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Health Care Reform and Abortion

By Susan Randall†

I. INTRODUCTION

The Health Security Act proposed by President Clinton presently includes, as a standard benefit, "[s]ervices for pregnant women."1 The provision may or may not cover abortion, depending on how broadly or narrowly it is interpreted; its studied ambiguity is a practical and political (and largely unsuccessful) attempt to avoid confronting the extremely divisive abortion controversy.2 Even though the Clinton administration has indicated that the plan covers abortion,3 members of the administration have also indicated that the President would sacrifice that coverage to accomplish reform.4

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† Assistant Professor of Law, University of Alabama School of Law. My thanks to the University of Alabama Law School Foundation for its generous support and to my colleagues Bill Andreen, Bill Brewhaker, Pam Bucy, Tim Hoff, Wythe Holt, Ken Randall, and Norman Stein for their valuable comments. Joe H. Sullivan, a doctoral candidate in the Department of Management Science and Statistics at the University of Alabama, capably performed the statistical analyses.
2 There is little dispute about coverage for abortion where the woman's life is endangered. However, the vast majority of abortions are not necessary to preserve the woman's life. Most are either medically necessary, implicating the woman's health (therapeutic), or elective (nontherapeutic). Opponents of the right to abortion generally do not distinguish therapeutic and nontherapeutic abortions. They believe that abortion is immoral, whether or not it is medically indicated; they further believe that providing funding or insurance coverage for medically necessary abortions will erode any existing distinctions.
The term "abortion" as used throughout this Article includes medically indicated abortions, whether the purpose is to preserve the woman's life or health, and elective abortions, rejecting any distinctions. See infra note 46.
3 Hillary Rodham Clinton, chair of the White House Task Force on Health Care Reform, testified before the Senate that "[t]he administration's proposal] will include pregnancy-related services, and that will include abortion in plans as insurance policies currently do." Tony Munroe, First Lady Defends Financing of Health Plan on Capitol Hill, WASH. TIMES, Oct. 1, 1993, at A15.
4 Prior to President Clinton's address to Congress in which he unveiled the health care plan, Senior Advisor for Policy Development Ira Magaziner stated that the administration was prepared to accept a plan without abortion coverage. Ellen Goodman, Keep Abortion Rights in Health-Care Reform, ATL. J. & CONST., Oct. 1, 1993, at A15.
Numerous advocacy and religious groups oppose national health insurance coverage for abortion, based on their underlying belief that abortion is morally wrong. This belief leads to two specific arguments against coverage: first, that coverage for abortion services will increase the frequency of abortion; and second, individuals morally opposed to abortion should not be forced to participate in it through taxes to cover the cost of national coverage for the unemployed or through the payment of their own premiums.

Part II of this article addresses the argument that providing coverage for abortion will increase abortion rates. Statistical evidence suggests that...
abortion rates are unaffected by state restriction of insurance coverage for abortion, and that state abortion funding (which affects the same population likely to receive free national health coverage supported by tax revenues) tends to increase abortion rates only marginally. Women who must decide whether or not to have an abortion are motivated by complex moral and social concerns which minimize the role financial considerations play in their decisions. Women do not decide to have abortions simply because the government or insurance will pay for the procedure; similarly, abortion costs prevent very few women from obtaining abortions.

Although restrictions on abortion funding affect abortion rates only minimally, they impose serious financial and medical burdens on poor women. Women who are denied funding must often fund their abortions with money that would otherwise be used for food, clothing or shelter. More importantly, many poor women are forced to delay their abortions while they obtain funds for the procedure and are thus subjected to the greater health risks of second-trimester abortions. Delay also poses heightened moral concerns because objections to abortion become more common and increasingly compelling as pregnancy advances.

Further, because most private health insurance presently provides coverage for abortion, excluding coverage from a national plan will deprive many women of part of their existing benefits, possibly resulting in financial hardship and in increasing numbers of delayed abortions with attendant health risks.

Finally, a properly structured national health insurance plan will likely reduce the demand for abortion by making family planning information and a variety of birth control methods easily accessible to all women.10 Ironically, defeating health care reform because it includes coverage for abortion may ensure that abortion rates remain high.

Part III addresses the contention that coverage will mandate public financial participation in abortion. The argument that health insurance will require the public to provide financial support for abortion ignores extensive and entrenched public support of abortion. Tax revenues and tax subsidies support abortion and abortion-related services. Given the present levels of state financial support of abortion, successful opposition to national coverage may result in increased or expanded public financial participation at the state level. Objections to including abortion coverage lose much of their force against this backdrop of extensive direct and indirect support of abortion.

10 See Levine, supra note 5.
II. The Impact of Insurance Restrictions and Funding Decisions: The States' Experience

It is popularly assumed that restricting public funds for abortion decreases abortions and conversely, that providing public funds for abortions, through Medicaid or national health coverage which would encompass it, increases abortions. That is the premise underlying the Hyde Amendment\(^\text{11}\) whose sponsor, Rep. Henry J. Hyde (R-Ill.), candidly stated: "I certainly would like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle-class woman, or a poor woman. Unfortunately, the only vehicle available is the HEW Medicaid bill. A life is a life.'\(^\text{12}\)

This section analyzes statistical data to assess whether this assumption is a valid basis for opposing abortion coverage in national health insurance. Providing national health insurance coverage for abortion would have two effects relevant to this analysis: all women will have abortion coverage, and many economically disadvantaged women will receive financial support for abortion for the first time since 1977.\(^\text{13}\) The section attempts to predict the effect of national coverage for abortion by examining abortion rates in several states before and after (1) the enactment of state laws restricting insurance coverage for abortion and (2) decisions by state courts ordering abortion funding for economically disadvantaged women.

The statistical analysis measures the effect of these legal changes by analyzing the rate of abortion for women aged 15 to 44 per 1,000 live births for the years 1975, 1979, 1980, 1981, 1982, 1984, 1985, and 1988\(^\text{14}\) and comparing those rates to regional rates. Many demographic and cultural factors affect abortion rates. A state's abortion rate may increase or decrease for reasons unrelated to changes in funding or insurance benefits: a state may implement or remove legal impediments to abortion; relevant characteristics of the population may change, including age, race, ethnicity, marital status, religious affiliation, income, and education; the availability of abortion may change due to clinic closings or the retirement of abortion providers; or social, religious or moral attitudes towards abortion or childbirth may shift. It is difficult in some instances and impossible in others to measure with any accuracy the extent to which these factors exist and indi-

\(^\text{11}\) Departments of Labor, Health, Education and Welfare Appropriations Act of 1977, Pub. L. No. 94-439, § 209, 90 Stat. 1418, 1434. First passed in 1977, the Hyde Amendment restricts federal abortion funding to cases in which the woman's life is endangered. See infra notes 43-44 and accompanying text.


\(^\text{13}\) See supra note 11.

\(^\text{14}\) These were the only years for which data was available. The data appears in Bureau of the Census, Statistical Abstract of the United States (1992, 1988, 1987, 1984 eds.). According to Stanley K. Henshaw, deputy director of research at the Alan Guttmacher Institute, information has become increasingly difficult to obtain largely because of harassment by antiabortion activists. See Goldsmith, supra note 7. This difficulty may account for the lack of information for the omitted years.
vidually affect abortion rates. This analysis does not attempt direct adjustments for demographic and cultural changes within a state. Instead, it accounts for possible fluctuations in rates resulting from demographic and cultural changes in two ways. First, the analysis considers the number of abortions per 1,000 live births, rather than the absolute number of abortions or the number per 1,000 women, to control for variations in population size and factors affecting fertility. Second, because other confounding factors would likely affect regional and state rates similarly, the analysis uses a ratio of state-to-regional abortion rates to reduce sensitivity to these other factors.  

The legal changes examined in this analysis affect varying segments of the population in the relevant states. Private insurance restrictions affect a substantial portion of the population. Other legal changes examined in this study, however, affect relatively small subgroups of the population: only public employees and their dependents are affected by restrictions on coverage of abortion in publicly negotiated group health insurance; only Medicaid-eligible women are affected by the restriction or provision of public funding for abortion. Any effects on the abortion decisions of women in an affected subgroup may be minimized by examining abortion rates for the entire state. In other words, there may be a “swamping effect” which could mask the real impact of legal changes on the targeted population. It would be more accurate to measure the effect of the relevant legal changes by examining only the population affected by those changes. However, existing data is insufficient to permit analysis of abortion rates of affected groups. Data on abortion rates for women affected by restrictions on private or government insurance is unavailable. Data on abortion rates for Medicaid-eligible women is also unavailable; when Medicaid does not provide funding for abortion, abortion providers cannot reliably identify particular clients as Medicaid-eligible.  

The statistical model used was: $Y_{jt} = M_t + C_s \times e_{ij} + r_{sj}$, where $Y_{jt}$ is the logarithm of the ratio of the state abortion rate to the regional abortion rate; $M_t$ is the true mean for state “s”; $C_s$ is the true change in the mean for state "s" resulting from insurance restrictions or the provision of funding; $e_{ij}$ is an indicator variable, 0 for the years before the restriction or funding and 1 for the years after the event; and $r_{sj}$ is a random variable having normal distribution with mean 0. (A logarithmic transformation was used to better fit the statistical model.) A similar model was used for pooling all the states experiencing a comparable insurance restriction or provision of funding, except the change, $C_s$ was modeled as the same for all the pooled states.

The analysis uses standard census regions: New England (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont); Middle Atlantic (New Jersey, New York, Pennsylvania); East North Central (Illinois, Indiana, Michigan, Ohio, Wisconsin); West North Central (Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota); South Atlantic (Delaware, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia); East South Central (Alabama, Kentucky, Mississippi, Tennessee); West South Central (Arkansas, Louisiana, Oklahoma, Texas); Mountain (Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming); Pacific (Alaska, California, Hawaii, Oregon, Washington).

Some studies have attempted to identify Medicaid-eligible women who were unable to afford to have an abortion and carried pregnancies to term. See infra notes 61-62 and accompanying text.
A. State Insurance Restrictions

Although there are no industry wide statistics on the frequency of abortion coverage under health insurance policies, most private insurance provides coverage for elective abortion. Several states, however, impose restrictions on insurance coverage of abortion. These restrictions have not reduced the abortion rate in those states. These states' experiences indicate that excluding abortion coverage from national health care will not reduce national abortion rates.

The restrictive state regulations fall into two basic categories. Idaho, Kentucky, Missouri, and North Dakota prohibit any health insurance coverage for elective abortion unless the mother's life is endangered, except by optional rider for which an additional premium must be paid. Similar statutes in Rhode Island and Pennsylvania were declared unconstitutional in 1984, and subsequently reenacted or amended. The most recent federal decision involving a provision of this type held the provision constitutional under the "undue burden" approach advanced in recent Supreme Court decisions.

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17 Statistics are not compiled on the extent to which private insurance or employer-provided group coverage provides abortion benefits. However, spokespersons for various insurers indicate that most of their company's policies include such coverage. Carolyn Lochhead, Abortion Foes Already Paying For It, S.F. CHRON., Oct. 11, 1993, at A1 (abortion coverage standard in most policies issued by Blue Cross, Travelers and their major competitors including HMOs); see also Christopher Dauer, Abortion Coverage in Health Plan Sparks Debate, NAT'L UNDERWRITER, Dec. 6, 1993, at 5 (no comprehensive studies available, but Blue Cross-Blue Shield, Aetna Life and Casualty, the Principal Financial Group, Employer's Health, Prudential, Cigna, and Travelers commonly provide elective abortion coverage); Jennifer Landes, Abortion Decision Could Affect Insurers, NAT'L UNDERWRITER, July 17, 1989, at 1 (majority of Aetna and Prudential group policyholders covered for abortion); Levine, supra note 5 (Blue Cross, Blue Shield, Pacificare, and Kaiser Permanente policies cover abortion).


The other type of restriction is narrower, prohibiting health insurance coverage of abortion in policies covering state or municipal employees. This restriction is in force in Idaho, Kentucky, Missouri, and North Dakota by virtue of their comprehensive statutory exclusions of coverage; Illinois, Massachusetts, Nebraska, Pennsylvania, and Rhode Island have enacted narrower restrictions specifically applicable to public employees. As applied to state employees, these restrictions are constitutional under the Supreme Court’s reasoning in *Maher v. Roe* and *Harris v. McRae*. As applied to other governmental employees, they have been held unconstitutional by one federal court; the state may choose not to provide health insurance coverage of abortion for its employees, but it may not compel other governmental employers, such as municipalities, to exclude abortion benefits.

Statistical analysis shows no decrease in state abortion rates coincident with these insurance restrictions. In each instance, with one exception, state abortion rates as compared to regional rates rose following the enactment of insurance restrictions. Rates increased by 12.3% in Rhode Island, 5.1% in Nebraska, 2.6% in Missouri, and 0.5% in Idaho. The single exception was Pennsylvania, which showed a 4.5% decrease which may be attributable to its enactment of the highly restrictive abortion laws challenged in *Planned Parenthood v. Casey*. Pooling these figures yields an overall 2.8% increase. It is reasonable to conclude that insurance restrictions on abortion coverage have had minimal or no impact on abortion rates.
B. Court-Ordered Funding and State Abortion Rates

In every fiscal year since 1977, Congress has restricted federal funding of abortions. In most years this restriction, popularly known as the Hyde Amendment, has precluded federal funding of abortion except where necessary to preserve the woman's life. In fiscal year 1994, the Amendment includes additional exceptions for cases of rape or incest or where the woman's life is threatened. The Supreme Court has upheld the Amendment against constitutional challenges, and ruled that states may similarly choose not to fund any abortion, whether it is characterized as therapeutic (medically necessary) or nontherapeutic (elective). Most of the states did in fact sharply restrict public funding of abortion following the Hyde Amendment. National health care reform proposals contemplate encom-

restrictions supports the conclusion that health insurance coverage of abortion will be unlikely to affect women’s decisions to terminate a pregnancy. Missouri, for example, imposes onerous restrictions on abortion, key provisions of which were upheld in Webster v. Reprod. Health Servs., 492 U.S. 490 (1989); although those restrictions might be expected to reduce abortion rates in Missouri, they did not do so.

See, e.g., supra note 11.


Harris v. McRae, 448 U.S. 297 (1980).

Maher v. Roe, 432 U.S. 464 (1977). A number of state courts distinguish between therapeutic and nontherapeutic abortions, finding state funding constitutionally required for the former but not the latter. However, national health insurance should cover all legal abortions, rejecting the therapeutic/nontherapeutic distinction. The realities of medical practice and the medical condition of pregnancy necessitate this approach.

First, the distinction between abortions necessary to preserve life and abortions necessary to preserve health is untenable. Physicians generally do not distinguish between procedures which preserve life and those which merely preserve health. In the abortion context, the distinction between life and health is unrealistic, given undisputed medical evidence that pregnancy and childbirth pose risks to otherwise healthy women and increase health risks for many women with preexisting medical conditions, such as sickle cell anemia, diabetes, hypertension, and heart, kidney, or lung disease. The distinction between life and health is blurred further because some of these conditions may involve a risk of death only as pregnancy advances. See Right to Choose v. Byrne, 450 A.2d 925, 938 (N.J. 1982). Second, the distinction between medically necessary and elective abortion is unwarranted. Pregnancy is a condition requiring medical care. As Justice Brennan explained, “Abortion and childbirth, when stripped of the sensitive moral arguments surrounding the abortion controversy, are simply two alternative medical methods of dealing with pregnancy . . . .” Beal v. Doe, 432 U.S. 438, 449 (1977) (Brennan, J., dissenting) (citations omitted). When a woman chooses abortion, she minimizes the physical impairments entailed by pregnancy and avoids the risks posed by childbirth. Early abortion poses far fewer risks to women than pregnancy and childbirth. Abortion is five to ten times safer than childbirth. Robin C. Duke & J. Joseph Speidel, Women's Reproductive Health: A Chronic Crisis, 266 JAMA 1846 (1991). Accordingly, abortions cannot be validly distinguished as either elective or medically necessary; there are always medical reasons to choose abortion over pregnancy and childbirth.

Twenty-nine states permit expenditure of public funds for abortions only to save the woman’s life. See generally NARAL, WHO DECIDES? A STATE-BY-STATE REVIEW OF ABORTION RIGHTS (3d ed. 1992).
passing the present system of Medicaid. Low-income residents of states that do not provide public funding will thus be newly afforded free or inexpensive coverage for abortion services.

A statistical analysis of the impact of state court decisions requiring abortion funding indicates that abortion rates are largely unaffected by the provision of Medicaid funds for abortion to low-income women. The provision of funds through health insurance is similarly unlikely to cause significant increase in abortion rates.

Thirteen states provide Medicaid funding for abortion. Seven of these do so voluntarily. The other six, California, Connecticut, Massachusetts, New Jersey, Oregon, and Vermont do so under judicial decisions holding that restrictions on public funding for abortions violate various state constitutional provisions. This section examines states that were forced to fund abortions by court order; abortion rates in these states may provide a more accurate basis for predicting the impact of federally mandated health insurance coverage than rates in states voluntarily providing funding.

Statistical analyses show no increase in state as compared to regional abortion rates coincident with the provision of funding in Massachusetts and Oregon. In Massachusetts, the state rate as compared to regional rates fell by 7.3% after court-mandated abortion funding. A decrease in the number of abortion providers may account for the decrease. In Oregon, the rate fell by 1.3%. Rates remained fairly stable, with slight increases, in California (1%) and Connecticut (2.9%). In Vermont, rates rose by 5.4%, which may be related to the decrease in Massachusetts; women often cross state lines to obtain abortion services. In New Jersey, rates also rose by 3.8%. There is, however, evidence that abortion rates in New Jersey were

48 Alaska, Hawaii, New York, Oregon, Washington, and West Virginia provide funding for medically necessary abortions. See NARAL, supra note 47. North Carolina provides funding for abortions during the first 135 days of pregnancy where: (1) the pregnancy is a result of rape or incest; (2) the woman's health would be impaired by the pregnancy (limited to one abortion for women over 18); (3) the fetus is deformed; (4) the woman is mentally retarded; or (5) the woman is less than 18 years old. 1985 N.C. Sess. Laws 479, § 93.


55 See Ellen Gamerman, Scarce South Shore Abortion Services Prompt Lobbying Effort, STATES NEWS SERV., June 22, 1993.
increasing before abortion funding was judicially mandated. It may be reasonable to view the court’s opinion as part of a shift towards greater social acceptance of abortion (and thus an increased rate of abortion) rather than a cause of that shift. If the trend in New Jersey is taken into account, rates decreased by 1.6% following the funding decision. Overall, pooling these figures shows a 0.2% decrease in abortion rates following the provision of state funding for abortion.

The conclusion that abortion funding does not cause significant abortion rate increases is supported by recent studies examining the impacts of state legislative decisions to restrict abortion funding. One study examined shifts in trends from abortions to births (reporting both as proportions of the reported pregnancy rate) following the 1985 imposition of state funding restrictions in Colorado, North Carolina, and Pennsylvania. The authors reviewed data on pregnancy rates, live births, and abortions, before and after funding restrictions; additional live births after restrictions were viewed as "displaced abortions." In each of the three states, live births as a proportion of the pregnancy rate increased slightly. In Colorado and Pennsylvania, the increase was 2.4% from 1984 to 1985; in North Carolina, the increase was 1.9%. Nationwide, the increase was 0.4%. By 1987, overall increases in the proportion of live births were 5.9% in Colorado, 3.4% in Pennsylvania, and 1.6% in North Carolina. A similar study found a 3-4% increase in birth rates in Michigan as compared to surrounding states following its restriction of abortion funding. The marginal increases in birth rates suggest that most women who are denied a Medicaid abortion finance them in other ways.

Earlier studies which examined the impact of the Hyde Amendment and parallel state restrictions of funding also support the conclusion that abortion funding for low-income women through health insurance will not significantly affect abortion rates. Although the specific conclusions vary, the studies estimate that funding restrictions prevented only 5-25% of low-income women from obtaining abortions. The studies attempted to quan-

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60 Korenbrot, supra note 56, at 558-60.
61 Mark I. Evans et al., The Fiscal Impact of the Medicaid Abortion Funding Ban in Michigan, 82 OBSTETRICS & GYNECOLOGY 555, 559 (1993) (noting impossibility of determining what percentage of increased births attributable to restricted Medicaid funding).
62 Appendix: The Impact of Changes in Arizona’s Abortion Funding—A Statistical Analysis, 1980 Ariz. St. L.J. 206, 214 (82% of Maricopa County residents eligible for county assistance obtained abortions despite funding restrictions); Willard Cates, Jr., The Hyde Amendment in Action: How Did the Restriction of Federal Funds for Abortion Affect Low-Income Women?, 246 JAMA 1109, 1112 (1981) (5% of Medicaid-eligible women living in states restricting funding carried their unwanted pregnancies to term); see also Julian Gold & Willard Cates, Jr., Restriction of Federal Funds for Abortion: 18 Months Later, 69 AM. J. PUB. HEALTH 929 (1979); James Trussel et al., The Impact of Restricting Medicaid Financing for Abortion, 12 Fam. Plan. Persp.
tify the number of low-income or Medicaid-eligible women who were forced to carry an unwanted pregnancy to term because of funding restrictions. For a number of reasons, it is very likely that the studies failed to count many Medicaid-eligible women who obtained abortions with their own funds and thus overestimate the number of women carrying unwanted pregnancies to term. First, abortion providers studied had no economic or legal incentive to determine which patients were Medicaid-eligible in the absence of funding; they did so voluntarily for purposes of the study, and compliance with study procedures was likely incomplete. Second, it is difficult to determine who is eligible for Medicaid: cards are valid only for short periods; eligibility depends on family structure and economic status, both of which may fluctuate; and women who want to terminate a pregnancy and could qualify for Medicaid may choose not to establish eligibility given funding restrictions. Even given the likelihood of over-counting women unable to obtain abortions, the studies concluded that Medicaid restrictions had minimal impacts.

C. Conclusions

Insurance restrictions appear to have no effect on abortion rates. The availability or unavailability of government funds appears to affect abortion rates; however, the effects are minimal, as demonstrated by a number of studies. Restricted government funding prevents some poor women from obtaining abortions, but the majority of poor women who want abortions get them. Collectively, these analyses suggest that women's abortion decisions are not contingent on the availability or unavailability of insurance coverage or government funding. Providing abortion coverage as a standard benefit in national health care is unlikely to cause abortion rates to rise.

The statistics comport with the nature of reproductive freedom. The decision to have an abortion is typically made for extremely compelling personal reasons. Women who have health insurance do not decide to have an abortion because their insurance will pay for it; nor do they decide against having an abortion because their insurance excludes coverage. Similarly, women who do not have insurance do not choose whether or not to have an abortion based on the availability of public funds.

Women who choose abortion are powerfully motivated by a variety of personal reasons, including health, financial status, physical or emotional immaturity, the desire to complete an education or to delay motherhood until marriage. Abortion is relatively inexpensive and cost is usually not a

120, 129 (1980) (82% of Medicaid-eligible women in Georgia and 77% in Ohio obtained abortions after funding restrictions).

controlling consideration in the context of these compelling personal considerations.64 This is particularly true for insured women who are likely to be employed. All of the data strongly suggests that extending health insurance coverage for abortion to poor women will not significantly increase abortion rates. To the contrary, national health insurance will likely reduce the demand for abortion by ensuring that all women have access to family planning and contraceptive services.65

If national health insurance excludes abortion coverage, however, a number of serious negative consequences will follow. Studies demonstrate that restricted abortion funding causes financial hardship and serious health risks for women who are denied direct funding. The most obvious consequences of restricting public funding are financial. Women who cannot afford the cost of an abortion undergo severe hardships to finance their choice. One study found that 58% of Medicaid-eligible women and 26% of other women suffered serious economic consequences arising from abortion costs, including inability to pay their rent or utility bills, to buy food, or to cover their children's expenses.66

A less obvious but more troubling consequence of making abortion financially difficult to obtain is that women are forced to delay abortions while they obtain necessary funds. The consequences of delay are serious. First, the risk of serious complications and death from abortions rises sharply as pregnancy advances. With each week after eight weeks gestation, the risk of death increases by about 30%; the risk of serious complications increases by about 20%.67 The risk of death for abortions performed at thirteen to fifteen weeks gestation is nine times greater than the risk at eight or fewer weeks.68 The most common cause of death from second-trimester abortion in the United States is infection; other causes include amniotic fluid embolism, hemorrhage, pulmonary embolism, and complications from anesthesia or analgesia.69 Second, advanced gestational age at the time of abortion implicates enhanced moral concerns about the procedure. Abortion is permitted until the point of viability,70 but the moral issues surrounding abortion become increasingly acute as pregnancy advances. The balance of maternal and fetal rights shifts toward the fetus as

64 See supra note 7. This observation is not intended to minimize in any way the very real and very troubling economic aspects of the abortion controversy. Costs may indeed preclude some women from exercising their constitutional right to an abortion and impose serious financial and physical hardships on others. See infra notes 66-69 and accompanying text.
65 See Levine, supra note 5.
67 Id. at 171.
viability approaches, making later abortions fraught with enhanced moral concerns for pro-choice as well as pro-life advocates.

One study cited above found that 65% of Medicaid-eligible women and 44% of other women delayed their abortions past ten weeks. Forty-two percent of those Medicaid-eligible women whose abortions were delayed (approximately 27% of the Medicaid-eligible women studied) cited financial problems as a reason for their delay. Delays averaged seventeen days, bringing the affected women, on average, into the twelfth or thirteenth week of pregnancy. Ten percent of non-Medicaid-eligible women who experienced delays in obtaining an abortion also cited financial considerations. The average delay for these women was twelve days. Thus, a significant minority of women delayed their abortions until the twelfth or thirteenth week of pregnancy as a result of financial difficulties.\(^7\)

Another study confirms the conclusion that financial constraints cause delayed abortions.\(^72\) Twenty-nine percent of women obtaining abortions at sixteen or more weeks gestation cited the need to raise money to pay for an abortion as a reason for their delay.\(^73\)

These consequences will persist and intensify if national health insurance excludes abortion coverage. They will persist because low-income women will continue to fund their own abortions, absent coverage or Medicaid funding. They will intensify as national health care replaces the present system of insurance because many women will lose their present coverage and be forced to fund their own abortions; those who are less affluent will also suffer these negative consequences.

Given the legality of pre-viability abortions and the reality that financial difficulties typically delay rather than prevent abortions, the focus of health care reform should be pragmatic. How can the troubling financial consequences of abortion for poor women be avoided? How can the abortions which do and will continue to occur be made as safe as possible for all women who choose abortion? How can the demand for abortion be reduced? The answers lie in national health insurance covering a full range of reproductive services, including family planning, contraception, prenatal care, childbirth services, and abortion. Coverage will ensure that women who choose to terminate a pregnancy obtain safe and early abortions.

III. Public Financial Support of Abortion

The second reason advanced against health insurance coverage for abortion is that such coverage will force individuals who oppose abortion on moral grounds to participate financially in abortion. This “participation” would occur through the payment of taxes (to cover the unemployed and

\(^7\) Henshaw, supra note 66, at 177-78.
\(^72\) Torres, supra note 63.
\(^73\) Id. at 174.
those who cannot pay their full share) or insurance premiums. The objections of individual insureds and taxpayers to providing funds for procedures to which they are morally opposed are understandable. However, widespread existing insurance coverage for abortion and substantial ongoing support of abortion through direct taxation and tax subsidies diminish their concerns about national coverage. Against a backdrop of legal abortion and extensive public financial support of abortion, objections to national insurance coverage of abortion lose much of their force.

A. Insurance

Abortion coverage exists in the great majority of private health insurance.\(^74\) Policyholders who are concerned that national health coverage for abortion will involve their "participation" in abortion must understand that national health coverage of abortion will merely preserve the status quo for most insureds. More than likely, those insureds who object to abortion are already "participating" in abortion under their existing policies.

Their concern is unwarranted on another level: they mistake the nature of insurance. Insurance is a mechanism by which an individual transfers risk—in this case, the risk of having to pay for medical care—to an insurance company in exchange for the individual's premium payment. The insured pays a small amount in exchange for the company's promise to pay potentially much greater amounts if uncertain future events occur. The individual insured's premium purchases a personal benefit. Opponents of abortion coverage argue to the contrary that insurance premiums "fund" abortion because insurance distributes as well as transfers risk. Because insurance companies distribute risk across a pool of insureds, some portion of an insured's premium payments will cover medical care for others, and that care may include abortion. It is, however, a gross distortion to characterize this scenario as involving the insured's financial support of abortion.\(^75\) Support of abortion as defined this broadly occurs routinely where, for example, an opponent of the right to abortion purchases goods from a seller who uses her profit to finance an abortion or hires a worker who uses her salary to finance an abortion. Given the structure of our society, virtually every abortion may involve social "participation" at these attenuated levels.

Payment of insurance premiums under a plan including abortion benefits does not constitute public funding of abortion. The fact that the public, including those morally opposed to abortion, appear unconcerned with private coverage of abortion suggests that the public generally agrees with this

\(^74\) See supra note 17.

\(^75\) See National Educ. Ass'n v. Garrahy, 598 F. Supp. 1374, at 1383-84 (D.R.I. 1984) (rejecting defendants' argument that the "consuming public's" private insurance premiums for abortion benefits is roughly equivalent to public funding of abortion).
assessment. There have, however, been suggestions to eliminate any possible moral concerns about participation in a health plan covering abortion. Before the release of his proposed legislation, President Clinton suggested an approach which would permit individuals morally opposed to abortion to avoid participation in plans covering abortion. As the President explained the approach: "If a person goes into a health-care plan that provides pregnancy-related services, the person can ask, does this include abortions or not? If it doesn't, they can go to another plan. If it does and they are offended by it, they can go to another plan."

The structure of the Health Security Act proposed by the administration contemplates extension of comprehensive minimum benefits to all individuals and would appear to preclude such an approach. However, the inherent ambiguity of the benefits provision would perhaps permit states or individual health plans to interpret the provision to exclude abortion, consistent with the President's suggestion. It may also be possible for some health plans to fall within the much-discussed conscience clause of the Health Security Act which allows health care providers to refuse to perform services in the benefit package based on religious or moral objections. Under the proposal as currently structured, states are responsible for ensuring access to a choice of health plans; presumably, if some plans opt not to cover abortion, individuals would have access to plans which did.

U.S. Reps. Jim Slattery (D-Kan.) and Jim Cooper (D-Tenn.) have suggested a plan which would permit women to buy individual supplemental abortion coverage for as little as eighteen cents per month or family coverage for fifty cents per month. However, this plan may not accomplish the goal of preventing financial support of abortion through premium payments; absent stringent accounting requirements, the use of supplemental insurance may not preclude the use of non-abortion premiums to finance abortions. Insurance is a risk-spreading mechanism, and risks are impossible to quantify precisely. If more abortions occur than an insurer predicts, costs may exceed the total abortion premiums. The insurer would presumably pay for those unexpected abortions with reserves composed of portions of all premiums.

76 Insurance companies will remove abortion coverage from standard policies if asked to, but such requests are apparently very rare. See Lochhead, supra note 17, at A1.
78 H.R. 3600, 103d Cong., 1st Sess. § 1001 (1993), states that eligible individuals are entitled to comprehensive benefits through their health plans. H.R. 3600 § 1101 sets out comprehensive benefits and succeeding sections, H.R. 3600 §§ 1111-1128, describe the items and services covered. H.R. 3600 § 1203(a)(1) charges states with the responsibility of certifying health plans; criteria for certification must include the plan's capacity to deliver the comprehensive benefits specified in the act. H.R. 3600 § 1203(a)(2)(C).
80 Supplemental Insurance Suggested for Abortions, STAR TRIB., Oct. 27, 1993, at 15A.
81 The provision of abortion coverage through optional rider in states which restrict insurance coverage for abortion, see supra notes 19-24 and accompanying text, suffers from similar defects. The fact that those who obtain coverage pay a few extra cents, see Levine, supra note 5, cannot eliminate the possibility that premiums paid by others will be used for abortion. None of the
Furthermore, requiring supplemental coverage unfairly penalizes women who choose abortion. As a medical procedure, abortion is far less expensive than pregnancy and related costs. As the district court in Coe v. Melahn observed, "the cost of a normal elective abortion is substantially less than the cost of a normal childbirth delivery. . . . [I]t is the payment of insurance premiums for elective abortions which, in fact, subsidizes childbirth deliveries."

Optimally, health-care reform should avoid these "compromises" as unnecessary because premiums do not constitute public funding of abortion. National coverage should include abortion benefits for everyone. Insurance will likely operate most efficiently if coverage is standardized. Decisions about standard coverages of specific procedures should depend on accepted medical practices and factors such as the safety, efficacy, and cost-effectiveness of the procedure. The values and purposes of insurance as a method of transferring and distributing risk may be seriously undercut if individual insureds or groups of insureds dictate coverage, specifying that their premiums may not finance medical procedures to which they object. Some will object to abortion. Others will object to coverage for substance abuse treatments, smoking-related cancers, treatments for Acquired Immune Deficiency Syndrome (AIDS), and so on. The result will be that personal health care decisions will become politicized, and individuals who need care will not receive it.

B. Taxation

The more difficult issue concerning public funding of abortion arises because the Health Security Act contemplates folding Medicaid benefits into a universal plan. Individuals who are unable to pay premiums for their guaranteed coverage will receive benefits paid for with tax dollars. Under such a plan, it would be impossible to continue the federal refusal to fund abortions for poor women; it would also be impossible for individual taxpayers to ensure that their money does not support abortion absent some type of supplemental abortion coverage such as that proposed by Reps. Slattery and Cooper.

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83 See Editorial, ST. LOUIS POST-DISPATCH, July 2, 1993, at 2B:
Just as it is not the government's place to determine, on religious grounds, what medical procedures it will subsidize, neither is it the prerogative of taxpayers. The basic argument of abortion foes—that they don't want their tax dollars paying for a procedure they find morally objectionable—is not accepted vis-a-vis other medical procedures.
A survey of recent news stories demonstrates the reality of these concerns. Many predict coverage battles over controversial procedures or illnesses. E.g., Lochhead, supra note 17, at A1.
84 See supra note 80 and accompanying text.
The concerns of individuals who oppose abortion on moral grounds and do not want to support it through taxes are understandable. However, taxpayers presently fund abortions in numerous ways. The most direct instance of funding occurs when federal or state governments pay for abortions. The number of directly federally funded Medicaid abortions is minimal because very few abortions are necessary to prevent the woman’s death.\footnote{85} There are far greater numbers of state-funded abortions because a number of states fund abortions for a wide range of reasons.\footnote{86}

Taxpayers also fund abortions when poor women are forced to use funds provided by government programs for basic living expenses to pay for abortions. One study found that such funds entirely financed abortions for 22% of Medicaid-eligible women and partially financed abortions for another 22%.\footnote{87} National health insurance coverage for abortion would eliminate the financial hardships necessitated by this unfortunately common practice without requiring additional public “participation” in abortion.

Less direct tax support for abortion occurs in numerous and varied ways, including: support of public hospitals which perform abortions or provide training in abortion procedures;\footnote{88} tax deductions for private health insurance, the majority of which includes coverage for abortion;\footnote{89} financing health care facilities that perform abortions with tax-exempt bonds;\footnote{90} personal income tax deductions for medical expenses related to abortion;\footnote{91} and

\footnote{85}Rachel Benson Gold & Sandra Guardado, Public Funding of Family Planning, Sterilization and Abortion Services, 1987, 20 FAM. PLAN. PERSP. 228, 233 (1988). The number of publicly-funded abortions dropped from approximately 295,000 in 1977 to 194,000 in 1978 following the passage of the Hyde Amendment. Most of those 194,000 abortions were funded by the District of Columbia and the 16 states which continued to provide funding. In the states that discontinued funding, the number of publicly funded abortions dropped 99%. Rachel Benson Gold, After the Hyde Amendment: Public Funding for Abortion in FY 1978, 12 FAM. PLAN. PERSP. 131 (1980).

\footnote{86}See supra notes 48-54 and accompanying text.

\footnote{87}Henshaw, supra note 66, at 178. The study surveyed Medicaid-eligible women obtaining abortions at a particular clinic to determine how they financed their abortions. The clinic studied charged $150 for first trimester abortions for Medicaid-eligible women ($50 less than the normal fee). At the time of the study, the average monthly payment to recipients of Aid to Families with Dependent Children (AFDC) was $244. Id. at 171.

\footnote{88}Some states have prohibited the use of public facilities to perform abortions. For example, Mo. Rev. Stat. § 188.215 (1993) makes it “unlawful for any public facility to be used for the purpose of performing or assisting an abortion not necessary to save the life of the mother. . . .” The Supreme Court has upheld such provisions against constitutional challenges. Webster v. Reprod. Health Serv., 492 U.S. 490, 507 (1989).

\footnote{89}I.R.C. § 106 (1993) (gross income does not include employer-provided health or accident coverage); see also Clymer, supra note 43, at A1 (citing Rep. Nancy Johnson’s (R-Conn.) argument that taxpayers already subsidize abortions for the middle class through the tax deductibility of private health insurance which covers abortions).

\footnote{90}H.R. 4922, 101st Cong., 2d Sess. (1990) (introduced but not acted upon) (would prohibit use of tax-exempt bonds to finance health care facilities providing abortion or abortion services).

tax-exempt status for nonprofit organizations that perform or finance abortion or abortion-related services.\textsuperscript{92}

Abortion is already publicly supported in many ways, most of which will continue regardless of whether a health care reform plan is implemented or whether that plan includes abortion benefits. Support through national health insurance would eliminate the inequities entailed by the current practice of selective nonfunding of abortion, while maintaining the status quo on public financial support of abortion. As long as abortion remains legal, attempts to limit or preclude any public financial connection with or support of abortion will likely fail.

\textbf{C. Alternative State-Level Participation}

A number of states provide abortion funding despite restrictions on federal funding.\textsuperscript{93} If national health benefits exclude abortion, these states would almost certainly continue to provide such funds; many would be required to do so by their state constitutions.\textsuperscript{94} Some additional states would likely initiate funding, perhaps for a broader segment of the population than those eligible for Medicaid,\textsuperscript{95} or mandate additional insurance coverages.\textsuperscript{96} None of these approaches appear to violate the Health Security Act.\textsuperscript{97} Hence, it is likely that excluding national coverage for abortion will result in greater numbers of state-funded abortions or increased state activity in assuring that abortion coverage exists. Ironically, successful opposition to national abortion coverage may merely shift the provision of funding or coverage to the states, requiring tax-based participation at the state rather than federal level.

\begin{itemize}
\item \textsuperscript{93} \textit{See supra} notes 48-54 and accompanying text.
\item \textsuperscript{94} \textit{See supra} notes 49-54 and accompanying text.
\item \textsuperscript{95} \textit{See} Hope v. Perales, 595 N.Y.S.2d 948 (App. Div. 1993) (extending state abortion funding beyond Medicaid-eligible women).
\item \textsuperscript{96} The National Abortion Rights League (NARAL) makes yearly determinations of the positions of state governors and legislative bodies on abortion. Based on NARAL's assessments, eight states in addition to those already funding abortion (Arizona, Colorado, Florida, Georgia, Maine, Maryland, New Mexico, and Virginia) are strongly committed to abortion rights. Strong executive or legislative support of abortion rights exists in sixteen more states (Arkansas, Delaware, Idaho, Illinois, Indiana, Iowa, Kansas, Minnesota, Montana, New Hampshire, Nevada, Rhode Island, South Carolina, Tennessee, Texas, and Wyoming). \textit{See generally} NARAL, \textit{supra} note 48.
\item \textsuperscript{97} The Act does not preclude direct state provision of benefits in addition to specified comprehensive benefits. H.R. 3600, 103d Cong., 1st Sess. § 1421 (1993) (pending). The Act specifically contemplates supplemental coverages so long as they do not duplicate comprehensive benefits. H.R. 3600 §§ 1203(h), 1422.
\end{itemize}
National health care reform should include abortion benefits. Such benefits are unlikely to increase abortion rates. Most women currently have abortion coverage; universal coverage will not change the status quo for those women. Those who do not currently have abortion coverage are willing to undergo severe financial hardships and serious physical risks to exercise their right to reproductive choice. While coverage will eliminate the hardships and risks, it will not affect the basic decision to terminate a pregnancy. Nor will abortion benefits mandate additional public financial support of abortion. Such arguments ignore existing and extensive public financial support for abortion and the likelihood that states will act if the federal government excludes abortion coverage from a national plan.

For the most part, national health insurance coverage for abortion will maintain the status quo. Any changes it would bring would be positive. Coverage would eliminate the severe financial hardships endured by low-income women who obtain abortions. Coverage would prevent delayed abortions caused by such financial difficulties, minimizing serious physical risks for affected women and avoiding the intensified moral concerns surrounding abortions which approach viability.

An informed debate must proceed from these premises: abortions will occur at roughly the same rates regardless of coverage; the public now supports and will continue to support abortion through taxes regardless of coverage. Those who persist in arguing that coverage will increase the abortion rate and public funding of abortion mistake the facts.