CHARLOTTE LOZIER INSTITUTE

On Point
September 2013

Multi-State Health Plans: A Potential Avenue to Tens of Thousands of Publicly Subsidized Abortions

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On January 1, 2014 state health exchanges, or the federal or "partnership" versions that will operate in their stead in a narrow majority of states, are required by law to be up and running. By October 1, 2013 consumers are supposed to be able to begin researching and comparing insurance options in these exchanges. Delays in the implementation of the Affordable Care Act are evident in nearly all areas of the law, including a feature called "multi-state plans" (MSPs) that are designed to be phased in over a four-year period for every state in the Union. Despite provisions of law including the Hyde Amendment governing appropriations for abortion; the Hyde-Weldon amendment barring discrimination against physicians, insurers, institutional providers and others with respect to their policies regarding providing, referring or paying for abortion; and the language governing the MSPs themselves, the Obama Administration and abortion funding advocates seem bent on pursuing numerous avenues for the ACA, and MSPs in particular, to make public abortion subsidies available to tens of thousands of girls and women of childbearing age. Here is how.

Multi-state health plans were created under Section 1334 of the Affordable Care Act.[1] The law provides for a minimum of two such plans in each state, one of which must be a nonprofit plan. The MSPs were a late substitute for the idea of a public option, a fully government-run plan that would have competed with – and, many advocates hoped, eventually supplanted – privately sponsored plans. Instead, the MSPs will be offered by heavily regulated private sector insurers operating under contracts these insurers directly sign with OPM. "Multi-state" is another word for "national" and the degree of regulation of plan content, control of medical-loss ratios, and other factors ensure that these plans will operate more like regulated utilities than truly private insurance.

Beginning in 2014, the MSPs are to be phased in over a four-year period. The ACA requires approved plans to be available in at least 60 percent of the states in the first year (30 states), 70 percent in the second year (35 states), 85 percent in the third year (presumably 43 states), and 100 percent in the fourth year (2017). One core rationale for these plans is to increase "competition" in the state exchanges, a goal in dramatic tension with the concept of heavily regulated plans, which by their heft and complexity are likely to be offered by only a handful of the largest health insurance companies in the country. In order to aid this regulated competition, the MSPs will have to offer price advantages that may well flow from the fact that their administrative (including promotional) costs will be borne by the taxpayer through the Office of Personnel Management. Both the companies and the Obama Administration have incentives to maximize participation in these plans.

[1] 42 U.S.C. 18054.

What these advantaged plans will do with respect to abortion coverage is not yet fully clear. However, Section 1334(a)(6) of the ACA states that:

> In entering into contracts under this subsection, the Director [of OPM] shall ensure that with respect to multi-State qualified health plans offered in an Exchange, there is *at least one* such plan that does *not* provide coverage of services described in section 1303(b)(1)(B)(i). (Emphasis added).

The cited section refers to the ACA's description of the Hyde Amendment regarding abortions that may be covered: those for reasons of rape and incest and a narrow set of conditions regarding physical threat to the life of the mother.

The ACA also included a provision, Section 1303(a)(1), making clear that state legislatures, some of which already had laws in place barring every health insurer in the state from offering abortion in any plans marketed and sold there, could adopt new opt-out legislation barring plans that cover elective abortions from participation in their state's exchanges. Five states adopted this exchange abortion limit in 2010, and since then the number of states doing so has grown to 23. Twenty-seven states and the District of Columbia currently have no such limitation.

On March 1 of this year, the Office of Personnel Management issued its final rule on the MSPs, acknowledging that a decision by a state to exclude abortion-covering plans from its exchange will apply to any and all MSPs offered in that particular state. Section 800.602(b) of the rule, titled "State Opt-Out," simply says, "An MSP may not offer abortion coverage in any State where such coverage of abortion services is prohibited by State law."[2] That states can block all qualified insurers, including MSPs, from their exchanges if they cover elective (non-Hyde) abortions is clear. But a strong case can be made that Section 1303(b)(1)(B)(1)'s reference to excluding abortion coverage can be read, in conjunction with other provisions of federal health law, to forestall the Obama Administration from seeking to compel any private insurance company to include elective abortion in its MSP.

A July 22, 2013 article in *Roll Call* reported on an email from the HHS Center for Medicare and Medicaid Services (CMS) to the article's author, quoting an unnamed CMS source to the effect that "the multistate plans will help [CMS to] '*ensure* that in each exchange, there is *at least one plan available that covers abortions* beyond those allowed by the Hyde Amendment and at least one plan that does not cover abortions

[2] "Patient Protection and Affordable Care Act; Establishment of the Multi-State Program for the Affordable Insurance Exchanges," Office of Personnel Management, 45 CFR Part 800; March 11, 2013; at https://s3.amazonaws.com/public-inspection.federalregister.gov/2013-04954.pdf (September 17, 2013).

beyond those permitted by the Hyde Amendment'." (i.e., rape, incest or danger to the woman's life)[3] But the ACA says nothing about such "ensuring" of abortion coverage in states where it is not precluded by state law. In fact, Section 1303(b)(1) of the ACA states that "[n]otwithstanding any other provision of this title (or any amendment made by this title) . . . nothing in this title (or any amendment made by this title), shall be construed to require a qualified health plan to provide coverage of *services described in subparagraph (B)(i) or (B)(ii)* [elective abortion] as part of its essential health benefits for any plan year; and . . . *the issuer of a qualified health plan* shall determine whether or not the plan provides coverage of services described in subparagraph (B)(i) or (B)(ii) as part of such benefits for the plan year." (Emphasis added)

This is exactly the type of "thumb on the scale" that the Obama Administration can be expected to apply to the ACA and to MSPs in order to drive the states that permit elective abortion in their exchanges or reluctant insurers wishing to participate in those exchanges to do something (provide abortion coverage under the unprecedented "segregated funding" scheme) they not only may not wish to do but are explicitly protected from being required to do in their MSP. Another way to place this thumb on the scale, for example, would be through the "Navigators" program, a separate stream of ACA funding that Planned Parenthood and similar entities are receiving that could be diverted to efforts to enroll girls and women in MSPs that include elective abortion and to discourage them from enrolling in plans that omit it.

Estimating how many girls and women will likely enroll in plans that cover elective abortion under the ACA is a complex and, absent details on MSP contracts, caveat-ridden business. We can, however, arrive at a reasonable estimate of the size of the pool of women of reproductive age (15-44) who will gain eligibility for such plans in the coming years. The Charlotte Lozier Institute has reviewed numbers compiled by the Henry J. Kaiser Foundation in 2010 for a paper titled "Access to Abortion Coverage and Health Reform."[4] The Kaiser paper estimates the number of currently uninsured girls and women age 15-44, by state, who are either likely to newly qualify for Medicaid or to qualify for premium credits in the state exchanges.

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[3] Rebecca Adams, "The Question of Abortion Coverage in Health Care Exchanges," *Roll Call*, July 22, 2013, at www.rollcall.com/news/the_question_of_abortion_coverage_in_health_exchanges-226547-1.html?pg=2 (emphasis added).

[4] "Access to Abortion Coverage and Health Reform," Henry J. Kaiser Foundation, Table 2, State Level Estimates of Percent of Uninsured Women Ages 15-44 Likely to Qualify for Federal Assistance Under the Patient Protection and Affordable Care Act," October 30, 2010, at http://kff.org/womens-health-policy/issue-brief/access-to-abortion-coverage-and-health-reform/ (September 17, 2013).

While state policies continue to develop and more states could conceivably block elective abortion in their exchanges, at present the majority of states (27) and the District of Columbia do not exclude elective abortion coverage from their exchanges. A smaller number of states (17) permit elective abortion coverage, using state funds, in their Medicaid programs. The vast majority of these states (13) do so as a result of state court rulings that are less protective than the Hyde amendment policy upheld by the U.S. Supreme Court governing federal funds.[5] The table below includes the numbers and percentages compiled by the Kaiser Foundation[6] and applies them to states that allow elective abortion in state exchanges or fund elective abortion through their Medicaid program, or both. The calculations were done by the Lozier Institute working with this 2008-2009 data. Note that the figures represent a maximum number of girls and women who may gain abortion coverage; in reality, the percentage of currently uninsured girls and women who will choose an MSP with elective abortion over an MSP that excludes this coverage is unknown.

Table 1: Estimates of Currently Uninsured Women and State Abortion Funding Policies

State	Funds Medicaid Abortions	Exchange Allows Plans with Elective Abortion	Number of Uninsured Women Age 15-44	Percent of Currently Uninsured Women Age 15-44 Potentially Eligible for Federal Assistance in 2014		Total Women Gaining Potential Abortion Coverage
				Medicaid	*Exchanges*	
Alaska	X	X	34,647	49%	43%	31,875
Arizona	X		302,354	58%		175,365
California	X	X	1,909,644	58%	36%	1,795,065
Colorado		X	213,345		37%	78,938
Connecticut	X	X	91,238	48%	41%	81,202
Delaware		X	28,325		40%	11,330
District of Columbia		X	17,640		32%	5,645
Georgia			516,501		31%	160,115
Hawaii	X	X	25,898	60%	28%	22,790
Illinois	X	x	469,469	54%	39%	436,606
Iowa		X	94,251		40%	37,700
Maine		X	29,488		44%	12,975

[5] *Harris v. McRae*, 448 U.S. 297 (1980).

[6] http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8021.pdf.

Maryland	X	X	196,542	53%	41%	184,749
Massachusetts	X	-	90,192			
Michigan		X	355,014		34%	120,705
Minnesota	X	X	125,338	46%	47%	116,564
Montana	X	X	38,227	51%	39%	34,404
Nevada		X	133,246		42%	55,963
New Hampshire		X	37,572		48%	18,035
New Jersey	X	X	329,250	53%	36%	293,032
New Mexico	X	X	122,238	66%	28%	114,988
New York	X	X	708,705	50%	40%	637,834
Oregon	X	X	160,498	58%	36%	150,868
Rhode Island		X	34,393		35%	32,329
Texas		X	1,781,564		37%	659,171
Vermont	X	X	14,6198	39%	47%	12,571
Washington	X	X	220,188	53%	42%	209,188
West Virginia	X	X	80,517	56%	37%	74,881
Wyoming		X	20,313		47%	9,547

Total: **8,181,305**

5,574,435

X – voluntarily funding abortion (not under court order).

How many abortions might, maximally, be funded through this expansion of the pool of girls and women who have insurance coverage for this procedure? Any calculation must take into account the fact that only a fraction of women who have abortions have private insurance coverage for the procedure *and* are willing to use that coverage for this personally and ethically sensitive purpose. According to a Guttmacher Institute study, only 30% of girls and women who had abortions in 2008 had private insurance for the procedure. Of those who did have private insurance, only about one-third actually used that insurance to pay for the abortion. While Guttmacher cites high co-pays and deductibles as a factor for limited use of the insurance, it seems more likely that, since an abortion paid for with cash would be more costly in any event, the low usage rate of private insurance for abortions has less to do with expense (as Guttmacher acknowledges) as with intense feelings about not disclosing abortion to third parties, even insurers. Overall, only about 12 percent of U.S. abortions were paid for with private insurance in 2008. [7]

It could be argued that expanding private coverage of abortion will therefore have a small impact on the public subsidies for abortion, but it is by no means certain that today's funding patterns will remain unchanged, as the heart of the abortion funding

[7] http://www.guttmacher.org/media/inthenews/2011/01/19/index.html ("Memo on Private Insurance Coverage of Abortion," Guttmacher Institute, January 19, 2011)(viewed September 13, 2013).

debate under ObamaCare, as with every other public program or private policy on the subject, is whether it represents a health practice or the unwarranted destruction of human life that is injurious to all involved. ObamaCare's conflicting policies represent a step, partial but by no means full, toward treating abortion as a basic medical treatment that should be no more controversial than dental hygiene or pap smears.

Overall, CLI's analysis concludes that some 5.57 million girls and women potentially gain coverage for abortion under ObamaCare, split roughly equally between Medicaid expansion and exchange insurance that covers elective procedures. If 2% of all women of childbearing age have abortions each year, an estimated 111,500 girls and women who will have abortions in coming years will have new coverage in effect for them. If only one third of the girls and women who are newly privately covered for elective abortions proceed and file for them, an additional 18,397 abortions will be paid for each year under ObamaCare's exchange expansion. Publicly funded abortions, on the other hand, could rise by as much as 53,600 – with roughly half of that increase occurring in New York and California, two states with high existing abortion rates. Taken together, the data suggest that ObamaCare's annual net increase in insured abortions that are either fully publicly funded through Medicaid or heavily subsidized through the exchanges could be as high as 71,000 to 111,500, depending on how many girls and women forego insurance and pay out-of-pocket.

These numbers are estimates at the outset of a dynamic process. Robert Moffit, Director of the Center for Health Policy Studies at the Heritage Foundation, argues that the MSPs will ultimately be a significant factor not in ensuring competition but in reducing it by exercising the advantages granted to them by OPM promotion and support. "What this does, "Dr. Moffit told *Kaiser Health News*, "is it will give larger plans an expanded market share. My view is you will see an acceleration of this consolidation in health insurance markets over time."[8] Whether or not this is an intentional result of this form of "public option," the implementation of ObamaCare could have a profound effect on the ability of millions of Americans to avoid participating indirectly in subsidizing abortions through public programs or quasi-private plans. A taxpayer may have an individual plan that does not cover elective abortion, but his or her tax dollars will be increasingly flowing to public and private plans[9] in other states that reimburse for abortions at a higher rate than previously

[8] Julie Appleby, "National Health Plans, Designed to Spur Competition, May Be Unavailable in Some States Next Year," *Kaiser Health* News, July 5, 2013. http://www.kaiserhealthnews.org/Stories/2013/July/05/multistate-national-health-insurance-plans-exchange-marketplace.aspx (September 13, 2013).

[9] The 10 largest private insurance plans in the country are United (noncommittal at this date on abortion coverage through the MSP but expected to do so where permitted), Wellpoint, Kaiser, Aetna,

seen in American health care. Moreover, the ability to avoid the companies that sponsor these plans may decrease over time as they grow in size and continue to curry favor from a government that views abortion as a form of therapy.

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Humana (has indicated it will not do an MSP), HCSC, Coventry Corp., Highmark, Independence Blue Cross, Blue Shield (has submitted a plan for 31 states that covers abortion where permitted), and Cigna. See (http://health.usnews.com/health-plans/national-insurance-companies).