State Funding Limitations

A Proven Weapon in Reducing Abortions

By Mary E. Harned
Staff Counsel, Americans United for Life

In a 2007 policy review for the pro-abortion Guttmacher Institute, author Heather D. Boonstra laments that "... the most tragic result of the [federal and state] funding restrictions . . . [on abortions for Medicaid recipients] is that a significant number of women who would have had an abortion had it been paid for by Medicaid instead end up continuing their pregnancy."[1] Ms. Boonstra believes this result—the birth of a child—is more "tragic" than other results she lists, including a woman "divert[ing] money meant for rent, utility bills, food or clothing for themselves and their children" to obtain an abortion.[2] She cites studies demonstrating the effect that restrictions on public funding have on abortion rates—two decades of studies showed that 18 to 35 percent of women who would have had an abortion continued their pregnancies after losing Medicaid funding. Another study similarly showed that about one-third of women who would have had an abortion if it were publicly funded gave birth to their babies.[3]

But for restrictions on Medicaid funding for abortions, these babies would have never been born and their mothers would have faced all of the physical and psychological risks that abortions present. It is indisputable that prohibitions on public (taxpayer) funding for abortions save lives.

While Ms. Boonstra mourns these statistics as "tragic," they give great encouragement to pro-life Americans who want to protect unborn babies and their mothers. But for restrictions on Medicaid funding for abortions, these babies would have never been born and their mothers would have faced all of the physical and psychological risks that abortions present. It is indisputable that prohibitions on public (taxpayer) funding for abortions save lives.

The 2011 legislative year has arguably harbingered a new era in the use of funding restrictions to protect the unborn and their mothers. At least nine states diverted or withheld family planning funding from Planned Parenthood or abortion providers in general. These actions are having an immediate effect on the nation's largest abortion provider. New Jersey's Governor Christie first vetoed Planned Parenthood funding in 2010, and then again in 2011, resulting in the closure of two locations in the state so far.[4] A $1.8 million cut in funding for Planned Parenthood in New Hampshire may lead to the closure of one or more of its six centers,[5] and other dramatic cuts are certain

to have an impact, including the elimination of nearly $50 million in Texas.

Not surprisingly, at least three of these states are already in litigation over their new restrictions. Planned Parenthood and its allies are going to stop at nothing to protect their taxpayer funding, and when they cannot win in legislatures, they turn to the courts.

However, now is not the time to back down—states should aggressively pursue commonsense limitations on abortion funding, including prohibitions or restrictions on the following:

- State-authorized or appropriated funding for abortion;
- State funding to organizations that perform, counsel on behalf of, or affiliate with organizations that perform or advocate on behalf of abortion, including eliminating or restricting funding of organizations like Planned Parenthood;
- The use of state facilities and employees for the performance of abortions;
- Insurance coverage of abortions for public employees;
- Private health insurance coverage of abortions;
- Abortion coverage within new state Exchanges created pursuant to the *Patient Protection and Affordable Care Act of 2010* (PPACA); and
- The use of research grants, school-based clinics, and legal funds to promote abortions.

ISSUES

State Medicaid Funding

First enacted in 1976, the Hyde Amendment[6] forbids the use of federal and state matching Medicaid funds for abortions or abortion coverage except in cases where continued pregnancy endangers the life of the woman or where the pregnancy resulted from rape or incest. This standard guides both federal and state funding for abortions under joint federal-state Medicaid programs for low-income women. At a minimum, states must provide coverage for abortions performed in accordance with the Hyde Amendment exceptions. However, a state may, using non-federal *and* non-matching state funds, pay for other abortions. Currently, 26 states and the District of Columbia apply the same funding limitations provided for in the Hyde Amendment to non-Medicaid state funds; six states additionally pay for abortions in cases of danger to the woman's health or fetal abnormality; and one state only pays for abortions when a woman's life is in danger (contradicting the federal standard). Seventeen states pay for "medically necessary" or all abortions.

Importantly, because the Hyde Amendment is an appropriations "rider" that must be enacted by Congress every year, the federal limitation on the use of Medicaid funds to pay for abortions faces potential elimination annually. A recent effort to codify the Hyde Amendment as a permanent prohibition on *any* federal funding for most abortions is gaining strong support in Congress; however there are also many

in Congress who would abandon the Hyde Amendment altogether. Further, regardless of what happens in Washington, states should enact their own limitations on the use of *state* funding for abortions, abortion referrals, abortion counseling, the subsidization of abortion providers, and insurance coverage for abortions.

Prohibitions on Recipients of State Funding

States subsidize the abortion industry and give imprimatur to the practice of abortion—often inadvertently—in many ways. Unless states expressly prohibit abortion providers from obtaining public funds and resources, they may acquire taxpayer-funded grants and assets to bankroll their abortion businesses. To prevent or stop this practice, states have enacted a variety of measures to prohibit the use of public funds, facilities, and personnel for the performance of abortions or the provision of abortion counseling and/or referrals.

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Federal and state family planning funds are often exploited by abortion providers. To prevent abortion providers from subsidizing their abortion practice with public funds, states may prohibit them from receiving family planning funding. A state may also restrict organizations that receive state funds from associating with entities that perform and/or provide counseling or referrals for abortion. For example, it may prohibit the commingling of state funding with other sources of funding used to provide, refer for, or counsel on behalf of abortions. In the same vein, a state can also require the segregation of staff, facilities, and administrative support services between segments of a business providing family planning and other state-supported services and those providing abortions, abortion referrals, or abortion counseling.

At least 20 states have enacted prohibitions on the *use* of family planning funds for abortions, and many of these states prohibit abortion providers from *receiving* family planning funds. In 2003, Planned Parenthood unsuccessfully challenged the limitations imposed in Texas. Earlier that year, the Texas legislature had diverted about $13 million away from clinics that provided abortions and abortion-related services. In response, Texas Health Commissioner Eduardo Sanchez sent out a letter to Planned Parenthood and other state clinics receiving state family planning funding ordering them to cease providing abortions or face a loss of state funding. Ultimately, the State of Texas prevailed in a four-year legal challenge to the limitations.

Other laws enacted by states to target the subsidization of abortion include prohibitions or restrictions on the following: the use of *all* state-authorized or appropriated funds for abortions (at least 20 states); the use of some or all public funds by *organizations* for abortions, abortion counseling, and/or abortion referrals (at least

24 states); the use of *specific* state funds or programs for abortion-related services (at least 10 states); the use of some or all public facilities, such as public hospitals or school health clinics, and/or public employees for the performance of abortions or abortion-related services (at least 14 states); state contracts with abortion providers for the provision of abortions (at least eight states); the use of research grants (at least four states); abortion-related activity in school-based clinics (at least six states); and the use of state-subsidized legal services and Interest on Lawyer Trust Accounts (IOLTA) to advance abortion (at least three states).

To assist states with enacting these and other measures, AUL has developed the "The Defunding the Abortion Industry and Advancing Women's Health Act."

Limitations on Insurance Coverage

Public Employees

Because state taxpayer funds subsidize insurance policies for state employees, 15 state legislatures have enacted restrictions on the amount and type of coverage provided for abortions. Two states strictly prohibit abortion coverage for public employees, while five states have an exception for circumstances where the life of the woman is endangered by a continued pregnancy. Eight states provide exceptions beyond the women's life to cases of rape, incest or fetal abnormality.

To assist state legislators in prohibiting health insurance coverage of abortions for public employees within their states, AUL has developed "The Employee Coverage Prohibition Act."

Private Insurance

A large number of private insurance plans cover abortions. In fact, according to the Guttmacher Institute, "87% of typical employer-based insurance policies in 2002 covered *medically necessary* or *appropriate* abortions."[7] Many pro-life Americans, along with state legislators, are now seeking a way to prohibit insurance coverage of most abortions in their states. It is an accepted principle of economics and public policy that when you subsidize or pay for a service or product, you increase demand for that service or product. Moreover, it is reasonable to conclude that this principle applies to the delivery of medical care in general and to the provision of abortion in particular. Given that more women have abortions when they are covered by public programs, and public *or* private insurance coverage of a procedure generally leads to increased usage of that procedure, it is logical to conclude that the incidence of abortion would increase with the subsidization of private insurance plans that cover abortion.

Currently, eight states have laws, dating back as far as 1978, that prohibit private insurance plans operating within their states from covering most abortions. All eight have an exception for when the mother's life is at risk and one state also allows coverage when a pregnancy is the result of rape or incest, the mother's health is at serious risk, or there is a fatal fetal anomaly. Notably, seven states explicitly permit abortion coverage through the purchase of an optional rider and payment of an additional premium.

AUL has drafted "The Abortion Coverage Prohibition Act" to help legislators restrict abortion coverage by private insurance plans in their states.

Health Insurance Exchanges

The federal *Patient Protection and Affordable Care Act* (PPACA), signed by President Barack Obama on March 23, 2010, requires individual States to operate and maintain "health insurance Exchanges." Individuals with income up to 400 percent of the federal poverty level will receive tax credits to apply toward health insurance plans in the new Exchanges.

Health insurance plans offering abortion coverage are allowed to participate in a state's Exchange(s) and to receive federal subsidies unless the State legislature affirmatively opts-out of offering these plans. If a qualified individual chooses a plan that covers abortion, his or her tax credit cannot be used to directly pay for abortions; however, the tax credit subsidizes the insurance plan which covers abortions.

Importantly, specific language in the PPACA permits a state to opt-out of allowing insurance plans that cover abortions to participate in that state's health insurance Exchange(s).[8] While some states have existing laws that prohibit insurance companies in the state from offering abortion coverage except through a separate rider, under the PPACA, states that do not want abortion coverage in their Exchanges are required to affirmatively opt out of allowing abortion coverage by Exchange-participating health plans through new legislation or a new amendment to an existing statute. Otherwise, participating insurance plans are expressly permitted to include abortion coverage.[9]

To assist state legislators in opting-out of providing health insurance plans with abortion coverage through their Exchange(s), AUL has developed "The Federal Abortion-Mandate Opt-Out Act." Similarly, for states wishing to both opt-out of permitting abortion coverage in the Exchanges and to prohibit private insurance coverage for abortion, AUL has developed the "Exchange and Private Insurance Coverage Prohibition Act."

MYTHS & FACTS

Myth: State Medicaid funding restrictions discriminate against poor women and unfairly restrict them from exercising their constitutional right to abortion.

Fact: The Hyde Amendment, which guides both federal and state funding for abortions under joint federal-state Medicaid programs for low-income women, has been upheld by the U.S. Supreme Court. The Court specifically found that the restrictions on the use of federal funds to pay for abortions for low-income women were not unconstitutional.[10]

Moreover, abortion providers, such as Planned Parenthood, often purposely set the average cost for a first-trimester abortion below what

the market would bear, in part, to facilitate the delivery of abortion services to lower income women. The average cost for a first-trimester abortion is approximately $300 to $400, well below the average cost for most other office or clinic-based surgical procedures.

Myth: Restrictions on abortion counseling and referrals violate an organization or individual's First Amendment (free speech) rights.
Fact: Restrictions on the use of state funds for abortion counseling or referral have never been declared unconstitutional for any reason. It is perfectly legitimate for states, through the allocation of state funds and other programs, to demonstrate and implement a preference for childbirth and adoption over abortion.[11]

Myth: Restrictions on private insurance coverage for abortions could lead more women to seek cheaper "back-alley" abortions.
Fact: Medicaid recipients—those in the most financial need—are already prohibited from receiving abortion coverage through Medicaid under the Hyde Amendment (with exceptions for rape, incest, and life of the mother), a law that was found constitutional by the United States Supreme Court.[12]

Further, a 2008 Guttmacher Institute study found that "only 30% of abortion patients had private insurance. Among those who did have private insurance, about one-third used their insurance and nearly two-thirds (63%) paid out of pocket. In all, 12% of abortions were paid for with private insurance."[13] If only 12 percent of abortions are currently paid for with private insurance, it is illogical to think that prohibiting private insurance coverage of abortion will somehow lead to the widespread procurement of illegal abortions. Further, "safe, legal" abortions are not in fact very safe. States should be encouraged to enact laws that favor childbirth over the trauma of abortion and that do not inappropriately classify abortion as health care.

Endnotes

[1] H.D. Boonstra, *The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States*, Guttmacher Policy Review 12, 16 (Winter 2007), available at http://www.guttmacher.org/pubs/gpr/10/1/gpr100112.html (last visited July 20, 2011).
[2] *Id.* at 15.
[3] *Id.* at 16.
[4] Planned Parenthood Affiliates of New Jersey, available at http://www.plannedparenthoodnj.org/health/ (last visited July 20, 2011).
[5] Planned Parenthood of Northern New England, available at http://www.plannedparenthood.org/ppnne/nh-defunds-planned-parenthood-37170.htm (last visited July 20, 2011).
[6] Hyde Amendment to the Medicaid Act, Title XIX of the Social Security Act (1976).
[7] Guttmacher Institute, *Guttmacher Institute Memo on Insurance Coverage of Abortion* (July 22, 2009; updated Sept. 18, 2009), available at http://www.guttmacher.org/media/inthenews/2009/07/22/index.html (last visited Aug. 22, 2011) (emphasis added).
[8] Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18023(a) (2011) (providing that "[a] State may elect to prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law to provide for such prohibition").
[9] *Id.* at § 18023(b)(1)(A)(ii) (2011) (providing that "the issuer of a qualified health plan shall determine whether or not the plan provides coverage of [abortion] . . . as part of such benefits for the plan year").
[10] *Harris v. McRae*, 448 U.S. 297 (1980).
[11] *See Rust v. Sullivan*, 500 U.S. 173, 198 (1991).
[12] *Harris*, 448 U.S. 297.
[13] Guttmacher Institute, *Memo on Private Insurance Coverage of Abortion* (January 19, 2011), available at http://www.guttmacher.org/media/inthenews/2011/01/19/index.html (last visited Aug. 22, 2011) (emphasis added).