I. States that regulate abortion in **all** insurance plans[1]:

Note: states that forbid abortion coverage generally include an exception if carrying the pregnancy to term endangers a woman's life.

a) states that allow any insurance plan within the state to offer abortion coverage only **by optional rider:**

Kentucky	No insurance coverage of abortion under any plan offered unless "by an optional rider for which there must be paid an additional premium." KRS 304.5-160.
Missouri	No health insurance issued in the state can provide abortion coverage for except by "optional rider for which there must be paid an additional premium." MO St 376.801.
North Dakota	No health insurance plan can provide coverage for abortion except by optional rider with an additional premium paid. N.D.C.C. §14.02.3-3. State also has a "Domestic Relations and Persons" and Abortion Titles which states that no funds of "this state or any agency, county, municipality, or other subdivision thereof" can be used to cover abortion. N.D.C.C. §14-002.3-01-02.
Pennsylvania	Any insurance plan offered within the state must provide an alternative policy which excludes abortion. 18 P.S. §3215(e).[2] Insurance for state employees cannot provide abortion except in cases of rape or incest (reported to law enforcement within 72 hours) or life-threatening pregnancies. 18 P.S. §3215(d).

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[1] This chart contains information about state abortion funding regulations prior to enactment of the Hyde Amendment provisions which required funding in cases of rape or incest. Subsequent to this amendment, most states are now providing abortion funding for rape and incest victims, or have indicated to HCFA that they are taking action to comply. States that are resisting compliance (as of May 31, 1994) include: Arkansas, Colorado, Idaho, Kentucky, Louisiana, Michigan, Mississippi, Montana, New Hampshire, North Dakota, South Dakota, Utah. Kansas has indicated that it will not be complying until 1995. *Status of State Responses to HCFA Concerning Compliance with Hyde Amendment.*

Since all states must provide abortion funding for Medicaid-eligible women in cases of life endangerment, the states listed in the "♀'s life endangered" column are those that specifically provide that funding is available in such situations.

[2] Until this statute was amended in 1988, it had required the insurance company to offer the non-coverage plan at a lower premium. 18 P.S. §3215(e).

c) states that **allow** (but do not require) any health care plan within the **state to exclude abortion coverage:**

Iowa	"A health insurance program provided by an employer may exclude coverage of abortion" (except if woman's life is endangered or "where medical complications have arisen from an abortion"). Iowa statute §216.13(2).
Montana	The statute requiring minimum benefits for health association plans specifies that charges for abortion do not need to be covered unless the woman's life is endangered. MCA §33-22-1521(2)(b)(xii).

II. States specifically restricting abortion coverage for state employees:

a) States that **totally prohibit** abortion coverage for employees

Colorado	The state Constitution includes a provision that prohibits the use of public funds for abortion "either directly or indirectly." Colorado Constitution, Article V. A Colorado Attorney General Opinion asserts that under the state constitution group health care for state employees must exclude abortion coverage. 1985 WL 194202 (Colo.A.G. 1985).
Massachusetts	The state employees insurance statute specifies that its "policy, administrative services, or similar contract shall contain a condition that coverage for abortions shall only be included" if necessary to prevent the woman's death. M.G.L. 32B §3A.
Pennsylvania	No abortion coverage for state employees except in cases of rape or incest (reported to law enforcement within 72 hours) or life-threatening pregnancies. 18 P.S. §3215(d). Similarly, any insurance plan offered within the state must provide an alternative policy that excludes abortion (except in cases of reported rape or incest, and life endangerment). 18 P.S. §3215(e).[3]

[3] Until this statute was amended in 1988, it had required the insurance company to offer the non-coverage plan at a lower premium. 18 P.S. §3215(e).

Rhode Island[4]	No abortion coverage for state employees except in cases of rape, incest or life endangering pregnancies. R.I.G.L. 32-12-2.1. All health insurance contracts within the state can only provide abortion coverage by "an optional rider for which there must be paid an additional premium." R.I.G.L. 27-18-28.

b) states that only allow coverage for state employees by **optional rider:**

Idaho	Can only offer abortion coverage if employee pays for additional coverage. Whether or not to offer the opt-in is at insurance company's discretion. I.C. §41-3439.
Illinois	A State Employees Group Insurance statute states that: "[N]othing in this Act shall be construed to permit ... the non-contributory portion of any such program to include the expenses of obtaining an abortion ..." 5 ILCS 375/6(a).
Nebraska	No publicly funded insurance may provide abortion coverage but "[t]his section shall not prohibit the insurer from offering individual employees special coverage for abortion if the costs for such coverage are borne solely by the employee." Neb.Rev.St. §44-1615.01.

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[4] Rhode Island's statute was found unconstitutional (as violative of Roe v. Wade) in National Education Assoc. of RI v. Garrahy, 779 F.2d 790 (1st Cir. 1986). Furthermore, there seems to be a discrepancy in some of the state's policy since a rider is available statewide yet the state employees plan specifically excludes abortion and does not mention a rider at all. According to NARAL, state employees are not entitled to the rider.

III. Broad Statutes/Exclusion Possible

States with **broad anti-abortion funding policies** that could possibly be interpreted as prohibiting coverage **but have not been used** to do so:

Arizona	Under the "Budgetary and Fiscal Provisions for State Agencies" statute, no public funds nor tax monies ... passing through the state treasury" may be expended for abortion. A.R.S. §35-196.02.
Arkansas	State constitutional provision excludes abortion funding of any kind by the state. AR Const. Amendment 68, §1.
Indiana	"Neither the state nor any political subdivision may make a payment from any fund under its control for the performance of an abortion ..." 16 I.C. 34-1-2.
Louisiana	No public funds "made available to any institution, board, commission, department, agency, official, or employee of the state ... or any political subdivision therefore" from any "federal or state public source shall be used in any way for, to assist in, or to provide facilities for an abortion." 40 L.A.R.S. 1299.34.5.
South Dakota	Although this statute is specifically addressing medical assistance payments, it may be broad enough to cover state employees health insurance. The language in the state's "Medical Services to the Indigent" statute broadly says that "No funds of the state of South Dakota or any agency, county, municipality or any other political subdivision thereof and no federal funds passing through the state treasury or any agency of the state ... county, municipality or any other political subdivision thereof" shall be used to pay for abortion services. 28 S.D.C.L. 6-4.5.
Wisconsin	The state has a "General Administrative Provision" to its budget provisions that broadly states that "no funds of this state or of any county, city, village or town or of any subdivision or agency of this state or of any county, city village or town and no federal funds passing through the state treasury shall be authorized for or paid to a physician or surgeon or a hospital, clinic or other medical facility for the performance of an abortion." W.S.A. 20.927.

Wyoming	The state has an "Abortion" provision that prohibits any type of public funding. W.S. 35-6-117.

IV. No Specified Restrictions on State Employees

States which restrict state medical assistance funding but do **not specify any regulations of abortion coverage** for state employees.

Alabama
Connecticut
Delaware
Florida
Georgia
Kansas
Maine
Maryland
Michigan
Minnesota
Mississippi
Nevada
New Hampshire
New Jersey
New Mexico
North Carolina
Ohio
Oklahoma
South Carolina
Tennessee
Texas
Utah
Vermont
Virginia
West Virginia

V. No Denial of Any Type of Funding

States with no **funding restrictions** mentioned in state statutes or state Medicaid plan or regulations.

Alaska
California
Hawaii
New York
Oregon

VI. Coverage Provided

States which **affirmatively provide** abortion coverage for state employees insurance.

Washington	If the state provides maternity care benefits, services or information by "any program administered or funded in whole or in part by the state," it must also provide women with "substantially equivalent benefits, services, or information to permit them to voluntarily terminate their pregnancies." RCW §9.02.160.

Insurance Coverage of Abortion

X = state government employees O = private sector insurance plans

July 5, 1994

State	No coverage	Coverage Only By Rider	Option to Exclude Coverage	Broad Funding Ban Language (Could Possibly Affect Insurance but Not Applied)	Ban on funding but No Restrictions on insurance	No State Funding Restrictions	Affirmatively Provide Coverage
Alabama					X		
Alaska						X	
Arizona				X			
Arkansas				X			
California						X	
Colorado	X				O		
Connecticut					X		
Delaware					X		
Florida					X		
Georgia					X		
Hawaii						X	
Idaho		X					

State	No coverage	Coverage Only By Rider	Option to Exclude Coverage	Broad Funding Ban Language (Could Possibly Affect Insurance but Not Applied)	Ban on funding but No Restric-tions on insurance	No State Funding Restric-tions	Affirma-tively Provide Coverage
Illinois		X					
Indiana				X			
Iowa			O/X				
Kansas					X		
Kentucky		O/X					
Louisiana				X			
Maine					X		
Maryland					X		
Massachusetts	X						
Michigan					X		
Minnesota					X		
Mississippi					X		
Missouri		O/X					
Montana			O/X				
Nebraska		X					

State	No coverage	Coverage Only By Rider	Option to Exclude Coverage	Broad Funding Ban Language (Could Possibly Affect Insurance but Not Applied)	Ban on funding but No Restric-tions on insurance	No State Funding Restric-tions	Affirma-tively Provide Coverage
Nevada					X		
New Hampshire					X		
New Jersey					X		
New Mexico					X		
New York						X	
North Carolina					X		
North Dakota		O/X					
Ohio					X		
Oklahoma					X		
Oregon						X	
Pennsylvania	X	O					
Rhode Island	X[1]	O					

[1] Rhode Island's statute requiring abortion coverage only by additional rider has been declared unconstitutional by the First Circuit Court of Appeals. Furthermore, even though the state has a rider provision, the state employees' insurance statute denies all coverage, therefore, according to NARAL, state

State	No coverage	Coverage Only By Rider	Option to Exclude Coverage	Broad Funding Ban Language (Could Possibly Affect Insurance but Not Applied)	Ban on funding but No Restric-tions on insurance	No State Funding Restric-tions	Affirma-tively Provide Coverage
South Carolina					X		
South Dakota				X			
Tennessee					X		
Texas					X		
Utah					X		
Vermont					X		
Virginia					X		
Washington							X
West Virginia					X		
Wisconsin				X			
Wyoming				X			
TOTAL:	3	7	2	7	25	5	1

employees cannot obtain abortion coverage.

To Jodie
fyi

NARAL *Promoting Reproductive Choices*

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ABORTION COVERAGE AND HEALTH CARE REFORM: PROTECTING WOMEN'S HEALTH

1. Do private insurance plans currently cover abortion services?

Yes. The majority of private health insurance plans currently provide coverage for abortion services. Typically if an insurance policy provides coverage for pregnancy-related care, it includes abortion as part of that coverage. Excluding abortion from national health care reform would take away coverage from millions of women who currently have it.

In the first large-scale study of abortion coverage in private health insurance, the Alan Guttmacher Institute recently found that two-thirds of fee-for-service plans and 70 percent of HMO's cover abortion. Abortion is covered by such major insurance carriers as Aetna, Blue Cross/Blue Shield, Kaiser Permanente, Pacificare Health Systems, Principal Financial Group and the Travelers.

2. Will excluding abortion from health care reform harm women's health?

Yes. Although the need for abortion will not be diminished by taking away insurance coverage, abortion will become even further marginalized and isolated from mainstream medical practice. Already 83% of counties have no abortion provider. Given the host of anti-choice tactics being pursued to make abortion unavailable -- from state-imposed restrictions to bombings and clinic blockades to murder -- exclusion from health care reform would have a devastating effect on women's ability to exercise the right to choose. Lack of coverage will result in fewer doctors performing abortions and increased cost and delay in obtaining the procedure, which would endanger women's health and lives.

If health care reform takes away coverage for abortion, only women who could afford an abortion and find a provider trained and willing to perform the procedure would have access to safe services. Those women unable to overcome these substantial obstacles would be compelled to resort to unsafe alternatives or forced childbearing, and others would suffer delays resulting in riskier procedures. The American Medical Association recently concluded that "as access to safer, earlier legal abortion becomes increasingly restricted, there is likely to be a small but measurable increase in mortality and morbidity among women in the United States."

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3. Will including abortion in the basic benefits package encourage abortion?

No. Maintaining coverage for abortion, which most private insurers currently provide, will not encourage or increase the need for abortion. Insurance coverage does not lead to abortion -- unintended pregnancy does. Women choose abortion for complex moral and ethical reasons and out of concern for their health and their families. Providing coverage for a full range of reproductive health services, including contraception, would actually help make abortion less necessary -- but excluding coverage for abortion would endanger women's lives.

4. Would it discriminate against women to exclude abortion from the basic benefits package?

Yes. Singling out abortion, a medical service that only women need, would create a two-tiered health system, one for men and one for women. While women would be denied coverage for abortion, a medical service only women need, men would have coverage for male-specific services such as prostate operations. In a June 12, 1993 editorial, the New York Times stated: "To provide abortion services under a health insurance plan is not to give women a new benefit. Instead it's to continue the coverage most Americans already have under their private plans. To do otherwise is to discriminate against women pure and simple."

5. If health care reform includes abortion, will doctors or Catholic or other religious hospitals be forced to provide abortions?

No. President Clinton's health care reform plan and other proposals include a conscience clause that would ensure that health care providers -- individuals and institutions -- are not required to provide health services they oppose based on religious beliefs or moral convictions. Pro-choice Americans support a reasonable conscience clause and do not want to force medical professionals to perform any procedure against their will. The conscience clause must not, however, deny access to abortion, family planning, sterilization or other guaranteed services.

6. Should the conscience clause apply to health care plans and employers?

No. Expanding the conscience clause to include employers or insurance plans would open the door to all kinds of discriminatory treatment and undermine the goals of health care reform. If employers or health plans are permitted to single out abortion, what will be next? Eliminating contraception coverage because an employer is morally opposed? Excluding blood transfusions because an employer has religious objections? Or refusing to cover treatment for AIDs patients because an insurance company says it is morally opposed to their lifestyle? Neither an individual's employer nor their health insurance plan should be permitted to take away coverage for medical services.

7. Will including abortion in the basic benefits package overturn the Hyde amendment and require the use of taxpayer dollars for abortion?

Health care reform will take government out of the business of paying directly for medical services. Tax dollars will go to purchase health insurance, and the choice of which treatment to pursue will be left to women and their doctors. The basic benefits package for health care reform cannot be based on the personal beliefs or objections of some taxpayers. Some Americans oppose contraception, abortion, blood transfusions and AIDs treatment for moral or religious reasons, but health coverage for such medical services should be available to those who need them.

8. Would a fair compromise be to exclude abortion from the basic benefits package and let women purchase coverage through a rider?

No. Singling out abortion to be covered only through a rider is discriminatory. It would raise women's insurance premiums and violate their privacy -- and it wouldn't work. According to a recent poll conducted by Hickman-Brown Public Opinion Research for NARAL, the vast majority of American voters -- 72 percent -- believe medically necessary or appropriate abortion should be included as part of the basic benefits package. A clear majority -- 53 percent -- are opposed to requiring women who want abortion coverage to pay for an additional rider.

Women's health needs should be addressed in the basic benefits package, not tacked on as an "extra" that costs women more. Offering coverage through a rider would in effect take away coverage millions of women have today through private health insurance. Women would be unlikely to purchase the rider, in part because abortion is rarely anticipated. Confidentiality needs may also prevent a woman from obtaining the rider because rider selection may be highly visible to a woman's employer. Moreover, insurance companies would be unlikely to offer a rider because they would quickly become targets for anti-choice violence, harassment and boycotts.

A rider for abortion will open the door to requiring riders for contraceptives, AIDs treatment, health care for smoking- related illness and other medical services some people oppose. Adequate health coverage for all Americans -- the primary goal of health care reform -- can best be achieved by assuring coverage for a guaranteed comprehensive benefits package, not by requiring separate riders for each health care need.

9. Are anti-choice forces trying to take away coverage for contraceptive services?

Yes. Anti-choice groups are trying to take away coverage for abortion and contraceptive services. The American Life League, for example, claims that contraceptive devices "such as the . . . birth control pill, the IUD, Depo-Provera, and Norplant act part of the time by interrupting a pregnancy, rather than preventing one. Their mandatory inclusion in all health plans' coverage means that pro-lifers would be paying for chemical abortions against their will." Helen Alvare, Secretariat for Pro-Life Activities for the National Conference of Catholic Bishops testified before a subcommittee in Congress that "contraception and sterilization are themselves elective procedures . . . . Such procedures have a poor claim to the status of essential health services, and they should not be forced upon employers and individuals who have moral or religious objections to them."

10. Would health care reform that includes abortion overturn parental consent or notice laws, mandatory waiting periods or biased counseling requirements?

No. Although these laws are harmful to women, they would not be overturned by national health care reform. A guaranteed benefits package that includes abortion will not change the constitutional standard used to review state abortion restrictions.

11. Would including abortion in the basic benefits package require states to allow abortion through the ninth month of pregnancy?

No. Under Roe v. Wade and Planned Parenthood of Southeast Pennsylvania v. Casey, states are permitted to restrict or even ban abortion after viability, except in cases where there is a threat to the life or health of the woman. National health care reform will not change that.

INCLUDING ABORTION SERVICES AND CONTRACEPTION IN NATIONAL HEALTH CARE REFORM:
Pro & Con

ANTI-CHOICE If pro-abortion lawmakers get their way, health care reform will dramatically expand women's access to abortion.

PRO-CHOICE Abortion is already covered by two-thirds of private insurance companies, including Blue Cross/Blue Shield, Kaiser Permanente and Aetna. By providing coverage for the full range of reproductive health services, including contraception and abortion, our nation can ensure that women have access to medically safe abortion and at the same time make abortion less necessary. But if opponents of choice succeed in using health care reform to advance their own agenda, women will lose critical coverage for reproductive health services and the promise of universal health care will be wasted.

ANTI-CHOICE Americans shouldn't be forced to use their tax dollars to pay for abortions, which is precisely what will happen if abortions are covered under national health care reform.

PRO-CHOICE Health care reform will take government out of the business of paying directly for medical services. Tax dollars will go to purchase health insurance, and women and their doctors will choose what course of treatment to pursue. Abortion is a health issue, and individuals must be able to make their own health decisions. Women and their doctors -- not politicians -- should make the complex and personal decisions about abortion and contraception without interference from the government. That is as true for low-income women as for women of means, and national health care reform must not perpetuate the discrimination that currently denies poor women access to reproductive health care. A primary goal of health care reform is to ensure that all Americans have access to a basic health benefits package.

In addition, some Americans oppose contraception, abortion and even blood transfusions for moral or religious reasons, but these medical services are legal, and should be available to those who need them. The new health care plan must cover the full range of women's reproductive health services, and adequately address the moral and religious views of opponents of choice through a conscience clause that ensures that medical professionals and religious institutions are not required to provide abortion services.

ANTI-CHOICE Providing coverage for abortion under health care reform will encourage women to use abortion as birth control, lead to abortion on demand and make the number of abortions skyrocket.

PRO-CHOICE Maintaining coverage for abortion, which most private insurers currently provide, will not increase the need for abortion. Insurance coverage doesn't lead to abortion -- unintended pregnancy does. Women choose abortion for complex moral and ethical reasons and out of concern for their health and their families. Providing coverage for the full range of reproductive health services, including contraception, would actually help make abortion less necessary -- but excluding coverage for abortion services would endanger women's lives. Abortion already is unavailable in 83 percent of U.S. counties. If the new plan fails to cover abortion services, more doctors and hospitals will be reluctant to perform abortions, more medical schools will stop teaching the procedure, and the already severe shortage of abortion providers will grow worse.

ANTI-CHOICE Health care reform that includes coverage for abortion services will overturn state laws, such as parental consent and waiting periods, that restrict abortion.

PRO-CHOICE Although constitutionally permissible waiting periods, informed consent and parental consent or notice laws are harmful to women, they would not be overturned by national health care reform. In addition, states will still be able to restrict third-trimester abortions. National health care reform will regulate health insurance, not the delivery of medical services.

ANTI-CHOICE Contraception and abortion are elective services that are distinctly different from other medical procedures.

PRO-CHOICE For women, reproductive health care is primary health care -- and contraception and abortion are important reproductive health services. President Clinton's health care plan and many other proposals cover services that are medically necessary or appropriate, and contraception and abortion rightfully are included. Americans should remember what risks women were forced to take when contraception and abortion weren't available. We don't want to go back to those days.

ANTI-CHOICE Abortion and contraception really are moral issues, not health issues -- and they don't belong in a national health care plan.

PRO-CHOICE Abortion and contraception are and always have been health issues. Abortion was made legal in the U.S. after women were forced to sacrifice their health and even their lives through back alley or self-induced abortion. To deny coverage won't reduce the number of abortions. It will make abortion more dangerous and difficult, cause fewer doctors to perform and fewer clinics to offer the procedure, and cause higher rates of infant mortality and more children to be born too early, too small and too sick. If some Americans consider this a political issue, it is because opponents of choice have spent decades terrorizing women at health clinics and trying to pass laws that make abortion illegal and inaccessible -- but abortion and contraception really are basic reproductive health services.

ANTI-CHOICE Since so many Americans strongly oppose abortion -- and even more oppose abortion funding -- the fairest system would exclude abortion from the plan and allow women who wish to purchase coverage for abortion to do so through riders offered by insurance plans or by allowing insurance plans to offer abortion coverage if they want to. That way, people who consider abortion morally repugnant won't be forced to subsidize it.

PRO-CHOICE Singling out abortion services to be covered only through a rider is discriminatory. It would raise women's insurance premiums and violate women's privacy -- and it wouldn't work. Women's health needs should be addressed in the basic benefits package, not tacked on as an "extra" that costs women more. Establishing a system of riders would effectively take away the reproductive health coverage millions of women have today through private health insurance. Women would be unlikely to purchase a rider because abortion is rarely anticipated and because selection of a rider would become known to an employer. Insurers would be unlikely to offer such coverage because they would quickly become targets for anti-choice violence, harassment and boycotts. A rider for abortion services also would open the door to requiring separate riders for other medical services such as contraception because some people are opposed to it, or treatment of AIDS patients because some lawmakers are opposed to their lifestyle. Opposition to a medical service does not give anyone the right to redline health care treatment for millions of Americans.

ANTI-CHOICE Mandating coverage for abortion and contraception would force physicians and hospitals that oppose these services to perform them, and force institutions such as the Catholic and Mormon Churches to subsidize them.

PRO-CHOICE President Clinton's health care reform plan and several other proposals include a strong conscience clause that would ensure that health care providers -- individuals and institutions -- can decline to provide health services they oppose because of personal religious beliefs or moral convictions. Pro-choice Americans support a reasonable conscience clause, and do not want to force medical professionals to perform any procedure against their will. The conscience clause must not, however, deny access to abortion, family planning, sterilization, or other guaranteed services. Neither a woman's employer nor her health insurance plan should be permitted to take away coverage for services that are part of the guaranteed benefits package.

ANTI-CHOICE "Are we going to be so fem-centric that we're going to condone the self-indulgent conduct of the body of a woman who has already demonstrated in most cases they were damned careless with it in the first place?"
-- Congressman Dick Armey, R-Texas, a leading Congressional spokesperson in the campaign to remove abortion coverage from health care reform.

PRO-CHOICE Congressman Armey's callous statement reveals the underlying motivation of anti-choice Members who want to remove abortion coverage from health care reform. Their goal is to punish women, pure and simple. Their policy claims about "taxpayer dollars" and "abortion on demand" are smoke screens that are meant to conceal their anti-woman, anti choice agenda.

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Please Deliver Immediately

TO: Jennifer Klein

FROM: Gordon Trapnell

DATE: July 11, 94

RE: _____

MEMO: _____

There are 10 pages being transmitted (including this cover sheet).

If there are any problems with the transmission of this fax, please call the above number as soon as possible.

Memorandum

From: Gordon R. Trapnell

Date: July 10, 1994

Re: Alternatives to Abortion Coverage

1. Alternatives to Abortion Coverage

The primary objective is to find an alternative to abortion benefits that can be elected by persons morally opposed to abortion. Success in diffusing this issue, however, requires meeting a more stringent standard: that no funds paid for insurance by persons objecting to abortion be used to pay for them.

To meet the latter standard, in addition to offering a benefit of equal value to abortion, it must be clearly demonstrated that no funds contributed by persons objecting to abortions subsidized such coverage for others. Further, for the separation to be credible with the general public, there must be an objective, easily understood accounting procedure that demonstrates that no money for from those electing the alternative to abortions was used to pay for abortions.

In addition, it must be demonstrable that no public dollars are used to pay for the abortion benefit. This prohibition applies to both government subsidies toward premiums and government subsidies toward cost sharing.

If the funding of abortions is entirely through a separable, designated premium addition (or "rider") to which there is an alternative, then the premium subsidy issue is only raised by subsidies that reduce the contributions paid by an individual covered for abortions below such addition. Otherwise the employee contribution can be used to pay for the abortion coverage.

Similarly, only if there is a cost sharing subsidy that reduces out of pocket payments by an insured individual below those required for any abortions received would the issue of public subsidy of abortions be raised. Further, under the presumption that all persons whose premiums are fully subsidized would be enrolled in a low cost sharing plan, the cost sharing subsidy issue is relatively unimportant.

An additional question relates to whether it is necessary to demonstrate that contributions made by an employer that does not wish to pay for abortions have not been so used. The question would only arise when employers pay the full premium, since if there is an employee contribution it can be argued that the abortion benefit was funded by the employee. It can also be argued that employer contributions are simply an extension of wages, and

thus do not represent employer use of funds.

2. Policy Choices

The most important policy choices are (i) whether the option is made only by individuals or family units that are subject to the risk of needing an abortion or are available to all insured units, and (ii) the nature of the alternative coverage. Other important choices involve how the question of public subsidies of premiums is handled.

We will discuss the latter first.

a. Premium and Cost Sharing Subsidies

One solution to the issue of public subsidy of premiums that are used to pay for abortions is to charge a minimum contribution to all those who are take the abortion option and who would otherwise contribute less than the average cost of abortion coverage.

If the individual or family unit in question receives cash assistance, cash benefits could be reduced by the average cost of abortion coverage. It could then be argued, however, that public funds had paid for the abortion coverage, since the rider premium had been paid from welfare funds. It can also be argued that once welfare payments have been made, that the money belongs to the recipients. But given that welfare payments are based on an assessment of needs (one of which is the cost of the abortion coverage or the alternative), this argument may not hold. It does force opponents to present a more complex argument.

The issue of whether welfare recipients are using their own money to pay for abortion would be highlighted if some states increase welfare payments by enough to offset the minimum required contribution (i.e. the average cost of abortion coverage). This would make it clear that the abortion coverage was in fact being paid from public funds, although the beneficiaries of fully subsidized premiums would only have the same choices that other covered individuals have, i.e. to be covered for abortions or elect the alternative offered.

To avoid these arguments, it may be necessary to prohibit such state supplementation. In the longer run, however, as welfare payments are increased with living costs, it would be impossible to determine whether supplementation had taken place.

Thus diffusing the use of public funds issue may require a demonstration that welfare benefits were actually reduced. This is only if the minimum contribution is relatively small, e.g. less than $1 a month.

There is the further problem of defining the appropriate premium for abortion coverage. This depends in turn on how it is determined for purposes of offering an equivalent benefit, discussed below.

b. Separable Rider

The most credible manner to address the problem of demonstrating that those objecting to abortions are not paying for them is to make abortion coverage a "rider", i.e. separable, self supporting benefit, for which the premium is fully self supporting. The same rider premium would be charged to those not electing abortion coverage, but the funds raised from these premiums would be used for an alternative purpose. Thus there would be two separable rider pools funded by the same unit premiums, which could vary by demographic category if a different manner than the basic coverage.

The difficulty with this approach is that a majority of the population to be insured has no need of abortion coverage and is fully cognizant of this (especially the male half). Thus large proportions of those who have no particular problem with abortions will elect alternative benefits if they are found desirable. Further, limitation of the coverage to individuals and family units who fear they may need it (which may exclude a substantial portion of those that do) will raise the average cost to those electing such coverage. A higher abortion rider premium will make the level of the alternative benefits correspondingly more attractive, increasing their election and thus reducing the base for the abortion coverage further. Also, the rider cost will become large enough that funding the differential premium for persons with fully subsidized premiums from reductions in cash benefits impractical.

Thus for a system in which funds used to pay for abortions are clearly separable from other health insurance funds, those electing the alternative can not select against the system (i.e. all males or women not in child bearing ages electing the alternative). If the cost of abortions is averaged only over those who believe that they have a need for them, the average cost will be unacceptably high. (The suggestion that the premium would rise to the average cost of an abortion is extreme since as a practical matter predictions of need could never be that efficient; and based on insurance purchasing patterns, many families with a relatively low risk are likely to elect coverage. But a benefit cost of $25 to $50 could occur with a separable, optional abortion benefit.)

Given the absence of appeal of paying for an abortion benefit (except perhaps for families with teen age girls or single women at higher risk for unwanted pregnancies), adverse selection can be anticipated the latter is unlikely to be achieved unless the alternative use of the funds is something without much general appeal or the choice can be phrased as a simple option to avoid

using the funds to support abortion (and to some general fund otherwise).

The election must be limited to those who have a moral problem with abortion. This may achieved if the election is presented as a negative, conscientious objection, rather than the election for a preferred use for some of a payer's premium dollars. This would almost certainly be effective in the absence of any further attention.

There would appear to be a danger, however, that such an attempt to present the choice in this context would fail. The anti-abortion movements can be counted on to mount campaigns to persuade a high proportion of the population to take the none-abortion option, especially when they discover that this will drive up the cost for those electing abortion coverage and make it unaffordable for those with completely subsidized premiums. The campaign could well succeed despite the wording with which the choice is presented. (There is also the probability that some future Administration will be opposed to abortions and reword the choice accordingly.)

To reduce the chances that such a campaign would be successful, the alternate use of funds must be <u>both noncontroversial</u> and <u>relatively unappealing</u>. Some candidates:

- Used to reduce government contributions for subsidies or for those previously eligible for Medicaid
- Contributed to a fund to be used to reduce the National debt.
- Improved medical services in prisons

[Note: On further reflection, I believe that contributing to something as generally accepted by the public to be good as medical research might be appealing enough to provide the basis for a successful campaign to solicit such contributions and limit the base for funding the abortion coverage. Hence we need an inspiration for the right combination of absence of controversy or base for moral objections and absence of general appeal. I feel confident with enough thought by political consultants, the right cause can be found. (There is of course the danger that Congress would substitute something more appealing.)]

c. Option Available Only to Women of Child Bearing Age

Another approach would be to offer the alternative only to women who could conceivably have an abortion, i.e. between the ages of 12 and around 50-55 (and perhaps at older ages for women willing to certify that they can still become pregnant). The average value of the alternative benefit would be higher, but it would be offered

to fewer individuals and family units. This could have the disadvantage of making the alternative appear more desirable (since it is larger) but the possible advantage of widening the types of alternatives that could be offered. Thus the alternative could be a medical service perceived to be an alternative to abortion, such as birth control counseling, norplants, etc.

The primary disadvantage of this approach is that it does not diffuse the issues of who pays for abortions. Further, within the structure and under the rationale of community rating, it is difficult to argue that within the global pooling, such payments have not taken place.

d. Option with the Same Actuarial Value

Another approach would be to base the value of the alternative on the "actuarial value of abortions", which would be further defined to be the community rate for abortion coverage, since all other rates are community rated. This would have the advantage of reducing the value of the alternative benefit to the this actuarial value, which would not be increased by a reduction in the base from those electing the alternative.

This approach is also unlikely to diffuse the issue sufficiently for general acceptance by the public. It would not clearly assure that no commingled funds had been used to purchase abortions. Further, the arguments about community rating could be turned around in support of the view that all premiums that are community rated are in fact supporting every benefit offered to anyone in the community.

3. Mechanism to Keep Funds Separate

The process through which funds that pay for abortions are separated from those that do not is important, and must be sufficiently visible that charges by abortion opponents that funds are really being commingled will not convince the general public. Elements that might be incorporated:

- Separate trust funds onto which abortion and non-abortion premiums are deposited, and disbursements made to the respective purposes.

- An advisory counsel, representative of both abortion proponents and opponents, that meets at least once a year and produces a report that in effect verifies that the levels of earmarked premiums for abortions were self supporting, and that no moneys from abortion objectors were used to pay for abortions.

4. Cost Estimates

As set forth in my August 18, 1993 memo to Ken Thorpe (copy attached), we estimate the cost per capita for abortions as around $5.25 with the cost spread over the entire population under age 65. This estimate was based on data relating to the fee screen used by an insurer and an estimate from the Guttmacher Institute that there are 1.6 million abortions in the U.S. annually. The general level of the estimate was confirmed by data from an HMO. The actual cost nationwide, however, must be regarded as highly uncertain, and could be as low as $2 or as high as $6.

The estimate derived before was for the full cost of abortions per capita, i.e. was not reduced by the cost sharing in the indemnity plans. It was also loaded for the full 15% administrative costs.

There would appear to be no conceptual reason why the premium differential that is the base for the non-abortion election could not be limited to the benefits. (Alternatively, only the marginal costs of paying for abortions in addition to all other administrative services could be used as the base.) Applying the average cost sharing in the indemnity plan and without administrative costs, the prior estimate would be reduced to $3.89 (and is in the high end of the range of potential costs, i.e. a range of $1.50 to $4.50 similarly adjusted).

The "rider" premiums by demographic category would be approximately as follows:

Single	$ 4.77
Couple	9.55
Single parent	8.90
Full family	14.11

If the alternative benefit is set at the "actuarial value" (as misdefined above), these would be the annual contributions to be made to the alternative cause.

If the separate funds approach is followed, however, these amounts would be increased roughly in proportion to the decrease in the base, i.e. roughly doubled if 50% elected the alternative benefit. In practice, the increase would not be strictly in proportion, since inevitably some of those later seeking abortions will be in families that have elected the alternative.

The most sensitive of these amounts is probably that for single parents, since most welfare recipients at high risk of unwanted pregnancies will fall in this category. Obviously, if the proportion taking the alternative benefit rises as high as 30%, the annual cost will rise above $12.

5. Additional Considerations

Another problem to consider is that some of the abortions performed will inevitably be for women in family units that have not elected the abortion option. Some of these women will be poor and others will be in effect the victims of parental or spouse elections. Some thought may be merited for their position.

Memorandum

To: Ken Thorpe

From: Gordon R. Trapnell

Date: August 18, 1993

Subject: Cost of Abortions in Uniform Benefit Plans

Coverage

The question concerns the cost to include (or omit) abortions in the uniform benefit plan mandated for employed persons and offered through the health alliances. Plans offered by alliances would negotiate rates to be paid to providers for abortions, which would normally be in outpatient hospital or clinic settings. The service would be subject to copayments in integrated care plans and to deductible and coinsurance in fee for service plans and out of network providers in point of service plans.

(Note that abortions are not a covered service in the FEHBP, i.e. not included in the Blue Cross/Blue Shield Standard plan that served as a model for the coverage. But we have always assumed that abortions would be included in any plan promulgated by the Clinton Administration, and prepared covered services estimates accordingly.)

Some Facts

The number of abortions in the U.S. has varied between 1.5 million and 1.6 million each year since 1980. It was thus appear to be highly inelastic and impervious to restrictions on payment in public and private health insurance plans. (If there were as much as a 5% change in utilization rates, abortion coverage would more than pay for itself in terms of reduced medical care costs alone, when normal delivery costs and birth defects and complications of pregnancy are taken into account (without considering the Medicaid burdens of additional AFDC caseloads). It seems reliable to use 1.6 million as a base.

The cost per abortion varies by a number of factors, being lowest in subsidized settings and highest in private hospitals in urban areas. For example, Planned Parenthood in Washington, D.C. charges $265. But one large private insurer's prevailing charge screen allows $690 (for CPT 59840) and $839 (for CPT 59841). These indicate that the Planned Parenthood figure is probably subsidized, but also indicates that HMOs could probably obtain low cost services if desired.

Analysis

If the average cost of abortions in the U.S. is $500 in 1994, then the average cost to pay for them will be $800 million. This would be around $3.47 per capita per year (1994 total population of 230,318,000). Loaded for administrative costs, the additional premium should be around $3.87.

If the average cost for insured persons is $765, the average cost per capita is $5.26.

From my "average employer sponsored plan" matrix, projected to 1994, the cost for "terminated pregnancies" is $7.98 per capita. This includes miscarriages, accidental abortions and still births as well as "induced abortions" (which I believe is the figure we want). In 1988, 27.3% of pregnancies ended in induced abortions and another 14.4% ended in other fetal losses. Applying these proportions to the average cost of employer plans per capita, we get an estimate of $5.22 per year per capita. (The apparent close agreement is undoubtedly a coincidence.)

Recommended Estimate

The premium figure probably represents the choice of providers made by insured individuals with access to whatever setting they like. The average figure reflects the choices available to the average woman seeking an abortion, which is heavily weighted to low income women. An estimate of $5.25 takes care of insurance as currently offered. An aggressive HMO may be able to negotiate a much lower figure.

Although there does not appear to be any impact of coverage on utilization in the national figures, it is still tempting to suggest that there must be some substitution effect, and that very small substitutions would be a high proportion of the total cost.

Memorandum

To: *Ken Thorpe*
Jennifer Klein

From: *Gordon R. Trapnell*

Date: *July 25, 1994*

Re: *Cost of Optional Abortion Coverage If Experience Rated*

The attached memorandum explains that the relationship between the average experience rates for all persons electing abortion coverage and those not electing it will be determined primarily by selection effects, i.e. by the average need for health care among the two groups, rather than the cost of abortions or the consequences of not having access to abortions. Further, the difference in the costs for the two groups will reflect many other aspects of the reform proposal and how coverage is financed. In particular, age-sex specific rates and risk adjustment would tend to produce experience rates that come closer to differences attributable to the presence of the abortion coverage.

In view of the complexity of the question and the interdependence of the answer with so many other aspects of health care reform, I have no easy answer for this one. With age-sex specific rates, however, I believe that the difference attributable to abortion coverage would be substantially less than if the cost of abortions is funded only by those who are willing to pay more for the coverage. I can not predict whether the difference would be less than the difference in whole population community rates.

One aspect is clear. The experience rate for a policy without abortion will not exceed the experience rate for a policy with abortion coverage, since many for whom abortion is not a practical possibility will always elect the lower cost policy. The question is thus how much less the experience rate for policies covering abortion will be.

cc: *Sharman Stephens*

Memorandum

To: *Ken Thorpe*
Jennifer Klein

From: *Gordon R. Trapnell*

Date: *July 25, 1994*

Re: *Cost of Optional Abortion Coverage If Experience Rated*

1. Proposal

The question has been raised concerning how rates for policies with and without abortion coverage would compare if the rates for all those enrolling for abortion coverage and those not electing it were experience rated separately. The differential cost to elect abortion coverage would then reflect all of the cost differences between the groups electing and not electing the abortion coverage.

2. Analysis

If each insurer and self insured plan must offer separate policies with and without abortion coverage, the rates may be set in several different ways.

- The difference can reflect the actual cost for that insurer of paying for abortions under the policies with abortion coverage.

- The difference in what that insurer's community rates would be with and without abortion coverage (the differential is reduced by any substitution effects).

- The difference can reflect the difference between the overall experience of those with and without abortion coverage, i.e. experience based rates for those with and without abortion coverage.

- The difference can reflect the difference between the overall experience of those with and without abortion coverage, adjusted for the actuarial composition of those electing and not electing abortion coverage.

- The difference can reflect the difference between the overall experience of those with and without abortion coverage, adjusted for the actuarial composition and average risk of those electing and not electing abortion coverage.

In addition, the differentials could be calculated from national data rather than the experience of a particular insurer. The last three of the above can be described as experience rated approaches, with and without adjustment for the actuarial and risk composition of the groups.

The question has been raised as to how the difference in average premium rates paid by those with and without abortion coverage would compare under one of the experience rated approaches.

3. Cost Impact

Under any of the experience rated options, the difference in premium rates attributable to coverage of abortions (or absence thereof) will be swamped by other major differences in utilization of health care services among the populations involved. The situation will also be very different depending on whether there is adjustment for the composition by age and sex adjustment (age is obviously not enough here) and by exposure to risk of needing medical services. If the premium rate without abortion coverage tended to be higher than that with abortion coverage, the premium rate would disappear, since a majority of those unwilling to pay for abortion coverage would have no objection if it did not cost more.

Without any adjustment for the different levels of need, nearly all single males, most females over age 50 and most families without (and perhaps a majority of those with) teenage girls will elect not to be covered for abortions unless the premium rates with abortion are the same or lower. At the other extreme, most women who have had abortions would be expected to elect coverage. Many of those women in child bearing ages who do not wish to become pregnant but unable to find a suitable method of contraception would also be expected to elect coverage unless they have personal objections to abortion. A key group would be the disabled population eligible for Medicaid, most of whom are not at risk of pregnancy and presumably would not pay more for abortion coverage.

It is difficult to project the overall profile of those electing abortion coverage. Among those not expected to elect such coverage, single males are the least expensive in the population. But adult females and those having children are the most expensive.

If there is age and sex adjustment, most of the effects above will be removed. The difference in experience rates will be determined on the relative costs for those electing abortions and those not electing abortions with age and sex groups. Since maternity accounts for a significant portion of health care expenditures, however, and those electing abortion coverage in any year are unlikely to bear children, there would be a significant

bias toward a higher premium for those unwilling to pay for abortion coverage. On the other hand, fear of needs for abortions could be correlated with other health care problems. The elections of the disabled population will become more important in determining the relative experience rates.

If there is risk adjustment in addition to age and sex adjustment, the impact will depend on the accuracy of the methods used, and whether pregnancy was considered a condition for which there should be risk adjustment. If risk adjustment is perfect and includes pregnancy, the average difference in premium rates would revert to the cost of abortion coverage, less any substitution effects.

cc: Sharman Stephens

Memorandum

To: *Ken Thorpe*
Jennifer Klein

From: *Gordon R. Trapnell*

Date: *July 25, 1994*

Subject: *Cost of Contraception Benefits in the HSA Benefit Package*

It has been proposed to offer health insurance policies with and without contraception, following the same general model as discussed for abortion coverage. The HSA benefit package includes the following types of contraception benefits (not including abortion which is not a method of contraception).

- Family planning consultation by PCP
- Contraceptive devices (apparently major expensive ones, not prophylactics, diaphragms, etc.)
- Oral contraceptives
- Vasectomies
- Tubectomies.

The relevant cost estimate is those services that would not be covered if the HSA benefit package did not regard any of the above as necessary medical care (which they appear not to be since most elections to control pregnancy are voluntary) or appropriate (which would appear to include all of the above). A large portion of counseling with regard to contraception occurs during office visits for other purposes. Similarly, many tubectomies are performed during caesarian deliveries for a relatively small additional charge. It is unlikely that these services would disappear if they were not covered. (It is interesting that an estimated 86% of health insurance plans and HMOs currently pay for sterilizations, presumably regarding them as "necessary and reasonable" medical care.)

We estimate the reduction in the average community rates for a HSA benefit package that excludes the contraception services listed above as 1.6%.

cc: *Sharman Stephens*

Memorandum

From: Gordon R. Trapnell

Date: July 13, 1994

Re: Cost of Optional Abortion Coverage:

1. Purpose

This memorandum is concerned with a specific proposal to structure coverage of abortions under health care reform in a manner that permits employers and employees to elect whether (i) to be covered for abortions and (ii) to pay for them.

2. Proposal

a. Elections

All health plans offered by employers would have two versions, one with and one without abortion coverage. Employers will decide whether abortion coverage is included in the base for the employer payment.

- If the employer chooses to include abortion coverage, the employer payment will be 80% (or more) of the average premium for a plans with abortion coverage. Employees who do not wish to have (or pay for) abortion coverage can elect the version of the chosen policy without it, and their contribution will be reduced by the percentage of the premium attributable to the abortion coverage (i.e. 20% of such difference if the employer is paying 80%). The employer contribution for those electing not to have abortion coverage is reduced by the employer share of the difference attributable to the abortion coverage.

- If the employer chooses not to include abortion coverage, the employer payment will be 80% (or more) of the average premium for plans without abortion coverage. Employees who wish to have abortion coverage can elect the version of the chosen policy with it, and pay (all of) the difference attributable to the abortion coverage.

Both employers electing not to pay toward abortion coverage and employees electing not to be covered for abortion coverage would have to certify under oath (i.e. a notary public) that such election was based on moral grounds. (Procedures similar to those used to establish grounds for conscientious objectors from military service? - or something less sectarian.] Once a election has been made, employers can not change it until the next open enrollment period. Individual elections can only be changed when a different

health care plan is selected.

b. Base of Premium Differential

The difference in premium rates for versions of health plans with and without abortion coverage would be set according to one of the following rationales.

- A predesignated rate, based on the estimated difference in the average premium rates that would be offered if abortion were included as a benefit and if it were not.
- A predesignated rate, based on the estimated community rate required to fund abortions, i.e. the numerator is the projected expenditures for abortions and the numerator would be the total population.
- The difference in the average community rates of plans that include abortion coverage and those that do not (where each plan determines the relevant community rates in each alliance area, presumably reflecting their actual overall experience).

The first of these calculation methods in effect allows for the substitution of other medical services for abortions by those not covered for them. The second does not. The last spreads the cost of abortions only over those with policies that include the abortion coverage.

For the third policy year, the predesignated rates could be recalculated based on data accumulated from the first year (and analyzed during the second).

3. Analysis

The funding effects of the abortion option are very different if the differential is based on a community rate rather than funded by those who believe they have a specific need for the coverage. The community rate under the first concept above would theoretically be slightly lower than the second, but is unlikely to be significantly different in practice since there are no substitutes (the fetus is terminated or a brought to term) and demand for abortions is highly inelastic. (For the latter reason we have not estimated a significant increase in abortions performed when there is a universal source of payment.) Further, the elasticity of demand is unlikely to be estimated with enough precision to be included in the kind of public methodology that would be required to support the calculation of the community rate.

The differential attributed to abortions will be substantially higher under a separate funds basis such as the third method

described above. How much higher depends on the degree of antiselection by employers and employees seeking lower costs for themselves, and how much the natural incentive to obtain lower outlays is impeded by the conscience statement.

Under the policy described, employers that choose not to pay for abortion coverage are essentially shifting the cost of paying for it to employees for those that elect abortion coverage, but will save a significant portion of the premium differential for those who do not. Further, in the absence of the certification, most employees would elect not to be covered, since they would not regard the need for an abortion to be a realistic possibility. Thus without the certification, the base for calculating the abortion differential will be relatively narrow, and the average cost over those that elect it will rise accordingly, along with the premium differential.

The degree of restraint produced by the certifications is thus crucial to the level of premium differential under the separate funds approach. Very different estimates can be obtained under an assumption that only those expressing comparable opinions in polls were willing to certify their objections and if the general public regards the certification in the same manner as say, speeding on an interstate highway or reporting purchases abroad to the U.S. customs. Accordingly, I will estimate the effect with a 33% objection ratio and a 67% objection ratio.

[Another danger is that the number of persons willing to state positions against abortion is likely to be increased to match the financially more advantageous position. (Abortion opponents should like the proposal, since it is likely to improve their standing in the polls.)]

Most larger employers are likely to make the coverage available as long as the rate differential is relatively minor (e.g. certainly if the differential is based on the full community rates). Most large employer plans will now pay for abortions. This practice is most likely to be continued, since no employees will be forced to have the coverage, and there is a tax advantage for employers to pay for it. Further, under the full community community rate concept, they will not have to cross subsidize the cost for the employees of employers that opt out. There should be a substantial opt out rate among small employers, corresponding to the actual religious beliefs of the owner-entrepreneurs and their key employees.

4. Cost Estimates

a. Community Wide Community Rates

Using the same cost basis as for my previous memoranda on this subject, we estimate the community rate for abortion services (i.e.

without administrative loads) would be $3.89 per capita with the cost spread over the entire population under age 65. This would constitute 0.29% of the average Health Security premiums ~~per capita~~ ($1,343). (The cost would be .33% of Health Security if a full administrative load was included.) This would be the applicable base for the differential under either of the first two calculation methods described above.

The (minimum) employer share of the abortion differential for employers not opting out would then be 0.23% of the premiums and the employee share (or savings if objecting) would be 0.6%. For objecting employers, the employer contribution would be decreased by the 0.23% and employees desiring coverage would have to pay the full 2.9% more.

b. Separately Funded Approach

Under the separately funded premium basis, the average premium differential will depend on the proportions of employers and employees that elect coverage. Opting out among employers should be relatively low among employers with as many as 50 employees, but rise as the size of the firm decreases, becoming as high as 75% (including those motivated primarily be cost considerations) among employers with fewer than 5 employees.

Among the employees of employers that do not opt out, those electing not to pay for abortion coverage would be expected to reflect those expressing strong moral objections to abortions in their own families (around 50% I believe). This proportion should rise to 75% or so among the employees whose employers refuse to pay for the coverage. (These are obviously wild guesses, and the actual results could be strongly affected by a number of unknown factors, including exactly what the certification says, whether it must be notarized, the publicity and effectiveness of campaigns to persuade employers not to offer the coverage (boycotts by abortion opponents?).

In view of the uncertainty surrounding the proportions of both employers and employees that opt out of the abortion coverage, estimates based on relatively low and high rates of participation may be considered. If only 33% are covered, the rates noted above will be trebled. If 50% are covered, the rates are doubled, and if 67% are covered the rates increase 50%.

Thus the cost is highly uncertain. The participation rate compounds uncertainty concerning just how much the abortions would cost under the new sets of conditions under health care reform.

c. Other Considerations

The basic cost estimate used above, $3.89 per capita, is derived from 1.6 million abortions and an average cost of $650, for

a cost of $4.47 per capita over 230.3 million persons under age 65, of which 87% would be paid by the insurance plans. The actual charges for abortion are somewhat lower than this, representing subsidies from a number of sources. For example, charges by Planned Parenthood in Washington D.C. average around $250. If the estimate were based on the actual payments for abortions by patients and their insurers, the cost differential attributable to abortion would be much lower, perhaps half of the figures noted above. Whether subsidies were continued would depend on many elements of the proposal and the environment created by the implementation of the program.

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, D.C. 20415

OFFICE OF THE DIRECTOR

Honorable Barbara A. Mikulski
Chairwoman, Subcommittee
on Aging
United States Senate
Washington, DC 20510-6300

Dear Senator Mikulski:

Thank you for your letter of August 2, 1994, requesting information concerning the Federal Employees Health Benefits (FEHB) Program. We are happy to provide you with the information you requested, and are responding to your questions in the order in which they were asked in your letter.

1) How many FEHBP plans are offered? How many are nationwide and how many are state or local plans?

There are currently 327 health insurance carriers participating in the FEHB Program. Fourteen are traditional fee-for-service plans available nationwide (seven open to all Federal employees and seven open only to members of specific employee organizations). The remainder are prepaid comprehensive medical plans (HMOs) serving specific geographic areas.

2) How many FEHBP plans offer abortion coverage to their enrollees? What percentage of the state plans and nationwide plans offer this coverage?

145 FEHB Program plans currently offer coverage for abortion. Nine fee-for-service plans (64 percent) and 136 prepaid plans (43 percent) offered abortion coverage in 1994.

3) Are there regulations which state that plans must inform the enrollee if they offer or do not offer abortion coverage? If it is not required that plans inform enrollees, do you have any information on how many state and nationwide plans volunteer this information?

All FEHB plans must describe their benefits in the individual plan brochures provided to all enrollees. All plans that changed their abortion coverage for 1994 noted that fact in their 1994 brochures in the section describing how their benefits changed in 1994.

Honorable Barbara A. Mikulski 2

4) Do insurers offer a plan that is the same in all benefits except one does not provide abortions? If so, is there any difference in the premium?

There are no FEHB Program plans that offer two separate benefit structures that are the same except for coverage for abortion.

5) What is the financial impact on 1994 premiums of FEHBP plans now that abortion can be covered?

We have no data on the behavior of Federal employees with respect to abortion. In estimating the financial impact on the 1994 premiums of FEHB plans, we assumed abortion coverage to be a cost neutral benefit. We do not project that the premium of any FEHB plan would increase or decrease as a result of any change in its level of abortion coverage, nor do we foresee any impact on overall FEHB Program costs as a result of such changes.

I hope this information is helpful.

Sincerely,

James B. King
Director

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To Jennifer Klein	From G. Trapnell
Co. (FYI)	Co. ARC
Dept.	Phone # 703-941 7400
Fax #	Fax #

August 8, 1994

Susan Tew of the Alan Guttmacher Institute
(212) 248-1111

The Guttmacher Institute conducted a survey in 1987 of family incomes of females obtaining abortions.

About a third had incomes < $11,000
Another third had incomes between $11,000 and $25,000
The other third had incomes over $25,000

They knew of no other survey on income and abortions