CATHOLIC DEMOCRATS

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An Integrated Analysis of U.S. Public Abortion Policy, the Role of Medicaid & Private Health Insurance, and the Relationship between Universal Health Care and the Abortion Rate

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Interpreting the impact of the Patient Protection and Affordable Care Act (the Senate Bill) on abortion has emerged as a key component of the debate in the U.S. House of Representatives that will determine whether health care reform will become a reality this year. This policy brief presents an analysis of two key aspects of the debate:

- The *status quo* of the abortion policy in the United States and the challenges in defining it; and,
- The relationship between the availability of health insurance that covers abortion services and the utilization of insurance for abortion services. It also includes a new study by the president of *Catholic Democrats*, Dr. Patrick Whelan, which was published this week in the New England Journal of Medicine and reviews the impact of universal health care in Massachusetts on the incidence of abortion.

SUMMARY

- Although it was generally agreed that the *status quo* should be the measure for the treatment of abortion in the national health care debate, consensus parameters were never established. This led to unwieldy negotiations within Congress, and a debate that was confusing to the general public.
- Groups on the right have raised the Hyde Amendment as the standard against which provisions governing abortion should be judged. Groups on the left have developed a more market-based perspective centered on the availability of health insurance that covers abortion services. Using the example of a single payer system, a prudent application of both standards would provide the most legitimate and effective basis for maintaining the de facto *status quo*.
- Medicaid is reviewed as an example of a federal program that indirectly supports state-funded abortion procedures with federal funding. While morality and theology are essential lenses through which to view this debate, so too are the conclusions drawn from the perspective of the cost accounting and finance worlds, which are more relevant to addressing the question, "What is a direct versus an indirect cost?"
- *Catholic Democrats* estimates that approximately 50% of the non-elderly population has health insurance that provides abortion coverage today. At the same time there is evidence that indicates that only 13% of abortions are paid for through health insurance. This is a strong indication that the availability of abortion coverage is significantly underutilized by women

having an abortion and mitigates the assertion that increased abortion coverage will lead to a dramatic increase in abortion

- A new study published in the New England Journal of Medicine by Dr. Patrick Whelan, president of *Catholic Democrats*, reviews the experience of the Commonwealth of Massachusetts under its universal health care system (in place since January 2007) and indicates that health insurance coverage increased while the number of abortions decreased.
- The Massachusetts experience reflects that of other industrialized countries all of which provide universal health care coverage**,** and have accompanying lower abortion rate**s** then the United States. The late Cardinal Basil Hume explained this phenomenon by saying, "*If that frightened, unemployed 19-year-old knows that she and her child will have access to medical care whenever it's needed, she's more likely to carry the baby to term. Isn't it obvious?"*
- The Senate Bill includes almost $1.5 billion for "pro-life" programs that would help reduce the incidence of abortion, including $250 million for the Pregnancy Assistance Fund and $1.2 billion for increased federal adoption funding.

THE *CATHOLIC DEMOCRATS* PERSPECTIVE

Catholic Democrats has supported the platform position of the Democratic Party regarding abortion that was introduced by President Barack Obama in August 2008. That position promotes adopting policies that will reduce the incidence of abortion, in addition to supporting existing law. The 2008 Democratic Platform represented the first time either political party has introduced and accepted a plank that supports policies to reduce the number of abortions.

Based on empirical evidence, we have advanced the position that the most effective means to address the moral tragedy of abortion in our nation is to implement policies that will reduce its incidence rather than seeking to criminalize the practice through individual state law or through a federal Constitutional amendment. It is our position that the criminalization of abortion is a less effective, or even a counterproductive means, of reducing the incidence of abortion,

Catholic Democrats supported the Senate Bill at the time of its passage. See *Catholic Democrats* "Litany of Moral Injustice." Based on our review, and that of legal experts like Timothy Jost, law professor at Washington and Lee University, we believe that the Senate Bill is in compliance with the Hyde Amendment. In our opinion, the bill could be strengthened, particularly with respect to expanded coverage for undocumented immigrants, increased federal subsidies for the mandated purchase of health insurance, and the implementation timetable. However, most importantly, the legislation will insure 31 million additional people, moves our country forward on a critical Catholic social priority, cuts the federal deficit, and creates the opportunity – otherwise not available – to build on a dramatically improved health care system

Also for purposes of this analysis, those groups that seek to overturn Roe. v. Wade will be referred to as Status Quo Right (SQR) groups, and those seeking to sustain Roe v. Wade will be referred to as Status Quo Left (SQL) groups.

THE ROLE OF THE *STATUS QUO* ABORTION POLICY IN THE UNITED STATES IN THE HEALTH CARE REFORM DEBATE

Last spring, at the beginning of the national debate on health insurance reform, it was generally recognized that one of the most divisive issues would be insurance coverage for abortion services. It was also generally recognized that the debate needed to be focused on the broader health-care crisis and should not be distracted by the prosecution of the debate on abortion – a debate in which even President Obama himself has said there exists some irreconcilable differences.

To keep the debate focused – and therefore constructive – there was a general agreement that the means to do this would be to craft legislation that would maintain the "*status quo*" of the de facto abortion policy in our country. Put another way, there was general agreement that health care reform legislation should not enhance the position of either side in the abortion debate.

However, while there was agreement to maintain the *status quo*, attempts to precisely define the *status quo* have proven to be unwieldy. The result has been predictable. Without an agreed upon standard against which to evaluate different legislative proposals with respect to abortion, the negotiation of the competing abortion proposals became untenable. Each side has predictably advanced proposals they believe conform to the *status quo* while criticizing the other side for overreaching.

DEFINING THE *STATUS QUO*

How one defines the *status quo* depends in large part on your position on abortion. SQR groups have focused on the legal *status quo,* citing the Hyde Amendment as the definitive law prohibiting direct federal payment for most abortions. They rarely make any reference to the fungibility of federal funds in those states that provide abortion coverage for poor women, or in other words, an indirect subsidization of abortion. The Hyde Amendment does not restrict private insurance plans.

On the other hand, SQL groups have focused on the availability of abortion coverage in an insurance market that is being restructured by national health care reform and which the Hyde Amendment arguably did not anticipate. In deference to the Hyde Amendment, to which they are generally opposed, the SQL groups accepted at the beginning of the health care debate that certain groups (e.g. federal employees, Peace Corp Volunteers, members of the military, and poor women in states that do not provide Medicaid coverage for abortion) would not acquire abortion coverage under any new health plan. They were not prepared to accept an interpretation of Hyde that restricted abortion coverage for whole new populations (e.g. women with incomes below 300% of the federal poverty level in states across the country, regardless of the Medicaid abortion coverage policies in those states).

In other words, SQR groups were focused on the principle of no federal funds contributing in any new ways to pay for abortion, while SQL groups were focused on confining the Hyde restrictions to those populations currently barred from receiving abortion coverage. Given that the Hyde Amendment was passed at a time when national health care reform was neither a clear vision nor a vivid memory of past reform efforts in the national consciousness, consideration of both sets of concerns in any new definition of the *status quo* seems both reasonable and necessary.

To illustrate this, consider the example of abortion coverage within a hypothetical "single payer system." Critics of the Senate Bill, and the House Bill prior to the Stupak Amendment, would argue that abortion services could not be offered by a government-run single payer system, regardless of the societal health benefits that would accrue under such a system. Their reasoning would be that the Federal Government as the sole payer would be subsidizing any abortion services. This rationale would lead to a dramatic decrease in the coverage for abortion, which *Catholic Democrats* estimates currently to be approximately 50% of the non-elderly population (see page 5). It can be reasonably argued that the elimination of abortion services would not maintain the *status quo*, regardless of how one interprets the application of the Hyde Amendment. So a prudent application of both the funding aspects and the abortion availability aspects of the Hyde Amendment would provide the most balanced basis for maintaining the *status quo*.

Aside from different interpretations of the *status quo*, the debate of whether or not the Senate Bill conforms to Hyde has been dominated by impassioned rhetorical arguments with little reference to actual data available.

THE *STATUS QUO* AND MEDICAID

Noticeably absent from the debate so far has been an analysis of how Medicaid fits into the *status quo*. Given that this is a means-tested program that provides insurance for approximately 16% of the U.S. population (primarily non-elderly), a review is provided here.

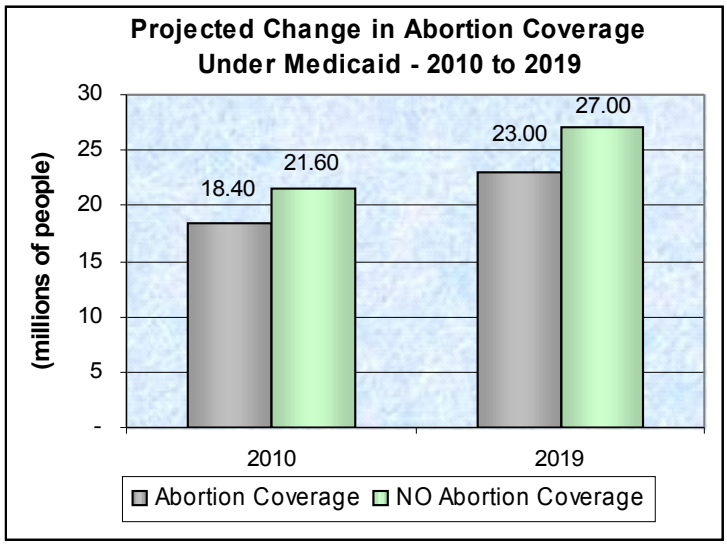
Medicaid was enacted by the Federal Government in 1965. The program, targeted to low income people, is administered by the states but funded jointly by the federal and state governments. Funding has historically been provided by a 55% / 45% split between the federal and state governments respectively.

The Medicaid program provided funding for abortion services subsequent to the enactment of Roe v. Wade, and prior to the enactment of the Hyde Amendment. Subsequently, a number of states have either passed legislation or have been mandated by state courts to provide coverage for abortion services. Today, seventeen (17) states provide for full state funding of abortion services through Medicaid. These 17 states comprise 46% of the U.S. population. Several other states provide funding under additional circumstances (*e.g.* abnormal genetic testing), and virtually all state Medicaid programs fund abortions for the Hyde Amendment exceptions (sexual assault, etc).

While Medicaid-funded abortion services in those 17 states are paid for with state funds, federal funds support the indirect costs, e.g. administrative expenses, of these Medicaid programs since all these states receive federal money. No one questions whether Medicaid is in compliance with the Hyde Amendment, yet federal dollars help support a network of programs nationally – administered by the Department of Health and Human Services – that provides abortion services. Medicaid is a component of both the legal and market *status quo*.

While morality and theology are essential lenses through which to view this debate, so too are the conclusions drawn from the perspective of the more objective realms of accounting and finance. The latter viewpoints are arguably more relevant in addressing the critical question, "What is a direct versus an indirect cost?" The case of Medicaid is instructive in evaluating the Senate Bill in

terms of understanding the *status quo* and in reconciling the inherent challenges for those who object to the Senate Bill on moral grounds.



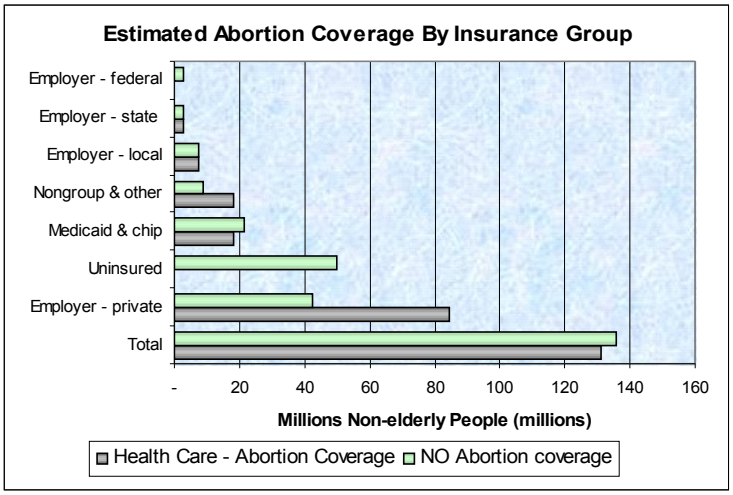
The Congressional Budget Office projects that the Senate Bill will cover an additional 10 million people under Medicaid between now and 2019. Of those covered, approximately 46% will receive coverage for abortion services. Abortion coverage for these 4.6 million (23.00 million less 18.40 million) people would have similarly increased under the House Bill – which was supported by the U.S. Conference of Catholic Bishops, once the Stupak Amendment was approved – because roughly half of all people covered live in states that provide public funding for abortion through Medicaid.

Some Evidence on the Relationship Between Abortion Coverage and Abortions

While the debate has focused on the incidence of abortion and the availability of health insurance that provides abortion coverage, little has been said about the causal effect between having health insurance that covers abortion and the use of that coverage.

SQR groups have charged that the Senate Bill will "open the flood gates" for federally-funded abortions. The implied logic of this perspective goes like this: national health care = abortion coverage, and abortion coverage = a watershed of abortions. However, the debate has lacked even the most rudimentary examination of the empirical evidence. *Catholic Democrats* offers some data and a new study that sheds some light on the SQR assertions.

The use of health insurance for abortion services



There have been at least two surveys that report the availability of health insurance with abortion coverage in the workplace – one by the Guttmacher Institute and one by the Kaiser Family Foundation. These studies show that between 87% and 46% of the people receiving health insurance in the workplace have abortion coverage. Medicaid provides abortion services to 46% of the poor population in the U.S. Based on this data, *Catholic Democrats*

estimates that approximately 50% of the non-elderly U.S. population currently has health insurance that covers abortion services.

Yet, a study by the Guttmacher Institute indicates that only "13% of all abortions in 2001 were directly billed by abortion providers to private insurance companies." Data is not available to determine the percentage of women with health insurance who have had an abortion, so both sides of the abortion issue have manipulated this statistic to support their case.

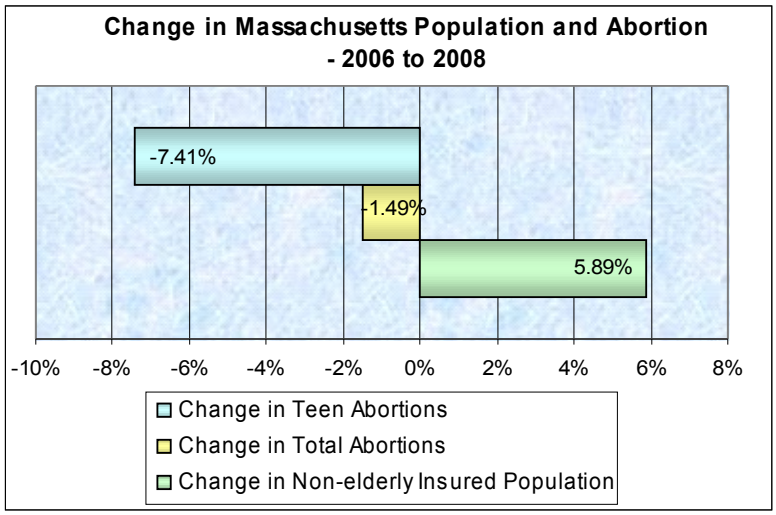
However, it is reasonable to assume that availability of health insurance to women having an abortion is likely to be normally distributed. Therefore, the data suggests that only 26% of abortions are paid for by health insurance providers, and the availability of health insurance coverage for abortion services is underutilized, i.e. women who have abortions and health insurance that covers the procedure do not use their insurance to pay for it. Consequently, the assertions that greater availability of health insurance providing abortion coverage will lead to "opening the flood gates" is, at least, overstated.

The impact of universal health care on abortion rates – the Massachusetts experience

A study published this week in the New England Journal of Medicine by Dr. Patrick Whelan, a pediatric and medical specialist at Massachusetts General Hospital and president of *Catholic Democrats*, was undertaken to see what impact the implementation of a universal health care policy in the Commonwealth of Massachusetts had on the incidence of abortion.

The Massachusetts plan, developed in part in consultation with the conservative-leaning Heritage Foundation, has been used as a basis of comparison to legislative proposals put forth in the national health care debate. It is similar to the proposed Senate Bill in mandating coverage, establishing an insurance exchange called the Massachusetts Connector, and does not include a public option.

Prior to the implementation of the Massachusetts program known as "Commonwealth Care," which provides subsidized health insurance to individuals with incomes below 300% of the federal poverty level, Massachusetts ranked ninth among states in the number of uninsured non-elderly adults (14% of the population in 2004-2005). Since implementation of the plan began in January 2007, the state ranks first with more than 94% of the non-elderly population being insured.



Dr Whelan's study found that since a universal health care system was implemented in Massachusetts in 2007, the number of insured non-elderly people has increased by 306,000 people to 5,499,000, an increase of 5.89%. At the same time the number of abortions has decreased from 24,245 to 23,838, a decrease of 1.49%. Abortions among teens decreased from 4,024 to 3,726, a decrease of 7.41%.

Sixty-three percent of newly insured adults were enrolled in the means-tested programs of Commonwealth Care or Medicaid.

Universal health care as an impetus to reduce abortion

A broader example can be seen in comparing the abortion rates in Europe, where universal health care coverage is available, to that of the United States. Data compiled by the United Nations indicates the United States has the highest abortion rates of any industrialized country. For example, Britain – whose population is approximately 8% Catholic versus 24% in the United States – has an abortion rate of 17.0 per 1,000 for women ages 15-44 compared to the U.S. which has an abortion rate of 20.0 per 1,000.

In an essay published this week, T.R. Reid (Washington Post, March 12, 2010) quotes the late Roman Catholic Archbishop of Westminster, Cardinal Basil Hume, who offered an explanation for the phenomenon of lower abortion rates in countries that provide universal health care and full abortion coverage. Cardinal Hume cited an anecdote to illustrate one important factor that is at the heart of the argument for those who believe that strategies to reduce abortion are the most effective means to address this moral tragedy:

> *If that frightened, unemployed 19-year-old knows that she and her child will have access to medical care whenever it's needed, she's more likely to carry the baby to term. Isn't it obvious?*

The results of the Massachusetts experience with the impact of universal health care on the incidence of abortion, and the UN data, are consistent with Cardinal Hume's explanation.

Abortion reduction legislation in the Senate Bill

In contrast to the initial House Bill, the Senate Bill includes central elements of the Pregnant Women Support Act which has the support of many of the pro-life Democrats who supported the Stupak Amendment. These measures would provide $250 million over 10 years to create a federal Pregnancy Assistance Fund and support pregnant victims of domestic violence. Also not frequently discussed is the increased federal adoption funding ($1.2 billion over the first two years) incorporated in the Senate Bill, but not in the House legislation.

CONCLUSION

The issue of abortion has been one of the primary obstacles to the passage of national health care reform. Central to this debate is whether or not the Senate Bill conforms to the *status quo*, a definition for which has not been agreed upon with SQR groups taking a strict legal perspective and SQL groups focused on not expanding the number of groups for whom abortion coverage is restricted. Both perspectives should be considered in this national debate, which will continue after a vote is taken on the Senate Bill.

The structure and administration of the federal Medicaid program – which in part defines the *status quo* – provides some instructive insights in evaluating these legislative proposals constructively.

Under current Medicaid law, federal funding indirectly supports abortion procedures for approximately 46% of the Medicaid population.
Critics of the Senate Bill have claimed that it will open the "floodgates" for abortion because of the increased health insurance coverage for abortion procedures. While health care coverage will increase for millions of people, our analysis and a review of the study by Dr. Whelan indicate that the utilization of abortion coverage will be much less than critics have claimed, and that passage of the Senate Bill will likely result in a decreased incidence of abortion.

Abortion-focused critics of the Senate health care reform bill currently under consideration in the House of Representatives have speculated wildly about the potential of the Senate Bill to expand the number of abortions but have chosen to overlook the unique contribution of the Senate Bill to abortion reduction programs, and have.

In summary, when joined to the moral imperative of providing care for an additional 31 million people, we believe that the final health care reform legislation bill deserves the support of all believing Catholics and other people of good will.