed an agreement with the National Institute for Social Security, so Belgium was scored "0" for the restrictiveness of its public funding. In France, women are reimbursed for 70–80 percent of the cost of the procedure, although women less than 18 years of age or women living in poverty may be reimbursed for the full cost of the procedure. Accordingly, France received a score of "0.2" for the restrictiveness of its public funding for first-trimester abortions. In Sweden, the cost is almost fully funded by the government, and patients pay only a minor fee ranging from the equivalent of $4 to $37,[128] so Sweden was scored "0.1" on this dimension. The National Health Service in the United Kingdom pays for abortions, but about 5 percent of women there seek abortions through the private or charitable sectors where they are responsible for payment. For that reason, the UK was coded "0.1" in restrictiveness of public funding.

Waiting periods. Nine countries require a waiting period between the time a woman requests an abortion and the procedure itself. These waiting periods vary considerably: Germany requires a three-day waiting period; the Netherlands, five days; Belgium, six days; France, seven days, and Denmark, up to two weeks. In some countries, such as France, exceptions are made if the required waiting period would move the abortion past three months.[129,130]

Parental consent or notification. Western European nations differ in their policies toward parental consent or notification regarding minors' abortions. Countries received a score of "0.5" if they require minors 16 years of age or younger to obtain the consent of or to notify at least one parent. If a country requires parental consent or notification for minors 18 years of age and younger, that policy was regarded as more restrictive and was assigned a score of "1" for the parental consent or notification category (Denmark, Finland, France, Greece, Luxembourg, and Spain). Table 7 shows that most countries do have a parental consent or notification requirement at least through age 16, although several countries provide ways to waive those restrictions in hardship cases.[131,132] The countries not imposing a parental consent or notification restriction are Austria, Belgium, Finland, Germany, Sweden, and Switzerland.[133]

Table 7 reveals other restrictions. Only three countries require abortions to be performed in a hospital (Denmark, Finland, and Iceland). Four countries (Finland, Greece, Iceland, and Luxembourg) require the authorization of two physicians before an abortion can be performed. These restrictions were each scored with a "1." Seven countries (Denmark, France, Germany, Italy, Luxembourg, Norway, and Portugal) require that the woman requesting an abortion be counseled before the procedure is performed or medication administered; this restriction was also scored with "1." The Netherlands has a postabortion counseling requirement that a woman must be instructed in and receive methods for preventing unwanted pregnancies, but this policy was not coded as restrictive because it does not impede women from accessing abortion.

Figure 2 shows that, overall, the policies of Western European countries toward first-trimester abortion differ widely in terms of their restrictiveness. Summing the measures of abortion restrictiveness, Switzerland and Sweden show the least restrictiveness, while Luxembourg and Denmark have the most restrictions overall. In order to examine the relationship between the intensity of first-trimester abortion restrictions and national abortion rates, these variables were correlated.

Later abortions

Table 8 shows that beyond about three months' gestation, most countries become more restrictive toward access to abortion. Many countries impose health reasons for obtaining abortions later in pregnancy, but the stringency of these requirements varies considerably. Spain, for example, permits abortion on request up to the fourteenth week. However, a request up to the twenty-second week may be permitted, but only if the woman's life or health is at risk or there are serious fetal abnormalities. At or after 22 weeks' gestation, the only grounds for obtaining an abortion are life-threatening fetal abnormalities, with no exceptions for a woman's

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Table 8. Abortion restrictions (>13 weeks gestation) by country.

Country	Public funding	Health reasons	Waiting period	Parental consent	Hospital only	Consent 2 MDs	Mandate counseling	Total
Austria	0	1	1	0	0	0	0	2
Belgium	1	1	1	0	0	1	1	5
Denmark	0	1	1	1	1	0	1	5
Finland	0.1	1	0	0	1	1	0	3.1
France	0.2	1	1	1	0	0	1	4.2
Germany	0.8	1	1	0	0	0	1	3.8
Greece	0	1	0	1	0	1	0	3
Iceland	0	1	0	0.5	1	1	0	3.5
Italy	0	1	1	1	0	0	1	4
Luxembourg	0.5	1	1	1	0	1	1	5.5
Netherlands	0	0.3	1	0.5	0	0	0	1.8
Norway	0	0.5	0	0.5	0	0	1	2
Portugal	0	1	1	0.5	0	0	1	3.5
Spain	0	1	0	1	0	0	0	2
Sweden	0.1	1	0	0	0	1	0	2.1
Switzerland	0	1	0	0	0	0	0	1
United Kingdom	0.1	0	0	0.5	0	0.5	0	1.1

Sources: IPPF, 2012; IPPF, 2009.

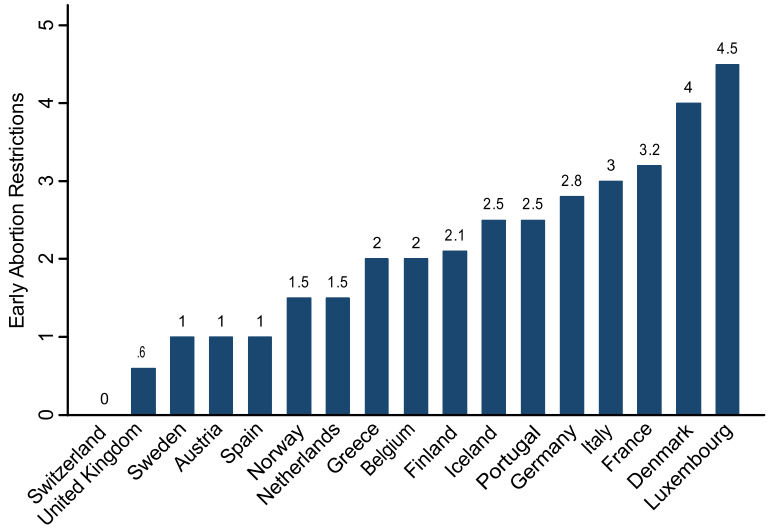

Figure 2. Early abortion restrictions (≤13 weeks gestation) by country. *Source*: IPPF, 2012, 2009.

health.[134] In Switzerland, abortion is available on request through 12 weeks from a woman's last menstrual period. After that, abortion access is limited to "avert a serious risk to the physical integrity of the woman or to avert serious mental distress (which includes rape, incest, foetal malformation)."[135]

Other Western European countries are less restrictive. For the United Kingdom, the policy is straightforward: abortion up to 24 weeks is permitted, "if continuing the pregnancy would involve risk—greater than if the pregnancy were terminated—of injury to the physical or mental health of the pregnant woman or any existing children of her family."[136] No explicit gestational limit is imposed if (1) abortion is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman, (2) "continuing the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated," or (3) "if there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped."[137] In the Netherlands, beyond 12 weeks, a woman must attest "to a state of distress about the pregnancy," and her physician must concur.[138] Abortions are seldom performed beyond 22

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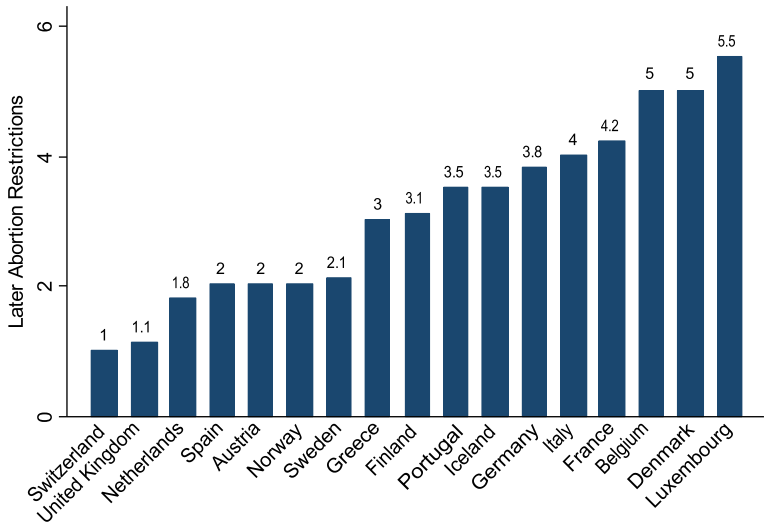

Figure 3. Later abortion restrictions (>13 weeks gestation) by country. *Data sources*: IPPF, 2012, 2009.

weeks in the Netherlands because fetal viability (often defined as twenty-four weeks) is mentioned as a limit in Dutch law.[139]

Public funding. If a country permits abortion beyond the first trimester, public funding is usually not curtailed. Belgium provides an exception here: no second-trimester abortion is available in-country unless there is a serious risk to the woman's health or "an extremely serious and incurable disease of the fetus."[140] Because there is no reimbursement of abortions performed abroad, public funding was scored "1."

Waiting periods. The presence or length of the waiting period between the time that a woman requests an abortion and the procedure is completed or an abortifacient administered is not different for early and later abortions in Western Europe. Nine countries require waiting periods for all induced abortions.

Parental consent/notification. Similar to waiting periods, parental consent requirements do not change between early and later abortions.

Hospital only. The requirement that abortions take place in a hospital setting does not change for early and later abortions. Three countries (Denmark, Finland, and Iceland) impose this restriction for all induced abortions regardless of length of gestation.

Consent by physicians and others. Consent procedures are more onerous later in pregnancy: four countries require the consent or approval of at least two physicians in early pregnancy, and seven countries require it for later terminations. In Sweden, second-trimester abortions are subject to the approval of the National Board of Health and Welfare and a medical doctor.[141]

Mandatory counseling. Requirements for counseling are the same for both early and later abortions.[142,143]

In comparison to the first trimester, most countries, as shown in Figure 3, impose more restrictions on abortion as the length of gestation increases. In order to test whether these restrictions are related to the country's abortion rate, these variables were correlated.

Findings

The ACA abortion restrictions focus on funding. While the ACA extends and subsidizes health insurance coverage generally, abortion is singled out for special treatment. The ACA addresses abortion by precluding public funding for this procedure except in the rare circumstances permitted by the Hyde amendment. Within the ACA parameters, states can decide whether *any* insurance policies offered in their health insurance marketplaces can provide abortion coverage or if most of those policies can. (The ACA does require that at least one policy in each state exchange must *not* offer abortion coverage.) About half of the states (26) have no bans on abortion coverage, and almost half (24) of the states do have some type of marketplace abortion

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ban. Table 5 shows that within state marketplaces, there is not perfect adherence with state bans and the above ACA abortion insurance requirement.

The ACA abortion requirements are supposed to operate within existing state abortion laws. The ACA does not dictate waiting periods, mandate parental consent, or require specific counseling for pregnancy terminations, but it explicitly does not preempt any abortion restrictions that states may impose. As a result, there is great variation in abortion restrictions across the states.

All Western European countries have abortion restrictions, too. Like the American states, there is great variation across these nations—from Switzerland not having restrictions in the first trimester (scored 0) to Luxembourg, which requires a waiting period, parental consent for minors, the consent of two physicians, and specific counseling (scored 4.5). Unlike the American states, Western European nations impose more restrictions later in pregnancy. No Western European nation with a liberalized abortion law completely precludes public funding of abortion.

Aside from public funding, Western European countries with liberalized abortion laws have more national abortion restrictions than does the United States, where most abortion restrictions (other than the Hyde amendment) are imposed by the states. Overall, the intensity of abortion restrictions in Western Europe are unrelated to the incidence of abortion ($r = -0.046$ for early abortions and $r = -0.014$ for later abortions, neither correlation significant at the 0.05 level). These correlations were also run omitting Austria, which had the oldest abortion data. Again, there was no relationship between national abortion rates and the intensity of abortion restrictions ($r = -0.128$ for early abortions and $r = -0.132$ for later abortions, neither correlation significant at the 0.05 level).

Conclusion

This study compares the ACA's treatment of abortion with how national health systems in other wealthy countries address pregnancy terminations. Western Europe was selected as a comparator because of its economic and cultural similarities to the United States. Upon closer examination, its reproductive health behaviors, such as sexual initiation and contraceptive prevalence, are similar as well. These practices are important to consider because they are risk factors for unintended pregnancy, usually a precursor to induced abortion.[144]

Like the United States, Western European countries, except for Ireland and Northern Ireland, have liberalized abortion laws with restrictions specifying the conditions under which legal abortion can occur. Indeed, Western European countries generally have more national restrictions than does the United States, where abortion restrictions are most often imposed by the states.

Abortion restrictions vary greatly among Western European countries. The intensity of a country's abortion restrictions, however, is unrelated to its abortion rate. For example, the Netherlands has a low abortion rate and a low score on the intensity of its abortion restrictions. The United Kingdom has an even less restrictive abortion policy, but a much higher abortion rate. Denmark has very intense abortion restrictions and a relatively high abortion rate.

Nonetheless, many Western European nations have abortion restrictions not uniformly found in the American states, such as parental consent, waiting periods, mandated counseling, and even the consent of two physicians.[145] Certainly, there are circumstances when any of these restrictions would be onerous for individual women, but research from the American states suggests that the lack of public funding for abortion services is a far more effective deterrent to obtaining abortion than are other restrictions.[146,147]

The endgame abortion compromise that assured the ACA's passage squarely centered on funding. As the ACA subsidies have been implemented, the Hyde amendment, prohibiting federal funding for most abortions, affects more Americans than ever before. Twenty-four states ban health insurance plans in their marketplaces from including abortion.[148] Even where marketplace insurance plans offer abortion coverage, payments for abortion coverage must be collected separately from the premiums for overall health insurance. This requirement is unique as well as ironic, specific prepayment for the possibility of an unplanned event—unintended pregnancy.

In contrast, most Western European countries have straightforward policies toward financing abortion; they fund first-trimester abortions either in part or completely. These practices differ markedly from American states' policies toward funding abortions for low-income women or the complex abortion funding scenarios mandated by the ACA. Currently, only 17 of the 50 American states fund Medicaid abortions for low-income women; the rest fund abortion only for rare

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cases (rape, incest, and to preserve a woman's life if the fetus is carried to term).[149]

The lack of abortion funding for many low-income American women, who experience high unintended pregnancy rates, creates real hardships for women and their families. For poor women, trying to raise the money to pay for an abortion often means delaying procedures.[150] Indeed, country reports from the UK[151] and the Netherlands[152] suggest that the median first-trimester abortion takes place a few weeks earlier in pregnancy in those countries than in the United States. In the United States, an estimated 72 percent of abortions occur under ten weeks' gestation,[153] while the corresponding figures for the Netherlands and the United Kingdom are 76 percent[154] and 77 percent,[155] respectively.

For the time being, U.S. abortion policy under the ACA continues to delay procedures for low-income women seeking abortion, exactly the opposite of what most Western European abortion policies do. Low-income American women who cannot raise $400–$550, the average price for a first-trimester abortion performed in a clinic, will continue to delay their procedures until they can secure the necessary funding or forgo the abortion altogether. Abortion costs rise with length of gestation; an abortion at 20–21 weeks is estimated to cost $1100–$1650 or more.[156]

In sum, the United States is not alone in having restrictions on induced abortion. The manner in which abortion is proscribed in the ACA, however, has no counterpart in Western Europe. For the most part, the ACA expands health insurance coverage but singles out abortion as the only health service that can be left out of health insurance policies. Unlike many Western European countries that increase restrictions as pregnancy progresses, the ACA restrictions focus on curtailing abortion coverage and not on length of gestation or the health of the pregnant woman. Western European nations, in the aggregate, demonstrate that the provision of public funding does not lead to high abortion rates, and that the additional abortion restrictions do not lower abortion rates.

The ACA abortion restrictions are analyzed here because they affect millions of women; abortion is a common procedure in the United States. At current rates, by age 45, nearly one in three American women will have experienced at least one abortion.[157] Notwithstanding these abortion restrictions, overall the ACA should benefit many women of reproductive age. While its abortion restrictions were designed to impede abortion access, the ACA's contraceptive mandates may ultimately reduce unintended pregnancy rates and, in turn, abortion demand.

Neither the implementation of the ACA, its accompanying abortion restrictions, or even its contraceptive mandates is static. Compared to abortion policies in Western Europe, there is no stable compromise[158] in the U.S. regarding the ACA or its abortion provisions. From 2010 to 2014, there were more than 50 attempts to repeal the ACA in the House alone.[159] In the first four months of the 114th Congress, no less than 29 abortion bills were introduced in the House. One bill that passed the House, "No Taxpayer Funding for Abortion and Abortion Insurance Full Disclosure Act of 2015," addressed abortion in the ACA specifically. This bill would have tightened the already stringent ACA abortion provisions by prohibiting federal funds from being used for any health benefits coverage that includes coverage of abortion (thus making permanent existing federal policies).[160] Another bill that the House passed would have prohibited any abortions after 20 weeks.[161]

These bills did not progress because of inevitable filibusters and presidential vetoes. But this situation is precarious. With a larger Republican Senate majority and a Republican president, additional abortion funding restrictions could become the law of the land.

Note

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