



## An Analysis of the Implications of the Stupak/Pitts Amendment for Coverage of Medically Indicated Abortions

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### Introduction and Results in Brief

This analysis examines the implications for coverage of medically indicated abortions<sup>1</sup> under the Stupak/Pitts Amendment (Stupak/Pitts) to H.R. 3962, the Affordable Health Care for America Act.<sup>2</sup> In this analysis we focus on the Amendment's implications for the health benefit services industry as a whole. We also consider the Amendment's implications for the growth of a market for public or private supplemental coverage of medically indicated abortions. Finally, we examine the issues that may arise as insurers attempt to implement coverage determinations in which abortion may be a consequence of a condition, rather than the primary basis of treatment.

*Industry-wide impact that will shift the standard of coverage for medically indicated abortions for all women:* In view of how the health benefit services industry operates and how insurance product design responds to broad regulatory intervention aimed at reshaping product content, we conclude that the treatment exclusions required under the Stupak/Pitts Amendment will have an industry-wide effect, eliminating coverage of medically indicated abortions over time for all women, not only those whose coverage is derived through a health insurance exchange. As a result, Stupak/Pitts can be expected to move the industry away from current norms of coverage for medically indicated abortions. In combination with the Hyde Amendment, Stupak/Pitts will impose a coverage exclusion for medically indicated abortions on such a widespread basis that the health benefit services industry can be expected to recalibrate product design downward across the board in order to accommodate the exclusion in selected markets.

*Supplemental insurance coverage for medically indicated abortions:* In our view, the terms and impact of the Amendment will work to defeat the development of a supplemental coverage market for medically indicated abortions. In any supplemental coverage arrangement, it is essential that the supplemental coverage be administered in conjunction with basic coverage. This intertwined administration approach is barred under Stupak/Pitts because of the prohibition against financial comingling. This bar is in addition to the challenges inherent in administering any supplemental policy. These challenges would be magnified in the case of medically indicated abortions because, given the relatively low number of medically indicated abortions, the coverage supplement would apply to only

<sup>1</sup> In this analysis, the term "medically indicated abortion" means any type of abortion for which there is a medical indication of need, as distinguished from abortions that have no medical evidence to justify insurance coverage.

<sup>2</sup> Affordable Health Care for America Act, H.R. 3962, 111<sup>th</sup> Cong. (1<sup>st</sup> Sess. 2009). Available at [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111\\_cong\\_bills&docid=f:h3962eh.txt.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3962eh.txt.pdf).

a handful of procedures for a handful of conditions. Furthermore, the House legislation contains no direct economic incentive to create such a market. Indeed, it is not clear how such a market even would be regulated or whether it would be subject to the requirements that apply to all products offered inside the exchange. Finally, because supplemental coverage must of necessity commingle funds with basic coverage, the impact of Stupak/Pitts on states' ability to offer supplemental Medicaid coverage to women insured through a subsidized exchange plan is in doubt.

*Spillover effects as a result of administration of Stupak/Pitts.* The administration of any coverage exclusion raises a risk that, in applying the exclusion, a plan administrator will deny coverage not only for the excluded treatment but also for related treatments that are intertwined with the exclusion. The risk of such improper denials in high risk and costly cases is great in the case of the Stupak/Pitts Amendment, which, like the Hyde Amendment, distinguishes between life-threatening physical conditions and conditions in which health is threatened. Unlike Medicaid agencies, however, the private health benefit services industry has no experience with this distinction. The danger is around coverage denials in cases in which an abortion is the result of a serious health condition rather than the direct presenting treatment.

The remainder of this analysis examines these issues in greater detail.

## **Overview of Current Federal Law**

### *1. The Hyde Amendment and Medicaid*

The Hyde Amendment has been part of each HHS-related appropriation since FY 1977. As set forth in the most recent annual Labor/HHS federal appropriations legislation,<sup>3</sup> the Hyde Amendment provides in pertinent part as follows:

Sec. 507. (a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated under this Act, shall be expended for any abortion.

(b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion.

(c) The term 'health benefits coverage' means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.

Sec. 508. (a) The limitation established in the preceding section shall not apply to an abortion-

(1) if the pregnancy is the result of an act of rape or incest; or

(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

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<sup>3</sup> Omnibus Appropriations Act, Pub. L. No. 111-8, 123 Stat. 524, 802-803 (Mar. 11, 2009).

(b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State's or locality's contribution of Medicaid matching funds).

(c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a state or locality to contract separately with such a provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds) \* \* \*

Under this Amendment, states may neither directly expend federal funds for abortion other than the procedures authorized by the Amendment nor use federal and matching state funds to purchase products that cover a broader range of abortions. At the same time, the Amendment preserves states' authority to either pay for, or purchase coverage of, additional abortion services using state and local funds that exceed federal Medicaid contribution requirements. Twenty-three states currently pay for some abortion services that extend beyond the limited range of coverage permitted under the Hyde Amendment and seventeen of those pay for all or most medically necessary abortions.<sup>4</sup>

## 2. *The Employee Retirement Income Security Act (ERISA)*

The Employee Retirement Income Security Act (ERISA) governs private employer-sponsored coverage in the U.S. Because most workers are employed by private firms, ERISA has a broad reach, affecting health plans that account for 81 percent of all persons covered by any employer-sponsored arrangement. The remaining population of workers and their dependents are enrolled in an ERISA-exempt plan (typically a plan offered by government employers and subject to separate legal requirements).<sup>5</sup>

ERISA contains few provisions regulating the content of employer-sponsored health benefit plans. Instead, the law relies on the health benefit services companies that sell products to employers, as well as employers themselves, to negotiate the terms of coverage. Despite the considerable investment of taxpayer financing that supports the employer-sponsored system (currently estimated at \$246 billion),<sup>6</sup> ERISA contains no mandatory exclusion of certain types of medically indicated treatments for abortion, instead leaving the matter to the discretion of purchasers and sellers. The best available research indicates that 87 percent of employer-based insurance plans cover medically appropriate abortions and that 46 percent of workers have coverage that includes some level of abortion services.<sup>7</sup>

The fact that an employer plan is subject to ERISA does not render state insurance law irrelevant. ERISA health benefit plans that cover participants and members by buying a health insurance product

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<sup>4</sup> Guttmacher Institute, *State Funding of Abortion Under Medicaid, State Policies in Brief*, 2009. Available at [http://www.guttmacher.org/statecenter/spibs/spib\\_SFAM.pdf](http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf).

<sup>5</sup> Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA. (GAO/HEHS-95-167, July 25, 1995).

<sup>6</sup> Joint Committee on Taxation, *Tax Expenditures for Health Care* (JCX-66-08), July 30, 2008. This document is available at [www.jct.gov](http://www.jct.gov).

<sup>7</sup> Two major studies have been conducted on this issue. A federally supported study conducted by the Guttmacher Institute and assessing levels of insurance coverage for a wide range of reproductive health services found that in 2002, 87% of typical employer-based insurance plans covered medically necessary or appropriate abortions. In a 2003 survey, the Kaiser Family Foundation found that 46% of insured workers had some level of abortion coverage. The number may be even higher considering that the survey also yielded a high (26 percent) "don't know" response rate. Guttmacher Institute, *Memo on Insurance Coverage of Abortion*, updated Sept. 18, 2009.

<http://www.guttmacher.org/media/inthenews/2009/07/22/index.html>.

are subject to state law with respect to the products that are purchased. Thus, state insurance content mandates or regulatory exclusions could affect certain ERISA plans. (In contrast, ERISA health benefit plans that self-insure are exempt from state insurance law.)

States exercise their powers under the McCarran-Ferguson Act<sup>8</sup> to regulate insurance, but only rarely regulate the terms of abortion coverage in the individual or group markets. Currently, five states<sup>9</sup> appear to regulate coverage of medically indicated abortions by banning coverage of most procedures except where the life of the mother is in danger. These state laws effectively impose a mandatory, regulatory coverage exclusion directly affecting benefit design of insurance products sold in their states. These states also allow for the sale of separate abortion riders, but the evidence available shows that markets for abortion-specific insurance products have not developed in these states.<sup>10</sup>

### *The Federal Employee Health Benefits Program*

The Federal Employee Health Benefits Program (FEHBP) reaches some 8 million beneficiaries, including federal employees and their spouses and dependents.

Unlike the ERISA market, the laws governing health benefit coverage for federal employees directly regulate abortion content. The annual federal appropriations statute governing the program provides in pertinent part as follows:

Sec. 613. No funds appropriated by this Act shall be available to pay for an abortion, or the administrative expenses in connection with any health plan under the Federal employees health benefits program which provides any benefits or coverage for abortions.

Sec. 614. The provision of section 613 shall not apply where the life of the mother would be endangered if the fetus were carried to term, or the pregnancy is the result of an act of rape or incest.<sup>11</sup>

Like the laws in the five states that have elected to regulate plan content, this statute reaches plan content by imposing a coverage exclusion on plans sold to federal employees, barring coverage for most medically indicated abortions. Furthermore, the legislation bars payments to any health plan that administers coverage reaching the prohibited types of treatments. This bar conceivably could cost a plan its federal contract even if its plan administration activities were limited to the coordination of benefits between its own product and a supplemental product offering coverage of excluded

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<sup>8</sup> 15 U.S.C. §§ 1011-1015.

<sup>9</sup> ID, KY, MO, ND, OK. OK limits coverage to life endangerment, rape or incest circumstances; and the other four states limit coverage to cases of life endangerment. Guttmacher Institute. Restricting insurance coverage of abortion. *State Policies in Brief*, 2009.

<sup>10</sup> Insurance departments in Idaho, Kentucky and Missouri say they do not track the existence of such riders (although presumably the content of such riders would have to be registered with a state's insurance department). It is very unclear if any riders are offered. North Dakota and Oklahoma officials report that insurers do not currently offer such riders. Oklahoma reports that one insurer has filed for a rider to offer abortion coverage to small groups, but apparently has not yet offered that coverage. Idaho reports that one of the state's major insurers will offer abortion coverage to small groups if they pay an additional premium charge. *How Would the House Abortion Limits Work?* MSNBC.

[http://www.msnbc.msn.com/id/33859329/ns/health-health\\_care](http://www.msnbc.msn.com/id/33859329/ns/health-health_care).

<sup>11</sup> The Omnibus Appropriations Act, 2009 (Pub. L. 111-8).

treatments. For this reason, it would appear that companies selling products to federal employees would not be permitted to offer supplemental abortion coverage without risking the loss of their plan administration financing unless they could demonstrate that the sale and administration of such a rider was completely segregated from general plan administration. This would be virtually impossible, since coverage determinations related to the supplement would of necessity have to be coordinated with the basic plan, causing administrative spillover into the base plan. While a federal employee in a state in which supplemental coverage is offered might buy such a supplement, not only is there no evidence that such a market exists, but the base plan would be barred from coordinating benefits with the supplemental insurer, thereby leaving the employee exposed to the risk of coverage denial from all sources of coverage.

There is evidence that in the absence of exclusion, the coverage norm would be to include a range of medically indicated abortion procedures. In 1994, the last year when products were not subject to such coverage exclusion, half of all products sold in the FEHBP offered at least some abortion coverage beyond the current limited coverage.<sup>12</sup>

#### *Interactions between regulatory law and the health benefit services industry*

In the absence of federal or state regulatory laws governing the design and administration of health benefits, the health benefit services industry has the discretion to design and administer products in accordance with market preferences. As noted, it appears to be customary for the industry to cover medically indicated abortion procedures, with 87 percent of health benefit plans offered reporting coverage of abortion services.<sup>13</sup>

Once regulatory law is introduced however, industry norms can begin to shift if the reach of the law is broad enough to affect a significant portion of the market. The health benefit services industry, like any large producer of goods and services functioning in a national economy, depends on standardization and norms. If certain types of products are excluded in certain large markets, over time the market as a whole for the product can be expected to shift, as manufacturers move to accommodate their product to reflect the regulated design. This is particularly true where the regulation deals with details of the product, that is, where the regulation attempts to redesign certain product details rather than some substantial aspect of the product that can be readily modified for certain customers. The analogy here would be regulations that address the inner workings of a car engine (crucial and detailed) rather than the color of a car, which can be modified with relative ease to satisfy the desire of certain customers (e.g., a red car with black trim).

The effect of regulatory law where the content of insurance coverage is concerned can be seen in the changed market for insured contraception. Prior to the enactment of state contraception coverage mandates, most health plans did not provide the benefit. As state laws regulating the inclusion of contraceptives have become more prevalent, the broader health benefit services market has been

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<sup>12</sup> Center for Reproductive Rights, *Federal Employees Deserve Comprehensive Reproductive Health Care* (NY, NY, July 2009)

<sup>13</sup> Adam Sonfield et al., *U.S. Insurance Coverage of Contraceptives and the Impact Of Contraceptive Coverage Mandates, 2002*, *Perspectives on Sexual and Reproductive Health*, 36(2):72-79 (2004).

affected.<sup>14</sup> National health benefit services companies report today that they routinely include contraceptive coverage in their plans in all markets, not only those directly affected by state law.<sup>15</sup>

This potential for regulation to spill over into unregulated markets can be expected to work in reverse, particularly where the regulation prohibits specific procedures and conditions and creates additional disclosure, network design, coverage determination, and provider payment complexity for plan administrators. The same national and regional companies that sell products in the private employee, federal-employee or the state-regulated markets can be expected to sell products in the exchange markets; indeed, a goal of health reform is to create a large new market of high quality insurance products for the 30 million people who will derive coverage through the exchange. Until now, the very large private employer market has been a dominant force in product design. But as the exchange market grows, its design requirements – particularly when combined with those from the large emerging Medicaid managed care market and the federal employee benefits market – can be expected to gain real dominance.

The critical task for companies faced with multiple markets, will be to design products that can compete in all markets. For example, Blue Cross of the National Capital Area might sell a PPO product in multiple forms: as a Medicaid managed care product; as a state-licensed insurance product in the individual and small group markets; as a product for federal employees; as an administered product in the self-insuring employer market; and finally as an insured product in the exchange. The company will want the plan “engine” to operate as much the same as possible across all markets, even if the “color and trim” aspects of its products (e.g., a benefit package supplement for vision and dental or its prescription drug plan) may vary for certain markets.

To be sure, sellers of health benefit services products do customize those products in certain ways, varying cost-sharing for example or adding entire benefit classes (such as a dental coverage supplement). But in the case of abortion services, the issue is not adding an entire benefit class that can be clearly described and efficiently administered. Instead, the challenge is to customize in certain critical but small-bore ways the range of procedures that a plan administrator will cover and the specific types of patients for whom additional procedures will be made available. Abortion regulations that allow coverage of most medically indicated procedures for most health conditions but prohibit a few procedures for a handful of conditions essentially compel changes in the inner workings of plan administration. Thus, as more and more markets demand these changes, the plan’s inner workings must change as well.

In effect, in order to preserve broader coverage of medically indicated abortions, the health benefit services industry will confront the challenge of adding coverage procedure by procedure for specific women and based on the specific details of their underlying health conditions. Accomplishing this task -- or offering an entirely separate plan that operates according to a separate set of rules -- will pose a major burden on the industry, one that it might undertake were it to receive direct financial incentives for doing so, or were it to conclude that the market is large enough. But where the market is for a handful of medical procedures for a small number of conditions – as crucial as they might be – the

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<sup>14</sup> Guttmacher Institute, Insurance coverage contraceptives, *State Policies In Brief*, [http://www.guttmacher.org/statecenter/spibs/spib\\_ICC.pdf](http://www.guttmacher.org/statecenter/spibs/spib_ICC.pdf), accessed November 13, 2009.

<sup>15</sup> Adam Sonfield et al., *U.S. Insurance Coverage of Contraceptives and the Impact Of Contraceptive Coverage Mandates, 2002*, *Perspectives on Sexual and Reproductive Health*, 36(2):72–79 (2004).

burdens associated with administering a parallel plan or a supplemental product will quickly work to outweigh the economic benefit of offering more product choice.

In sum, while the additional coverage of medically indicated abortions may be minimal from an actuarial viewpoint, as studies of contraceptive coverage have suggested,<sup>16</sup> the administrative burdens can be considerable. Enrollment materials and summary plan benefit materials would need to be altered to reflect broader coverage for members who buy additional coverage either as a separate plan or via a coverage supplement. Individual coverage determinations will differ for women depending on the procedures to be used, the severity of their health conditions, and the medical evidence in the case. Coverage determinations and grievance and appeals procedures will have to be separately administered to respond to different coverage rules. Medical provider networks may have to be augmented in order to make the fuller range of coverage accessible to members, with separate negotiated payment rules. Most importantly, extensive interaction in order to coordinate benefits between the basic plan and the supplemental plan (or the separately purchased coverage supplement) is necessary to assure that costs are apportioned properly and that coverage risks are distributed according to the terms of the plan.

For example, consider a case in which an abortion is medically indicated as a result of a woman's health. In this case, coverage might be available through a basic plan if the condition were determined to be life-threatening, but only through the supplemental plan if the condition that led to the abortion were determined to only threaten her health. Making such a determination might be difficult, particularly where the health threat is severe and long-lasting. Significant interaction between the administrators of the basic and supplemental plans would be essential to resolve the evidence; where the administrator is the same person, the task inevitably would require construing the plan terms across all products.

One can begin to appreciate why the market for supplemental coverage is limited. Where companies are precluded from participating in markets if they offer certain abortion services, offering alternative plans or a supplement leaves them exposed to the risk that in administering the supplement in relation to the base plan they will be considered to be administering a prohibited product. The only way to avoid this outcome might be to assure that the cost of the supplement is high enough to absorb all administrative costs over both the base plan and the supplement, as well as the actuarial risk of need. Making this type of adjustment would of course drive up the price of the product.

The legal risks inherent in offering a supplement in a market that legally prohibits the commingling of plan administration duties can be expected to drive the industry away from the sale of a plan supplement. These problems are compounded by the fact that the market can be expected to be extremely small where the product is not for a broad swath of benefits such as vision and dental care but instead for a handful of procedures for a handful of serious conditions.

Thus, it is not surprising that the supplemental coverage market for medically indicated abortion procedures that are excluded from a basic plan has not grown, either for federal employees or in states that prohibit basic abortion coverage. There are just too many difficulties – legal and technical – to justify the cost, and the market is infinitesimal when one considers the handful of women who might need this critical protection. While the numbers of women in need of this additional coverage are of

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<sup>16</sup> “Contraceptive Coverage Must Be Included in the Federal Employees Health Benefits Program,” National Women’s Law Center. <http://www.nwlc.org/pdf/federalconcov.pdf>.

course small, the financial risks that the absence of the protection creates for families can of course be considerable, since medically indicated abortions, when undertaken in response to serious health conditions, can run into the thousands of dollars.

### **The Stupak/Pitts Amendment**

On November 7, 2009, during floor debate on the Affordable Health Care for America Act (H.R. 3962), the House adopted the Amendment offered by Representatives Stupak and Pitts to broaden the bill's prohibition on federal funding for abortion.<sup>17</sup> The Amendment provides in pertinent part as follows:

(a) IN GENERAL -- No funds authorized or appropriated by this Act . . . may be used to pay for any abortion or to cover any part of the costs of any health plan that includes coverage of abortion, except in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself, or unless the pregnancy is the result of an act of rape or incest.

(b) OPTION TO PURCHASE SEPARATE SUPPLEMENTAL COVERAGE OR PLAN – Nothing in this section shall be construed as prohibiting any nonfederal entity (including an individual or a state or local government) from purchasing separate supplemental coverage for abortions for which funding is prohibited under this section, or a plan that includes such abortions, so long as –

(1) such coverage or plan is paid for entirely using only funds not authorized or appropriated by this Act, and

(2) such coverage or plan is not purchased using (A) individual premium payments required for a Exchange participating health benefits plan towards which an affordability credit is applied; or (B) other nonfederal funds required to receive a federal payment, including a state's or locality's contribution of Medicaid matching funds.

(c) OPTION TO OFFER SEPARATE SUPPLEMENTAL COVERAGE OR PLAN – Notwithstanding [the foregoing] nothing in this section shall restrict any nonfederal QHBP offering entity from offering separate supplemental coverage for abortions for which funding is prohibited under this section, or a plan that includes such abortions, so long as –

(1) premiums for such separate supplemental coverage or plan are paid for entirely with funds not authorized or appropriated under this Act

(2) administrative costs and all services offered through such supplemental coverage or plan are paid for using only premiums collected for such coverage or plan; and

(3) any nonfederal QHBP offering entity that offers an Exchange-participating health benefits plan that includes coverage for abortions for which funding is prohibited under this section also offers an Exchange-participating health benefits plan that is identical in every respect except that it does not cover abortions for which funding is prohibited under this section.

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<sup>17</sup> 155 Cong. Rec. H12962 (Nov. 7, 2009).



The Amendment, as passed, thus appears to represent an amalgam of the Hyde Amendment and the FEHBP coverage exclusion provision in its construction. Summarized as follows, the Amendment would:

- Prohibit the use of funds under the Act either to directly pay for abortion or to buy an exchange product that covers abortions other than the narrow range of permissible abortions.
- Prohibit the coverage of all but the allowable abortions under the public plan.
- Permit states and localities to use their own funds either to pay directly for abortions or to buy a plan covering abortion, as long as the purchase is with funds other than mandatory state expenditures under the Act.
- Permit companies to sell supplemental coverage or plans that include broader abortion coverage, but only to the extent that “administrative costs and all services offered through such supplemental coverage or plan” are paid for using only “premiums collected for such coverage or plan.”
- Prohibit companies from offering supplemental coverage or plans that cover abortions unless they also offer an exchange plan that is identical in every respect except that no prohibited abortion coverage is included.

### **The Potential Impact of the Stupak/Pitts Amendment**

The Stupak/Pitts Amendment can be expected to influence the industry as a whole by considerably broadening the market for products that exclude all but a limited number of abortion procedures. The Congressional Budget Office projects that within six years of the exchange being implemented, 30 million people will get their health insurance through the exchange, including three million who will not receive subsidies and nine million who will receive exchange-based coverage through their employer.<sup>18</sup> In effect, the size of the new market is large enough so that Stupak/Pitts can be expected to alter the “default” customs and practices that guide the health benefits industry as a whole, leading it to drop coverage in all markets in order to meet the lowest common denominator in both the exchange and expanded Medicaid markets.

Furthermore, for the reasons outlined above, because the Stupak Amendment bars the subsidization of plan administration activities in connection with prohibited procedures, it can be expected to chill the development of abortion coverage supplements as well as entirely separate plans to non-subsidized women. The refusal of plans to engage in plan administration in connection with broader coverage arrangements may also begin to affect access to abortion coverage in states that voluntarily offer such coverage under Medicaid if plan administrators seek to avoid coordination of benefits activities across basic and supplemental coverage.

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<sup>18</sup> Congressional Budget Office, Letter to Rep. Dingell, Nov. 6, 2009. Available at [http://www.cbo.gov/ftpdocs/107xx/doc10710/hr3962Dingell\\_mgr\\_Amendment\\_update.pdf](http://www.cbo.gov/ftpdocs/107xx/doc10710/hr3962Dingell_mgr_Amendment_update.pdf).

Finally, the Amendment can be expected to have spillover effects on plan administration activities in connection with abortions related to women with serious health conditions that result in abortion, even where abortion is not the primary treatment sought, which may result in the denial of coverage for a broad range of medical treatments. This result flows from the difficulties associated with administering exclusions tied to a limited range of medically indicated procedures.

1. Impact on currently uninsured women and women who are employees (or spouses or dependents of employees) of small businesses

Of the 12.02 million women ages 18-45 who are classified as uninsured under the 2009 Current Population Survey, more than 10.5 million have family incomes below 400% of the federal poverty level,<sup>19</sup> the income cutoff for subsidies in the Senate Finance Committee measure.<sup>20</sup> These women will qualify either for coverage through Medicaid or for a subsidized exchange product. They will be barred from enrolling in plans with abortion coverage exceeding Hyde Amendment or Stupak/Pitts Amendment restrictions. States might subsidize a broader range of abortion procedures for these women, but the Stupak/Pitts provisions barring the commingling of funds in relation to plan administration may lead plans to resist coordination of benefits efforts with state programs. A plan that cooperates with a state Medicaid agency may be determined to put its own exchange or federal employee benefit plan participation at risk.

The small number of more affluent women (those earning too much to qualify for a subsidy) who gain access to individually-purchased exchange products might be able to afford to purchase supplemental coverage for additional medically indicated abortion procedures (if such a supplement exists) or a supplemental plan. But the Stupak/Pitts Amendment effectively requires that this additional coverage be administered separately from other plans. As a result, the cost of the supplement or the separate plan could be expected to be far higher than simply the cost of the additional procedures, as noted above. In other words, compared to other conditions, the cost of supplemental coverage for certain medically indicated abortions would be disproportionately high because of the additional administrative expenses resulting from the Amendment. This added cost can be expected to drive down the market, leaving women in need of these procedures with serious financial exposure.

Medically indicated abortions carried out early in pregnancy may be relatively inexpensive. But the cost of abortions performed later in pregnancy and as part of other treatment for serious health conditions could be considerable. Indeed, medically indicated abortions carried out later in pregnancy and flowing from underlying health conditions or severe fetal abnormalities can carry a price tag in the thousands of dollars.<sup>21</sup> With the risk of cost for these conditions effectively excluded from the larger risk pool, the cost of a supplement or a plan that carries additional coverage could be considerable.

Women covered through small employers that elect to purchase coverage through the exchange would confront the same barriers as individual women who do not receive subsidies. Approximately 36

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<sup>19</sup> U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2009.

<sup>20</sup> America's Healthy Future Act of 2009, S. 1796, 111th Cong. (1st Sess. 2009), Sec. 1206.

<sup>21</sup> Stanley Henshaw and Lawrence Finer, *The Accessibility of Abortion Services in the United States, 2001*, Perspectives on Sexual and Reproductive Health, 35(1):16-24 (2003) (nonhospital surgical abortion charges ranged up to \$3000 at 16 weeks and \$2000 at 20 weeks); Agency for Healthcare Research and Quality, National and regional estimates on hospital use for all patients from the HCUP Nationwide Inpatient Sample, 2007 (mean charges for threatened abortion, abortion without D&C, and abortion with D&C, aspiration curettage or hysterotomy were \$9,964 to \$13,802).

percent of employees work for small employers (those with 99 or fewer employees).<sup>22</sup> If it is assumed that the figure is comparable for women and men, then millions of women who today derive coverage through small employers might be affected, depending on the extent to which small employers switch to exchange purchasing.<sup>23</sup>

To the extent that small employers migrate into the exchange system (as envisioned), the impact on employer-sponsored abortion coverage could be considerable as smaller employers that now regularly include abortion coverage in their plans move into a market in which similar plans may no longer be available unless specially marketed either as more comprehensive plans or as more limited plans linked to an abortion supplement. Simply put, the market for these women is highly speculative. Because the bills contemplate opening the exchange to employer plans of increasing size over the years,<sup>24</sup> the impact of the Stupak/Pitts Amendment on women with employer-sponsored coverage could be dramatic, especially since there is no indication that companies would develop comprehensive or supplemental products that cover a wider range of medically indicated abortions.

To be sure, a migration over time of thousands of smaller employers might encourage health benefit services companies to create supplemental abortion coverage products or offer plans that provide for more generous abortion coverage. But two facts militate against this. The first is the virtual non-existence of supplemental coverage products to date in states that bar the sale of products that offer abortion coverage. The second is that in contrast to a program such as Medicare Part D, which creates supplemental coverage for an entire class of benefits (prescription outpatient drugs), no federal policy will offer a financial stimulus for the creation of such a market. Indeed, federal policy is designed to push the price of supplemental coverage higher by prohibiting the integration of administration costs into a single administrative scheme.

## 2. Impact on women covered by large employers outside of the exchange

Ostensibly the Stupak/Pitts Amendment does not have a direct effect on large employers operating outside the exchange. At the same time, the Senate Finance Committee measure allows subsidies for individuals for whom employer coverage is not affordable or whose employer plans have low actuarial value. The interaction between public support to persons covered under ERISA plans and the Amendment is unclear. Even were a bright line to be maintained, with such individuals removed from their plans and enrolled in exchange plans, the interaction between the markets could further drive the industry to shift away from current abortion coverage norms and toward product designs that meet exchange and Hyde Amendment requirements.

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<sup>22</sup> U.S. Census Bureau, Statistics about Business Size (including Small Business), Employment Size of Employer and Nonemployer Firms, 2004.

<sup>23</sup> Bureau of Labor Statistics, Labor Force Statistics from the Current Population Survey, 2009. (There are approximately 67 million women over 16 currently in the workforce, of which 36 percent may be assumed to work in small businesses.)

<sup>24</sup> The House bill would permit employers with more than 50 employees to participate in beginning in 2015 and the Senate Finance Committee's bill would permit states to open their exchanges to large firms with over 100 employees starting in 2017. Affordable Health Care for America Act, H.R. 3962, 111<sup>th</sup> Cong. (1<sup>st</sup> Sess. 2009), Sec. 202(c)(3); America's Healthy Future Act of 2009, S. 1796, 111<sup>th</sup> Cong. (1<sup>st</sup> Sess. 2009), Sec. 1101 (new Sec. 2230(a); 2235(d)).

### 3. Impact on the health benefit services industry

#### *Withdrawing coverage of medically indicated abortions from all markets*

For the reasons noted above, health benefit services companies operating in either the Medicaid or exchange markets could be expected to resist offering coverage supplements or broader plans, since the legal and technical complexities of doing so far outweigh the potential market for the products. Not only would companies have to absorb all costs of administration into the supplemental or separate plan fee, but companies would confront having to expand provider networks to assure access to the full range of medically indicated abortions in the case of women who purchase expanded coverage. Health care providers can be expected to resist participating in supplemental networks if only because they will resist making their services available to some but not all of their insured patients, without any clear idea of which patients have which level of coverage. Furthermore, companies that offer supplemental coverage or separate plans may find extensive unwillingness to participate among providers that refuse to furnish abortions; while the legislation prohibits plan discrimination against providers that refuse to furnish abortions, it does not protect plans from providers who refuse to join a plan that offers broader coverage for medically indicated abortions, even if the provider does not have to furnish the treatment.

Furthermore, as the proportion of women of childbearing age covered by an abortion-related treatment exclusion grows, companies offering coverage products in the employer-sponsored market ultimately may elect to simply remove the procedures from their products so that they can be sold in all markets. Under these circumstances, what is the norm today in the employer-sponsored market – broad coverage of medically indicated abortions – is likely to narrow considerably as the industry seeks to restructure its product design to meet the most restrictive demands. If this consequence flows, then the industry, confronting the challenges of distinguishing between enrollees for a handful of covered procedures and specific conditions, can be expected simply to eliminate certain procedures and conditions from coverage altogether, leaving women and families exposed.<sup>25</sup>

#### *The spillover problem of coverage denials where the need for an abortion is secondary to the treatment of a medical condition*

An additional consideration is the potential for spillover effects from the administration of an exclusion that imposes a life-threatening coverage standard. If the entire industry moves to this life-threatening standard, it is likely that all women will risk coverage denials, regardless of the market in which their coverage is obtained.

Stupak/Pitts and Hyde, for that matter, presume that abortion is the immediate subject of the claim for coverage. In these cases, plan administrators must make complex decisions about whether treatment is for a life threatening condition or one that threatens health. But difficulties mount where the abortion procedure is part of broader treatment for a serious health condition, essentially an unfortunate downstream consequence of upstream treatment for a significant health problem, leading to the unwanted loss of a pregnancy. In these circumstances, how are plan administrators to distinguish between the abortion procedure and the rest of the treatment? Will the entire cost of a course of treatment (e.g., surgery to repair a damaged pelvis following an automobile accident) be denied if

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<sup>25</sup> Interview with Robert Laszewski. Health Bill Abortion Clause May Derail Insurance, Julie Rovner, *National Public Radio*. November 14, 2009.

abortion is part of the procedure? Health plan administrators, confronted with the prospect of a legal violation for paying for the excluded abortions, may elect to deny the treatment altogether, claiming that it is all related to the excluded treatment. As the denial is appealed, the financial consequences for patients potentially will be enormous.

This tendency to exclude entire classes of treatment where coverage of a particular treatment for a particular underlying condition is excluded can be seen in the case of HIV/AIDS, where the exclusion typically runs not only to HIV/AIDS itself, but also to conditions and health problems that are considered “AIDS-related.”<sup>26</sup> High risk pregnancies themselves could be identified as potentially abortion-related. Conditions such as diabetes (observed in 1% of pregnancies<sup>27</sup>) which are poorly controlled can lead to serious health consequences for both the woman and the fetus, including major congenital abnormalities, and a higher risk of spontaneous loss, which might in turn trigger an abortion if the pregnancy cannot be saved. Management of recurrent pregnancy loss<sup>28</sup> or complicated multi-fetal pregnancies (increasingly prevalent with widespread use of assisted reproductive technologies) may also be considered abortion-related conditions. Similarly, uncontrolled hypertension, trauma during pregnancy, seizure disorders and other conditions, all require complex management<sup>29</sup> and may persist beyond the pregnancy, and may result in abortion-related care. These concerns have increasing individual and public health consequence as age at pregnancy<sup>30</sup>, body mass index and associated metabolic and cardiovascular abnormalities, Cesarean section rates, multi-fetal pregnancy rates, and use of assisted reproductive technologies<sup>31</sup> have all increased dramatically in recent years.<sup>32</sup> Additionally, in response to more limited access to abortion services, there may be an increase in self-induced abortion, potentially through increased self-administration of misoprostol. Coverage for treatment of complications such as hemorrhage and incomplete abortion in such cases could be denied.

Thus, as an increasing proportion of the market for health benefits becomes subject to exclusionary regulation, coverage for all women can be expected to diminish industry-wide. Moreover, plan administrators, cognizant of the exclusionary regulations under which they operate, may be more likely to broadly interpret the exclusion in order to avoid the sanctions of being barred from the market or losing the right to collect subsidies. Since there is no similar sanction for improper claims denials other than to reinstate the coverage following a successful appeal, the risks all weigh in favor of overly broad interpretation of the exclusion.

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<sup>26</sup> *McGann v. H and H Music Company*, 946 F. 2d 401 (5<sup>th</sup> Cir., 1991); *Doe v. Mutual of Omaha*, 1798 F. 3d 557 (7<sup>th</sup> Cir, 1999), cert. den. 528 U.S. 1106 (U.S. Jan. 10, 2000).

<sup>27</sup> American College of Obstetricians and Gynecologists, Practice Bulletin, Number 60, *Pregestational Diabetes Mellitus*, March 2005.

<sup>28</sup> American College of Obstetricians and Gynecologists, Practice Bulletin, Number 24, *Management of Recurrent Pregnancy Loss*, February 2001.

<sup>29</sup> *Guidelines for Perinatal Care*; American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, pp 175-203, 2008.

<sup>30</sup> Between 1991 and 2001 the number of first births per 1000 women 35 to 39 years of age increased 36% and 70% for women aged 40–44 years. National Vital Statistics System, annual file; 2003.

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5419a5.htm>

<sup>31</sup> The reported number of ART cycles has increased from 64,681 to 134,260 ART cycles in 2005, and from 14,507 live-birth deliveries in 1996, to 38,901 in 2005. Centers for Disease Control and Prevention. *2005 Assisted Reproductive Technology (ART) Report: Section 5- ART Trends, 1996-2005*. Atlanta: Centers for Disease Control and Prevention; 2007.

<sup>32</sup> Luke, B., & Brown, M. (2007). Elevated risks of pregnancy complications and adverse outcomes with increasing maternal age. *Human Reproduction*, 22(5), 1264-1272.

## **Conclusion**

One of the great challenges in insurance reform is the unintended consequences of regulation. The Stupak/Pitts Amendment is intended to reach only a specific part of the market. But the cumulative effect of the provision, in combination with existing federal laws governing Medicaid and federal employee health benefits (as well as the law of certain states) inevitably can be expected to move the entire health benefits industry away from its current inclusive coverage norms and toward a new norm of exclusion. The provisions of the legislation, as well as the technical challenges that arise in benefits administration, militate against the creation of a supplemental coverage market. Thus, if the result of national health reform is to move millions of women into a market that operates subject to the exclusion, then it is fair to predict that the entire market for coverage ultimately will be affected as a product tipping point is reached and virtually no supplemental market appears.

In addition, given past experience and the sanctions that arise from a violation, it is reasonable to predict that in interpreting and applying the exclusion, health plan administrators will err on the side of coverage denial. This is because the legal risks associated with coverage determination are all on the side of incorrectly awarding coverage, not erroneously denying it. This balancing of risks can be expected to lead insurers to calibrate coverage determinations in a way that works against women whose medical conditions ultimately lead to an abortion that they never willingly sought.