Introduced by: Samantha Crowley, Juliana Craig, Laurie Lapp, Tessa Meurer, Andrew Norton, Leela Shah, Sophia Vrba, Charlotte Urban, Nick VanDerwerker, University of Wisconsin School of Medicine and Public Health; Aliya Neha Siddiqui, Megan Quamme, Medical College of Wisconsin; Priya Desai, Boston University School of Medicine; Sara Kazyak, Aarti Patel, Wayne State University School of Medicine; Sairandri Sathyanarayanan, Renato Guerrieri, McGovern Medical School at UTHealth; Grace Keegan, University of Chicago Pritzker School of Medicine; Julia Silverman, University of Connecticut School of Medicine; Anudeeta Gautam, Christopher Dasaro, Krysten Floyd, Lewis Katz School of Medicine at Temple University; Lavinia Wainwright, Eastern Virginia Medical School; Adrina Kocharian, University of Minnesota School of Medicine; Kayla Tran, Rosalind Franklin University Chicago Medical School; Elisabeth McCallum, University of California, Irvine School of Medicine; Kyle Cotner, University of Toledo College of Medicine; Shreya Mandava, University of Virginia School of Medicine; Emily Ridge, Central Michigan University College of Medicine; Cecily Negri, Southern Illinois University School of Medicine; Kayla Edwards, University of Cincinnati College of Medicine; Brooke Buckingham, University of Toledo College of Medicine; Jenna Gage, University of Texas Medical Branch at Galveston; Anand Singh, Anne Burnett Marion School of Medicine at Texas Christian University; Kimberly Ibarra, Radhika Patel, Sam Houston State University College of Osteopathic Medicine; Rajadhar Reddy, Baylor College of Medicine

Subject: Coverage and Reimbursement for Abortion Services

Sponsored by:

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, At the June 2022 Annual Meeting of the House of Delegates, the American Medical Association recognized that “healthcare, including reproductive services like contraception and abortion, is a human right”\(^1\); and

Whereas, Access to abortion services has significantly decreased across the country due to the overturning of Roe v. Wade (1973) by Dobbs v Jackson Women’s Health Organization (2022)\(^2\); and
Whereas, The cost of abortion services in 2020 ranged from $489 to $873, $493 to $1191, and around $1068 for first-trimester medication abortions, first-trimester aspiration abortions, and second-trimester abortions respectively; and

Whereas, Most patients in the United States must pay out-of-pocket for abortion care due to state restrictions prohibiting abortion coverage in insurance plans; and

Whereas, Half of patients seeking abortion care in the US have incomes below the federal poverty line, and thus qualify for Medicaid; and

Whereas, Many patients report delaying receiving abortion care due to insufficient income to cover out of pocket expenses; and

Whereas, The Hyde Amendment, passed in 1977, bans state use of federal Medicaid dollars to pay for abortions with exceptions only for rape, incest, and life of the pregnant person; and

Whereas, People of color are more likely to be impacted by the Hyde Amendment restrictions, with 29% of Black women and 25% of Hispanic women receiving Medicaid compared to 15% of white women aged 18-49; and

Whereas, Nearly 30% of Medicaid-eligible pregnant patients in Louisiana who would have gotten an abortion if it was covered under Medicaid instead gave birth; and

Whereas, Medicaid programs in 35 states and the District of Columbia only cover abortion services in the case of rape, incest, or danger to life of the pregnant person; and

Whereas, Twenty-five states have laws restricting abortion coverage in insurance plans offered through the Affordable Care Act marketplace; and

Whereas, Senator Tammy Duckworth introduced the EACH Act of 2021 which calls for the Federal Government to not prohibit, restrict, or otherwise inhibit insurance coverage of abortion services by State or local government or by private insurance; and

Whereas, At this Interim 2022 Meeting, the AMA House of Delegates is considering Board of Trustees Report 4 – Preserving Access to Reproductive Health Services, a report which serves as a review of the AMA policy compendium on reproductive health services and covers duplicative policy and personal viewpoints on abortion, but declined an opportunity to address insurance as a barrier to abortion access; and

Whereas, Our AMA has policy (H-5.998) opposing legislation which denies established and accepted medical care to any segment of the population, but lacks clarifying language that the AMA will advocate for explicit coverage for abortion services; and
Whereas, The overturning of Roe v. Wade in June 2022 necessitates urgent action by the AMA to address the recent onslaught of abortion bans introduced at the state and federal level and subsequent exacerbation of barriers to access abortion services in the United States\textsuperscript{15,16}; therefore be it

RESOLVED, That our AMA advocate for legislation and regulation to publicly fund the provision of abortion, including through any federal, state, locally funded or subsidized health coverage; and be it further

RESOLVED, That our AMA advocate that all evidence-based abortion methods be federally mandated health benefits in all Medicaid programs and all Affordable Care Act marketplace plans; and be it further

RESOLVED, That our AMA oppose restrictions that prevent physicians and other health professionals who provide abortion from participating in or being reimbursed by federal and state funded or subsidized health coverage; and be it further

RESOLVED, That our AMA-MSS immediately forward this resolution to the Interim 2022 Meeting of the House of Delegates.

References:

and Infant Health. Published online December 2020:81.


16. Graham L. Protecting Pain-Capable Unborn Children from Late-Term Abortions Act. Published online September 13, 2022:27.

Relevant AMA Policy:

**D-5.999 Preserving Access to Reproductive Health Services**

Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will review the AMA policy compendium and recommend policies which should be amended or rescinded to reflect these core values, with report back at the 2022 Interim Meeting.

**E-2.2.3 Mandatory Parental Consent to Abortion**

In many jurisdictions, unemancipated minors are not permitted to request or receive abortion services without their parents’ knowledge and consent. Physicians should ascertain the law in their state on parental involvement to ensure that their practices are consistent with their legal obligations. In many places, the issue of confidentiality for minors who seek an abortion implicates competing ethical concerns apart from the abortion issue itself. When an unemancipated minor requests abortion services, physicians should:

(a) Strongly encourage the patient to discuss the pregnancy with her parents (or guardian).
(b) Explore the minor patient’s reasons for not involving her parents (or guardian) and try to correct misconceptions that may be motivating the patient’s reluctance to involve parents. If the patient is unwilling to involve her parents, encourage her to seek the advice and counsel of adults in whom she has confidence, including professional counselors, relatives, friends, teachers, or the clergy.

(c) Explain to the minor patient under what circumstances the minor’s confidentiality will be abrogated, including:
   (i) life-threatening emergency; or
   (ii) when parental notification is required by applicable law.

(d) Try to ensure that the minor patient carefully considers the issues involved and makes an informed decision.

(e) Not feel or be compelled to require a minor patient to involve her parents before she decides whether to undergo an abortion.

**E-4.2.7 Abortion**
The Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion in accordance with good medical practice and under circumstances that do not violate the law.

**E-7.3.5 Research Using Human Fetal Tissue**
Research with human fetal tissue research has led to the development of a number of important research and medical advances, such as the development of polio vaccine. Fetal tissue has also been used to study the mechanism of viral infections and to diagnose viral infections and inherited diseases, as well as to develop transplant therapies for a variety of conditions, for example, parkinsonism.

However, the use of fetal tissue for research purposes also raises a number of ethical considerations, including the degree to which a woman’s decision to have an abortion might be influenced by the opportunity to donate fetal tissue. Concerns have also been raised about potential conflict of interest when there is possible financial benefit to those who are involved in the retrieval, storage, testing, preparation, and delivery of fetal tissues.

To protect the interests of pregnant women as well as the integrity of science, physicians who are involved in research that uses human fetal tissues should:

(a) Abstain from offering money in exchange for fetal tissue.

(b) In all instances, obtain the woman’s voluntary, informed consent in keeping with ethics guidance, including when using fetal tissue from a spontaneous abortion for purposes of research or transplantation. Informed consent includes a disclosure of the nature of the research including the purpose of using fetal tissue, as well as informing the woman of a right to refuse to participate.

(c) Ensure that when fetal tissue from an induced abortion is used for research purposes:
   (i) the woman’s decision to terminate the pregnancy is made prior to and independent of any discussion of using the fetal tissue for research purposes;
   (ii) decisions regarding the technique used to induce abortion and the timing of the abortion in relation to the gestational age of the fetus are based on concern for the safety of the pregnant woman.

(d) Ensure that when fetal tissue is to be used for transplantation in research or clinical care:
   (i) the donor does not designate the recipient of the tissue;
   (ii) both the donor and the recipient of the tissue give voluntary, informed consent.

(e) Ensure that health care personnel involved in the termination of a pregnancy do not benefit from their participation in the termination, or from use of the fetal tissue for transplantation.
**H-5.980 Oppose the Criminalization of Self-Managed Abortion**
Our AMA: (1) opposes the criminalization of self-managed abortion and the criminalization of patients who access abortions as it increases patients’ medical risks and deters patients from seeking medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-managed abortion and the criminalization of patients who access abortions; and (3) will oppose efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients and requirements that physicians function as agents of law enforcement – gathering evidence for prosecution rather than as a provider of treatment.

**H-9.982 Late-Term Pregnancy Termination Techniques**
(1) The term 'partial birth abortion' is not a medical term. The AMA will use the term "intact dilatation and extraction"(or intact D&X) to refer to a specific procedure comprised of the following elements: deliberate dilatation of the cervix, usually over a sequence of days; instrumental or manual conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of the fetus to effect vaginal delivery of a dead but otherwise intact fetus. This procedure is distinct from dilatation and evacuation (D&E) procedures more commonly used to induce abortion after the first trimester. Because 'partial birth abortion' is not a medical term it will not be used by the AMA.
(2) According to the scientific literature, there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D&X. The AMA recommends that the procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgment, acting within standards of good medical practice and in the best interest of the patient.
(3) The viability of the fetus and the time when viability is achieved may vary with each pregnancy. In the second-trimester when viability may be in question, it is the physician who should determine the viability of a specific fetus, using the latest available diagnostic technology.
(4) In recognition of the constitutional principles regarding the right to an abortion articulated by the Supreme Court in Roe v. Wade, and in keeping with the science and values of medicine, the AMA recommends that abortions not be performed in the third trimester except in cases of serious fetal anomalies incompatible with life. Although third-trimester abortions can be performed to preserve the life or health of the mother, they are, in fact, generally not necessary for those purposes. Except in extraordinary circumstances, maternal health factors which demand termination of the pregnancy can be accommodated without sacrifice of the fetus, and the near certainty of the independent viability of the fetus argues for ending the pregnancy by appropriate delivery.

**H-5.990 Policy on Abortion**
The issue of support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures.

**H-5.988 Accurate Reporting on AMA Abortion Policy**
Our AMA HOD cautions members of the Board of Trustees, Councils, employees and members of the House of Delegates to precisely state current AMA policy on abortion and related issues in an effort to minimize public misperception of AMA policy and urges that our AMA continue efforts to refute misstatements and misquotes by the media with reference to AMA abortion policy.
**H-295.923 Medical Training and Termination of Pregnancy**
1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.
2. Our AMA supports the availability of abortion education and exposure to procedures for termination of pregnancy, including medication abortions, for medical students and resident/fellow physicians and opposes efforts to interfere with or restrict the availability of this education and training.
3. Our AMA encourages the Accreditation Council for Graduate Medical Education to consistently enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists’ recommendations.

**H-5.995 Abortion**
Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of his state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice.

**H-5.998 Public Funding of Abortion Services**
The AMA reaffirms its opposition to legislative proposals that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

**H-5.993 Right to Privacy in Termination of Pregnancy**
The AMA reaffirms existing policy that (1) abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances good medical practice requires only that the physician or other professional withdraw from the case so long as the withdrawal is consistent with good medical practice. The AMA further supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities.

**H-5.997 Violence Against Medical Facilities and Health Care Practitioners and Their Families**
The AMA supports the right of access to medical care and opposes (1) violence and all acts of intimidation directed against physicians and other health care providers and their families and (2) violence directed against medical facilities, including abortion clinics and family planning centers, as an infringement of the individual’s right of access to the services of such centers.

**G-605.009 Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted**
1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.

2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine’s response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
   a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;
   b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
   c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;
   d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;
   e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;
   f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and
   g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.

**H-5.983 Pregnancy Termination**
The AMA adopted the position that pregnancy termination be performed only by appropriately trained physicians (MD or DO).

**H-5.989 Freedom of Communication Between Physicians and Patients**
It is the policy of the AMA: (1) to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient;
(2) working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship;
(3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications; and
(4) to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients.
Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted

1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.

2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine’s response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:

   a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;
   b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
   c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;
   d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;
   e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;
   f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and
   g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.

Support for Access to Preventive and Reproductive Health Services H-425.969

Our AMA supports access to preventive and reproductive health services for all patients and opposes legislative and regulatory actions that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

Reproductive Parity H-185.937

Our AMA supports legislation and policies that require any health insurance products offering maternity services to include all choices in the management of reproductive medical care.

Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act H-185.925

1. Our AMA supports improvements to the essential health benefits benchmark plan selection process to ensure limits and exclusions do not impede access to health care and coverage.
2. Our AMA encourages federal regulators to develop policy to prohibit essential health benefits substitutions that do not exist in a state’s benchmark plan and the selective use of exclusions or arbitrary limits that prevent high-cost claims or that encourage high-cost enrollees to drop coverage.

3. Our AMA encourages federal regulators to review current plans for discriminatory exclusions and submit any specific incidents of discrimination through an administrative complaint to Office for Civil Rights.

Relevant MSS Policy:

5.000MSS Abortion

5.001MSS Public Funding of Abortion Services: AMA-MSS will ask the AMA to: (1) continue its support of education and choice with respect to reproductive rights; (2) continue to actively support legislation recognizing abortion as a compensable service; and (3) continue opposition to legislative measures which interfere with medical decision making or deny full reproductive choice, including abortion, based on a patient’s dependence on government funding. (AMA Sub Res 89, I-83, Adopted [H-5.998]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS Res 27, A-16) (Reaffirmed: MSS Res 059, A-21)


5.005MSS MSS Stance on Challenges to Women’s Right to Reproductive Health Care Access: AMA-MSS opposes legislation that would restrict a woman’s right to obtain medical services associated with her reproductive health, as defined in policy 5.001 MSS, on the grounds that they interfere with a physician’s ability to provide medical care. (MSS Res 6, A-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS Res 27, A16) (Reaffirmed: MSS Res 059, A-21)

5.006MSS Transparency on Restrictions of Care: AMA-MSS (1) supports advocating that all medical institutions provide medically accurate information on the full breadth of reproductive health options available for patients, including, but not limited to, all forms of contraception, emergency care during miscarriages, and infertility
treatments, regardless of the institution’s willingness to perform the aforementioned services; (2) endorses the timely referral of patients seeking reproductive services from healthcare providers with religious commitments to accessible health care systems offering the aforementioned services, all the while avoiding any undue burden to the patient; and (3) supports advocating that all facilities and hospitals disclose all restrictions in care at their facility, and all physicians seeking employment at their facility. (MSS Res 13, A-17) (Amended: MSS Res 125, Nov. 2020)

5.007MSS Ending the Risk Evaluation and Mitigation Strategy (REMS) on Mifepristone: AMAMSS will ask the AMA to support efforts urging the Food and Drug Administration (FDA) to lift the Risk Evaluation and Mitigation Strategy (REMS) on mifepristone. (MSS Res 14-I-17)

AMA-MSS Digest of Policy Actions/4

5.008MSS Expanding AMA Support for Advanced Practice Providers who Provide FirstTriemester Abortion Care: AMA-MSS supports state and federal legislation that allows appropriately trained and credentialed advanced practice clinicians to perform first trimester medical and aspiration abortions in accordance with individual state licensing requirements. (MSS Res. 08, I-19)