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## AN EXPANSION OF *RIGHT TO CHOOSE V. BYRNE*: PUBLIC FUNDING FOR ABORTIONS FOR THOSE BUYING INSURANCE UNDER THE NEW HEALTH CARE BILL

Saranne Weimer<sup>\*</sup>

### I. INTRODUCTION

In 1973, the Supreme Court decided one of the most well-known cases in history—*Roe v. Wade*.<sup>1</sup> In this landmark decision, the United States Supreme Court held that the constitutional right to privacy extends to a woman's right to have an abortion.<sup>2</sup> From 1973 through 1977, Medicaid<sup>3</sup> covered the costs of an abortion without restriction.<sup>4</sup> In 1966, Republican Senator Henry Hyde introduced an amendment to the Appropriations Bill,<sup>5</sup> which would place restrictions on the coverage of abortion.<sup>6</sup> In 1977, Congress passed the first version of the Hyde Amendment, and has been readopted it in some form every

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<sup>1</sup> See 410 U.S. 113 (1973).

<sup>2</sup> See *id.* at 154.

<sup>3</sup> Social Security Act of 1965, 42 U.S.C. § 1396 (West 2012). Medicaid is a health program available for individuals and families with low incomes. The program is jointly funded by the state and federal governments but is managed by the states. See *Medicaid Information by Topic*, CTR. FOR MEDICAID AND MEDICARE SERVS., <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/By-Topic.html> (last visited May 21, 2012).

<sup>4</sup> *Public Funding for Abortion: Medicaid and the Hyde Amendment*, NAT'L ABORTION FED'N (2006), [http://www.prochoice.org/pubs\\_research/publications/downloads/about\\_abortion/public\\_funding.pdf](http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/public_funding.pdf).

<sup>5</sup> Labor, Health, Education and Welfare Appropriation for Fiscal Year 1976, Pub. L. 94-439, § 209. The Appropriations Bill is used to provide money to discretionary (non-mandatory) programs through Congress. Appropriations measures provide about forty percent of total federal spending for a year. Appropriations bills provide money to agencies and projects authorized through the authorization bills. See JESSICA TOLLESTRUP, CONG. RESEARCH SERV., 97-684, THE CONGRESSIONAL APPROPRIATIONS PROCESS: AN INTRODUCTION (2012), available at <http://www.fas.org/sgp/crs/misc/97-684.pdf>.

<sup>6</sup> See TOLLESTRUP, *supra* note 5.

year since.<sup>7</sup> Initially, the restrictions under the Hyde Amendment allowed for abortion coverage in several circumstances including rape, incest, life endangerment, and physical health of the mother.<sup>8</sup> The scope of the amendment, however, has changed over time to become significantly more restrictive and the definition of “necessary” is narrow, leaving no room for coverage to protect the general health of the mother.<sup>9</sup>

Despite these federal restrictions on coverage, in 1982, the New Jersey Supreme Court decided *Right to Choose v. Byrne* where it held that the State Constitution requires New Jersey to fund the cost of medically necessary abortions<sup>10</sup>—including those necessary for the preservation of the *health* of the mother<sup>11</sup>—if Medicaid covers the cost of childbirth.<sup>12</sup> The court found that to fund only childbirth and not abortions necessary for the health of the mother was a violation of the Equal Protection guarantees of the New Jersey Constitution.<sup>13</sup> Thus, it became a requirement that New Jersey pay the cost of abortion services necessary for the health of the mother without using any federal funds. The decision remains largely untouched since 1982.

On March 23, 2010, health care in the United States underwent an enormous makeover when President Obama signed two bills into law to reform the health care system.<sup>14</sup> The Patient Protection and Affordable Care Act<sup>15</sup> (PPACA) and the Health Care and Education

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<sup>7</sup> *See id.*

<sup>8</sup> *Public Funding for Abortion, supra* note 4.

<sup>9</sup> By 1981, the restrictions had been narrowed so much so that funding was only available for life endangerment of the mother. *See Public Funding for Abortion, supra* note 4. In 1993, Congress re-included rape and incest. *See id.* This is the version that still exists today. *Id.*

<sup>10</sup> *Right to Choose v. Byrne*, 450 A.2d 925, 928–29 (N.J. 1982). The New Jersey Supreme Court rejected a definition of “medically necessary” that was limited to the preservation of the life of the mother. *Id.* (rejecting the statutory definition of N.J. STAT. ANN. § 30:4D-6.1); *see infra* Part III. The court recognized that New Jersey accords a high priority to the preservation of health and held that “[b]y granting funds when life is at risk, but withholding them when health is endangered, the statute denies equal protection to those women entitled to necessary medical services under Medicaid.” *Right to Choose*, 450 A.2d at 934.

<sup>11</sup> As noted above, this is broader than the restrictions placed on the use of federal funds for abortion. *See Public Funding for Abortion, supra* note 4.

<sup>12</sup> *See Right to Choose*, 450 A.2d at 937.

<sup>13</sup> *See id.* at 933 (citing N.J. CONST., art. 1, para. 1).

<sup>14</sup> *See infra* text accompanying notes 15–20.

<sup>15</sup> Pub. L. No. 111-148, 124 Stat. 199 (codified in scattered sections of the Internal Revenue Code and 42 U.S.C.).

Reconciliation Act<sup>16</sup> (HCERA)<sup>17</sup> institute major changes that have begun to take effect and will continue to do so through 2014.<sup>18</sup> These bills seek to make health care coverage more accessible through government intervention; the bills essentially provide some form of government-subsidized health insurance for all individuals whose income level is up to four hundred percent of the federal poverty level.<sup>19</sup> This will drastically increase the number of individuals who have government-provided or government-subsidized health insurance.<sup>20</sup> Every one of the health care plans that the government provides or allows to be sold through the Exchange will cover the cost of childbirth, but exclude abortion to the extent that the Hyde

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<sup>16</sup> Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of the Internal Revenue Code and 42 U.S.C.).

<sup>17</sup> These two bills together are often referred to as the “Affordable Care Act” or “ACA” and therefore this Comment will use these terms to refer to both of the bills together. A consolidated version of the two bills is available at <http://www.ncsl.org/documents/health/ppaca-consolidated.pdf>. The

constitutionality of the ACA was challenged as an invalid exercise of Congress’ power after it became law. As this comment was being prepared for publication, the Supreme Court largely upheld the constitutionality of the ACA, but it did limit the power of Congress to condition continued receipt of federal funding for existing Medicaid programs on States’ participation in the Medicaid expansion created in the ACA. *See Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

<sup>18</sup> William Branigin, *Obama Signs Higher-Education Measure into Law*, WASH. POST, Mar. 30, 2010, <http://voices.washingtonpost.com/44/2010/03/obama-signs-higher-education-m.html?hpid=topnews>; *H.R. 3590: Patient Protection and Affordable Care Act*, GOVTRACK.US, <http://www.govtrack.us/congress/bill.xpd?bill=h111-3590> (last visited May 15, 2012).

<sup>19</sup> *See* Peter Grier, *Health Care Reform Bill 101: Who Gets Subsidized Insurance?*, CHRISTIAN SCI. MONITOR, Mar. 19, 2010, <http://www.csmonitor.com/USA/Politics/2010/0320/Health-care-reform-bill-101-Who-gets-subsidized-insurance>. One of the major changes that will occur is the implementation of the American Health Benefit Exchange (Exchange), discussed *infra*, which is essentially a state-operated marketplace to buy insurance subsidized by the government.

<sup>20</sup> Currently, certain individuals whose income levels are up to 133% of the federal poverty level qualify for Medicaid. *See* Mary Agnes Carey & Andrew Villegas, *New Law Offers Hope for Homeless Health Care*, KAISER HEALTH NEWS, Aug. 10, 2010, <http://www.kaiserhealthnews.org/Stories/2010/August/20/homeless-health-care.aspx>. For pregnant women, income levels to qualify for Medicaid extend to 200% of the federal poverty level for the time she is pregnant and sixty days following delivery. *Pregnant Women*, DEP’T OF HUMAN SERV. DIV. OF MED. ASSISTANCE & HEALTH SERV., <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/pregnant/> (last visited May 21, 2012). Through a separate program, State Children’s Health Insurance Program (SCHIP) coverage is expanded for children in families whose income is too high to qualify for Medicaid but still have limited resources. *See* CONG. BUDGET OFFICE, Pub. No. 2970, THE STATE CHILDREN’S HEALTH INSURANCE PROGRAM (2007), available at <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/80xx/doc8092/05-10-schip.pdf>.

Amendment requires, unless the State separately pays for the abortion coverage.<sup>21</sup> This raises a serious question for the State of New Jersey: Will the holding of *Right to Choose v. Byrne* extend to all of these individuals whose abortions are necessary for their health? If so, will New Jersey be required to pay the full cost of abortions for every woman in this position?

After *Right to Choose*, New Jersey is required to provide coverage for procedures beyond what is covered under federal law. New Jersey uses a broader definition of “necessary” than the federal government.<sup>22</sup> Imagine two concentric circles. In the innermost circle would be the circumstances that the federal government recognizes as “necessary” and therefore these are the procedures for which federal funds are available. The outermost circle would be what New Jersey considers “necessary.” It includes everything that the federal government deems necessary, as well as a whole other set of circumstances where only the health of the mother is of concern. In discussing the expansion of coverage, this Comment refers to the women who fall outside the innermost circle but still within the outer circle, where only health concerns make an abortion necessary. This is because women in the inner circle still have federal funds available to them and receive coverage without issue. So the question becomes, now that the government is acting on behalf of individuals purchasing insurance under the ACA,<sup>23</sup> whether or not they too are entitled to public funding for these same procedures. Essentially, will New Jersey have to pay for every “necessary” abortion, which the federal government does not recognize as necessary, for women earning up to four hundred percent of the federal poverty level? If the question is answered in the affirmative, should every qualifying woman receive complete coverage or a portion of the cost?

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<sup>21</sup> The ACA requires that Qualified Health Plans (QHPs) be sold through the Exchanges. To be a QHP, certain services must be covered. This includes the cost of childbirth-associated expenses. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1302, 124 Stat. 119 (2010) (to be codified in scattered sections of the Internal Revenue Code and 42 U.S.C.). See also *Focus on Health Reform*, THE KAISER FAMILY FOUND. (Apr. 2010), available at <http://www.kff.org/healthreform/upload/7908-02.pdf> (“[T]his uniform benefit package, referred to as the essential health benefits . . . must include at least the following general services . . . maternity and newborn care.”); *Patient Protection and Affordable Care Act of 2009: Health Insurance Exchanges*, NAT’L ASS’N OF INS. COMM’RS (Apr. 20, 2010), [http://www.naic.org/documents/committees\\_b\\_Exchanges.pdf](http://www.naic.org/documents/committees_b_Exchanges.pdf) (QHPs must include “essential health benefits” and the Essential Health Benefit Requirements include maternity and newborn care.).

<sup>22</sup> See *supra* note 10 and accompanying text.

<sup>23</sup> The issue of state action is discussed *infra* in Part V.A.

This Comment will address the central holding of *Right to Choose v. Byrne* and the potential implications it will have as the remaining portions of the ACA are implemented.<sup>24</sup> This Comment will argue that the holding of *Right to Choose* should extend to these women who will purchase their insurance through the American Health Benefit Exchange (Exchange) and that each of these women should receive full coverage. Instead of waiting for the New Jersey Supreme Court to decide this issue, the legislature should step in and mandate coverage for these women. Administratively, funding should look identical to the way that Medicaid and Family Care already operate. This Comment will argue that although covering only portions of the cost of an abortion, based on a sliding scale, may seem like a more “fair” way to administer coverage, there are several problems with such a method. Additionally, since cost-sharing already exists through premiums and copays in a way that is based on income, full coverage is a better policy. Part II will begin by examining the Hyde Amendment in closer detail. Part III will examine the holding of *Right to Choose v. Byrne* and what a “medically necessary abortion” is under federal law as compared to New Jersey state law. Parts IV and V will explore the current public health care options and the changes that will occur with the implementation of the ACA. Part VI and VII will examine potential solutions and the implementation of coverage.

## II. THE HYDE AMENDMENT

As discussed above, the Hyde Amendment,<sup>25</sup> passed in 1977,

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<sup>24</sup> This issue of abortion funding would be open to challenge by any woman receiving some form of government-subsidized health insurance who requires a medically necessary abortion, as defined by the state of New Jersey, but which falls outside of the federal definition of “medically necessary.”

<sup>25</sup> The Current Text of the Hyde Amendment reads:

None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, *shall be expended for any abortion.* (b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion. . . . The limitations established in the preceding section shall not apply to an abortion— (1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

Omnibus Appropriations Act of 2009, Pub. L. 111-8, §§ 507–08, 123 Stat. 802 (emphasis added).

places serious limitations on a woman's access to an abortion.<sup>26</sup> The Hyde Amendment is attached each year to the Appropriations Bill and will continue to last only for so long as Congress continues to adopt it.<sup>27</sup> Although subject to Congressional renewal each year, the Hyde Amendment has been readopted every year in some form.<sup>28</sup> The current Hyde Amendment, which has been in place since 1993, provides for the use of federal funds for abortion only in instances of rape, incest, and the preservation of the life of the mother.<sup>29</sup>

With the passage of the ACA, there was overwhelming concern from the conservative right and religious organizations that the government would bypass the Hyde Amendment,<sup>30</sup> despite the fact that the ACA specifically prohibited public funding for abortion services.<sup>31</sup> The main concern from these groups was that ACA funds do not come from the Appropriations Bill (to which the Hyde Amendment is attached) but are delegated *directly* to the ACA.<sup>32</sup> This

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<sup>26</sup> See *supra* note 9 and accompanying text.

<sup>27</sup> Memorandum from the Nat'l Right to Life Comm., Douglas Johnson & Susan T. Muskett, *Why the Hyde Amendment Will Not Prevent Government Funding of Abortion Under H.R. 3200, the House Democratic Leadership Health Care Bill* (Sept. 3, 2009), available at <http://www.nrlc.org/AHC/NRLCmemoWhyHydeAmtWillNotPreventGovtFundingOfAbortion.pdf>.

<sup>28</sup> See *Public Funding for Abortion*, *supra* note 4; see also *supra* note 9 and accompanying text.

<sup>29</sup> See P.L. 111-8, 123 Stat. 802 §§ 507–08.; see also *Public Funding for Abortion*, *supra* note 4.

<sup>30</sup> See Johnson, *supra* note 27; Dan Gilgoff, *Does House Health Care Bill Fund Abortion? Depends on Whom You Ask*, U.S. NEWS, Aug. 4, 2009, <http://www.usnews.com/news/blogs/god-and-country/2009/08/04/does-house-healthcare-bill-fund-abortion-depends-on-whom-you-ask>.

<sup>31</sup> See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1303, 124 Stat. 119 (2010) (Nothing in the Act requires states to cover abortion services described in subparagraph (B)(i) or (B)(ii) of the section as part of its essential health benefits for any plan year. Section (B)(i) specifically delineates “abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.”). Subsection (B)(ii) allows public funding for those which federal funding is permitted based on the law in effect as of the date that is six months before the beginning of the plan year involved. *Id.* at (B)(ii). Therefore, each year, states are free to exclude abortion services, which federal funds are not available for, six months before the start of the plan year. See *id.* The Act even allows states the option of *excluding* services in their qualified health plans for which federal funding is available in the six months before the plan year begins. This means that states are free to exclude from coverage abortions necessary to save the life of the mother and abortions in instances of rape or incest. See *id.*

<sup>32</sup> See Johnson, *supra* note 27; Gilgoff, *supra* note 30.

2012]

COMMENT

1685

means that the restrictions attached to the Appropriations Bill, specifically the Hyde Amendment, do not apply to these funds. On March 24, 2010, however, the day after President Obama signed the ACA into law, he issued an Executive Order requiring the continued restrictions in compliance with the Hyde Amendment to apply to the ACA.<sup>33</sup> The executive order reads, in pertinent part:

Following the recent enactment of the Patient Protection and Affordable Care Act (the “Act”), it is necessary to establish an adequate enforcement mechanism to ensure that federal funds are not used for abortion services (except in cases of rape or incest, or when the life of the woman would be endangered), consistent with a longstanding Federal statutory restriction that is commonly known as the Hyde Amendment . . . . The Act maintains current Hyde Amendment restrictions governing abortion policy and extends those restrictions to the newly created health insurance exchanges . . . that will be operational in 2014.<sup>34</sup>

Despite the issuance of this Executive Order, concern still exists that the government will provide federal money for abortions that fall within the scope of the Hyde Amendment.<sup>35</sup> These concerns, however, do not seem merited, as all actions by the government thus far indicate that the restrictions will apply to all monies designated to the ACA.<sup>36</sup> The focus of this Comment therefore will assume that the restrictions of the Hyde Amendment apply to *all* aspects of the ACA.<sup>37</sup>

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<sup>33</sup> Exec. Order No. 13535, 75 Fed. Reg. 15599 (Mar. 24, 2010), *available at* <http://www.whitehouse.gov/the-press-office/executive-order-patient-protection-and-affordable-care-acts-consistency-with-longst>. President Obama’s Executive Order was written in order to obtain the necessary support to pass the new health care bill; Obama was worried that conservative Democrats would not support the bill without assurances that abortions would not be covered. *See* Mimi Hall, *Health Care Law Raises Questions on Abortions*, USA TODAY, July 14, 2010, *available at* [http://www.usatoday.com/news/washington/2010-07-15-abortion15\\_ST\\_N.htm](http://www.usatoday.com/news/washington/2010-07-15-abortion15_ST_N.htm).

<sup>34</sup> Exec. Order No. 13535, *supra* note 33.

<sup>35</sup> Newer concerns are over the “high risk pools” that were not specifically prohibited from using funds for elective abortions in the Executive Order. High Risk Pools are a temporary way for individuals with preexisting medical conditions to receive coverage before the bill prohibits health insurance providers from rejecting individuals based on these conditions. This restriction will become effective in 2014 and the high-risk pools will no longer exist. *See* Hall, *supra* note 33.

<sup>36</sup> *See, e.g.*, Exec. Order No. 13535, *supra* note 33.

<sup>37</sup> Also note that certain sections of the ACA directly address the issue of abortion. *See supra* note 31.



### III. *RIGHT TO CHOOSE* V. *BYRNE* AND “MEDICALLY NECESSARY ABORTIONS”

New Jersey is one of seventeen states that has rejected the Hyde Amendment’s definition of “medically necessary” and created its own standard,<sup>38</sup> offering abortion coverage in all or most health circumstances.<sup>39</sup> Some of these states have done so through legislation and others through court mandates.<sup>40</sup> In New Jersey, this was done through a court decision.<sup>41</sup>

In *Right to Choose v. Byrne*, four pregnant women, a medical doctor, two nonprofit associations, and a religious association for abortion rights brought suit against the state officials responsible for administration of the state Medicaid statute, claiming denial of equal protection of the law after being refused Medicaid reimbursement for abortion procedures.<sup>42</sup> The court certified two classes: Medicaid-eligible women seeking funding for elective non-therapeutic<sup>43</sup> abortions and Medicaid-eligible women seeking funding for abortions which are medically necessary for the protection of the health of the women, although the pregnancies are not life-

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<sup>38</sup> The states are: Arkansas, Arizona, California, Connecticut, Hawaii, Illinois, Maryland, Maine, Minnesota, Montana, New Jersey, New Mexico, New York, Oregon, Vermont, Washington, and West Virginia. See *Women’s Health Policy Facts*, THE KAISER FAMILY FOUND. (June 2008), <http://www.kff.org/womenshealth/upload/3269-02.pdf> (citing *State Policies in Brief: State Funding of Abortion under Medicaid*, GUTTMACHER INST. (2008)). The focus of this Comment will be on the issue as it applies to New Jersey, although the problem will be common to each of these seventeen states. Because so much of the outcome will depend on a finding of state action, the way that each of these states organizes its “Exchanges” will play a major factor in the outcome of the court decisions. In states where the legislature has expanded access to funding for abortions, the analysis may be different and the outcome would depend on their own statutes. Therefore, although this may become a common problem in each of these states, this Comment focuses on New Jersey.

<sup>39</sup> *Public Funding for Abortion*, *supra* note 4.

<sup>40</sup> *Portrait of Injustice: Abortion Coverage under the Medicaid Program*, CTR. FOR REPROD. RIGHTS (May 1, 2004), <http://reproductiverights.org/en/document/portrait-of-injustice-abortion-coverage-under-the-medicaid-program>; see also *Hope v. Perales*, 634 N.E.2d 183 (N.Y. 1994); *Comm. to Defend Reprod. Rights v. Myers*, 625 P.2d.779 (Cal. 1981); *Doe v. Maher*, 515 A.2d 134 (Conn. Super. Ct. 1986); *Right to Choose v. Byrne*, 450 A.2d 925 (N.J. 1982); *Planned Parenthood Ass’n v. Dep’t of Human Res.*, 663 P.2d 1247 (Or. Ct. App. 1983); *Womens Health Ct. of W. Va., Inc. v. Penepinto*, 446 S.E.2d 658 (W.Va. 1993).

<sup>41</sup> See *Right to Choose*, 450 A.2d at 938; *Public Funding for Abortion*, ACLU, n.2 (July 21, 2004), <http://www.aclu.org/reproductive-freedom/public-funding-abortion>.

<sup>42</sup> *Right to Choose*, 450 A.2d at 929.

<sup>43</sup> Elective non-therapeutic abortions are those that are not necessary for the life or health of the mother. See *id.* at 937.

2012]

COMMENT

1687

threatening.<sup>44</sup> The court held that elective, non-therapeutic abortions do not involve the life or health of the mother, and therefore the state “may pursue its interest in potential life by excluding those abortions from the Medicaid program.”<sup>45</sup> But when it came to abortions necessary for the life or health of the mother, the court found that governmental interference is “unreasonable.”<sup>46</sup> Essentially the New Jersey Supreme Court held that, while completely elective abortions did not require public funding, abortions that were necessary for either the life or health of the mother must be funded for Medicaid-eligible women because Medicaid pays the costs associated with childbirth for these women.<sup>47</sup>

The main dispute in the case was the enforceability of N.J.S.A. section 30:4D-6.1, which excluded abortion coverage unless the life of the mother was in danger and required the doctor to submit a written report detailing the reasons. The statute, no longer interpreted as restrictive as the literal reading, says:

No payments for medical assistance shall be made . . . for the termination of a woman’s pregnancy for any reason except where it is medically indicated to be necessary to preserve the woman’s life. In any case where a pregnancy is so terminated, the act shall be performed in a hospital and the physician performing the act shall submit in writing a report to the division stating in detail his reasons for finding it necessary to terminate the pregnancy.<sup>48</sup>

By the time the issue reached the Supreme Court of New Jersey, lower courts had already considered the issue three times.<sup>49</sup> Because

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<sup>44</sup> See *id.* at 929.

<sup>45</sup> See *id.* at 937.

<sup>46</sup> See *id.*

<sup>47</sup> See *id.*

<sup>48</sup> N.J. STAT. ANN. § 30:4D-6.1 (West 2010).

<sup>49</sup> In *Right to Choose v. Byrne* [hereinafter *Right to Choose I*], 398 A.2d 587, 589–90 (N.J. Super. Ct. Ch. Div. 1979), the Chancery division enjoined the defendants from enforcing N.J.S.A. § 30:4D-6.1 and ordered the issuance of guidelines for funding Medically Necessary Abortions. See *Right to Choose*, 450 A.2d at 929. In response to this, the Department of Human Services proposed guidelines that incorporated the terms of the 1977 Hyde Amendment which permitted funding in those instances “where severe and long lasting physical damage to the mother would result if the pregnancy were carried to term” when so determined by two physicians. *Id.* at 929–30. These regulations were challenged and in *Right to Choose v. Byrne*, 405 A.2d 427 (N.J. Super. Ct. Ch. Div. 1973) [hereinafter *Right to Choose II*] the chancery division found that the regulations discriminated “against Medicaid eligible women with a medical necessity for an abortion without warrant of a compelling state interest, in violation of equal protection of the law.” *Id.* at 930. The court reached this decision by holding that health is a fundamental liberty shielded by the Fourteenth

the initial considerations of the case were largely based on federal law, the New Jersey Supreme Court granted certiorari to decide whether there was a state law claim.<sup>50</sup> The court engaged in a balancing analysis to determine whether the statute violated the Equal Protection guarantees of the New Jersey Constitution.<sup>51</sup> The court found that the statute restricting funding to abortions necessary to save the life of the mother was in violation of the New Jersey Constitution because a woman's right to terminate her pregnancy "outweighs the State's asserted interest in protecting a potential life at the expense of her health."<sup>52</sup> The court found that "the right to choose whether to have an abortion is a fundamental right of all pregnant women, including those entitled to Medicaid reimbursement for necessary medical treatment"<sup>53</sup> and that the statute "discriminates between those for whom medical care is necessary for childbirth and those for whom an abortion is medically necessary" because the statute only provides funds when their lives are at stake but withholds them when only their health is endangered.<sup>54</sup> Instead of declaring the statute unconstitutional, however, the court decided to interpret it in a less restrictive manner.<sup>55</sup> The court found that an appropriate interpretation was to

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Amendment to the Federal Constitution. *Id.* The Department of Human Services then issued new guidelines requiring the State to pay for all medically necessary abortions and determined that a finding of medical necessity could be based on (1) physical, emotional, and psychological factors, (2) family reasons, and (3) age. *Id.* (citing N.J.A.C. 10:53-1.14). In *Right to Choose v. Byrne*, 413 A.2d 366 (N.J. Super Ct. Ch. Div. 1980) [hereinafter *Right to Choose III*] the court awarded attorneys fees to the plaintiffs finding that N.J. STAT. ANN. § 30:4D-6.1 violated both Federal and State Constitutions. Shortly after this decision, the United States Supreme Court determined that the Hyde Amendment did *not* violate the Federal Constitution. *See Harris v. McRae*, 448 U.S. 297, 316-17 (1980). After that decision, which effectively overruled *Right to Choose II* and *Right to Choose III* because they were based on an interpretation of the Federal Constitution, the New Jersey Supreme Court decided to hear the case to determine if, as a matter of state law, plaintiffs could succeed on the merits. *See Right to Choose*, 450 A.2d at 926.

<sup>50</sup> *See Right to Choose*, 450 A.2d at 927-28.

<sup>51</sup> *See id.* at 936. The New Jersey Supreme Court does not analyze Equal Protection claims in the same way as the U.S. Supreme Court. Instead of using "tiers" of analysis the New Jersey Court uses a balancing test, particularly appropriate when a statute indirectly infringes on a fundamental right. *Id.* The New Jersey Supreme Court uses such a framework to analyze state claims because "conflicting individual and governmental interests do not easily fit into a rigid analytical structure." *Id.*

<sup>52</sup> *See id.* at 937.

<sup>53</sup> *Id.* at 934.

<sup>54</sup> *Id.*

<sup>55</sup> *See id.* at 938. The statute still exists in the same wording quoted, but it is now

2012]

COMMENT

1689

extend the limitation to cover abortions necessary to preserve the health of the woman.<sup>56</sup> The court also found that the determination of what is medically necessary for a woman's health should be made by a physician with the guidance of the Department of Human Services regulations.<sup>57</sup>

The holding was largely based on the New Jersey Supreme Court's finding that the New Jersey Constitution offers more protection than the Federal Constitution.<sup>58</sup> The court based this finding on the wording of the New Jersey Bill of Rights<sup>59</sup> and several different decisions in which the court reached the conclusion that by protecting life, liberty, and the pursuit of safety and happiness, Article I, Paragraph 1 of the state constitution also protects the right of privacy.<sup>60</sup> The court believed that relevant case law stood for the proposition that "under some circumstances, an individual person's right to control her own body and life overrides the state's general interest in preserving life."<sup>61</sup>

Although the court declined to go as far as the chancery court, which found that the New Jersey Constitution provided a fundamental right to health,<sup>62</sup> the State Supreme Court found that New Jersey affords a "high priority to the preservation of health,"<sup>63</sup> and therefore it would not be in accord with the state constitution to allow a prohibition on funding when the health of the mother is at

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interpreted with this expanded meaning. *See supra* text accompanying note 51.

<sup>56</sup> *See Right to Choose*, 450 A.2d at 938.

<sup>57</sup> *See id.*

<sup>58</sup> *Id.* at 933. "The [New Jersey] [S]tate Bill of Rights has been described as expressing the social, political, and economic ideals of the present day in a broader way than ever before in American History." *Id.*

<sup>59</sup> The New Jersey State Bill of Rights reads, "all persons are by nature free and independent, and have certain natural and unalienable rights, among which are those of enjoying and defending life and liberty, of acquiring, possessing, and protecting property, and of pursuing and obtaining safety and happiness." *Id.* at 933 (quoting N.J. CONST. art. I, para. 1).

<sup>60</sup> *See id.* The court notes that the right to privacy was found in various cases. *Id.* (citing *State v. Saunders*, 381 A.2d 333, 344–48 (N.J. 1977) (finding that the State Constitution provides a right to sexual contact between consenting adults); *In re Grady*, 426 A.2d 467, 474 (N.J. 1981) (finding a state constitutional right to sterilization); *In re Quinlan*, 355 A.2d 647, 652, 663–64, 669–70 (N.J. 1976) (finding a state constitutional right to terminate life), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976)).

<sup>61</sup> *See Right to Choose*, 450 A.2d. at 933 (quoting *Grady*, 426 A.2d 467).

<sup>62</sup> *See id.* at 930 (citing *Right to Choose II*, 405 A.2d 427 (N.J. Super. Ct. Ch. Div. 1973)).

<sup>63</sup> *Id.* at 934.

issue.<sup>64</sup> The court's main holding was that the challenged statute discriminates between those for whom medical care is necessary for childbirth and those for whom medical care is necessary for an abortion.<sup>65</sup> The court found that the statute denied equal protection to women entitled to *necessary medical services* under Medicaid<sup>66</sup> solely because of what the necessary procedure was<sup>67</sup> and skewed the decision "in favor of childbirth at the expense of the mother's health."<sup>68</sup> The court, however, was careful to note that it was not holding that the government must fund all medically necessary abortions, but rather that if the government decides to fund the cost of medically necessary procedures to bring a child to term, *then* it must fund the cost of medically necessary abortions.<sup>69</sup> It is important to note that the United States Supreme Court has found no constitutional violation in these instances.<sup>70</sup> Where funding is skewed in favor of childbirth, the U.S. Supreme Court has upheld such restrictions.<sup>71</sup> As discussed below, this aspect of the decision becomes important because under the ACA every insurance plan covers medically necessary childbirth costs.<sup>72</sup>

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<sup>64</sup> *Id.* at 935 n.6. The court found that drawing a distinction between life and health is not rationally related to any legitimate government interest and therefore would fail the most basic equal protection analysis. *Id.* at 936. The court described N.J. STAT. ANN. § 30:4D-6.1 as "an attempt to achieve with carrots what the government is forbidden to achieve with sticks." *Id.* (quoting L. Tribe, *American Constitutional Law*, § 15-10 at 933 n.77 (1978)).

<sup>65</sup> *See id.* at 934.

<sup>66</sup> *Id.* "We hold that the state may not jeopardize the health and privacy of poor women by excluding medically necessary abortions from a system providing all other medically necessary care for the indigent." *Id.* at 937.

<sup>67</sup> *See Right to Choose*, 450 A.2d at 934.

<sup>68</sup> *See id.* at 934-35.

<sup>69</sup> *See id.* at 935 n.5 & n.6, 937.

<sup>70</sup> *See Webster v. Reprod. Health Servs.*, 492 U.S. 490, 521-22 (1989) (upholding statute prohibiting public employees and public facilities from being used for abortions (therefore restricting use of government funds), unless the abortion is necessary to save the life of the pregnant woman); *Poelker v. Doe*, 432 U.S. 519, 521 (1977) (finding no constitutional violation when city elects to provide publicly financed hospital serves for childbirth without providing corresponding services for non-therapeutic abortions).

<sup>71</sup> *Webster*, 492 U.S. at 537.

<sup>72</sup> The ACA requires that QHPs are sold through the Exchanges. *See Qualified Health Plan Defined*, OFFICE OF HEALTH REFORM INTEGRATION, available at <http://hcr.amerigroupcorp.com/wp-content/uploads/2011/04/HRI-0120.pdf>. To be a QHP, certain services must be covered. This includes the cost of childbirth-associated expenses. *See Patient Protection and Affordable Care Act*, Pub. L. No. 111-148, § 1302, 124 Stat. 119 (2010); *see also Patient Protection and Affordable Care Act of 2009: Health Insurance Exchanges*, NAT'L ASS'N OF INS. COMM'RS (Apr. 20, 2010),

## IV. THE SYSTEM TODAY

Before engaging in an analysis of how the system is going to change, it is important to examine the system as it currently exists. The American health care system is different from the health care systems in many other industrialized nations.<sup>73</sup> Instead of having a system of comprehensive access to care, the United States relies heavily on employer-provided health insurance without mandating that employers provide health insurance.<sup>74</sup> This leaves millions of Americans uninsured or dependent on public programs.<sup>75</sup>

There are three main public programs in the United States that provide medical coverage to Americans: Medicare, Medicaid, and State Children's Health Insurance Program (CHIP).<sup>76</sup> Medicare is essentially a program for the elderly.<sup>77</sup> For this Comment, the role of Medicare is largely irrelevant. Medicaid is a health program for individuals that meet certain criteria, primarily low income or disability.<sup>78</sup> It is jointly funded<sup>79</sup> by the federal and state governments and is managed by the states.<sup>80</sup> There are different qualifying factors and circumstances that qualify individuals for Medicaid, the most

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[http://www.naic.org/documents/committees\\_b\\_Exchanges.pdf](http://www.naic.org/documents/committees_b_Exchanges.pdf) (QHPs must include "essential health benefits" and the Essential Health Benefit Requirements include maternity and newborn care); *Focus on Health Reform*, THE KAISER FAMILY FOUND. (Apr. 2010), available at <http://www.kff.org/healthreform/upload/7908-02.pdf> ("[T]his uniform benefit package, referred to as the essential health benefits . . . must include at least the following general services . . . maternity and newborn care.").

<sup>73</sup> See Janet M. Calvo, *The Consequences of Restricted Health Care Access for Immigrants: Lessons from Medicaid and SCHIP*, 17 ANNALS HEALTH L. 175, 177 (2008).

<sup>74</sup> *Id.* at 177–78.

<sup>75</sup> *Id.* at 178.

<sup>76</sup> *Id.*

<sup>77</sup> *Frequently Asked Questions*, MEDICARE.GOV, <https://questions.medicare.gov/> (last visited April 15, 2012).

<sup>78</sup> *Medicaid Eligibility*, CTRS. FOR MEDICARE & MEDICAID SERVS, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html> (last visited Aug. 6, 2012).

<sup>79</sup> The federal government's share of funding is known as the "Federal Medical Assistance Percentage" or "FMAP." See *Kaiser Commission on Medicaid Facts: Medicaid and the Uninsured*, THE KAISER FAMILY FOUND. (June 2010), available at <http://www.kff.org/medicaid/upload/7235-04.pdf>. Normally, the FMAP is at least 50% in every state and can be higher in poorer states. *Id.* Currently, the federal government is providing increased FMAPs to most states under the American Recovery and Reinvestment Act so that FMAPs range from 56% to 85%. *Id.*

<sup>80</sup> *Id.* The federal government and the states share the cost of Medicaid. The states design their own Medicaid programs in accordance with broad federal rules. See *Kaiser Commission on Medicaid Facts: Medicaid and the Uninsured*, *supra* note 79.

common of which is low income.<sup>81</sup> Income levels are based on percentages of the federal poverty level.<sup>82</sup> Typically, the qualifying level for Medicaid is 133% of the federal poverty level.<sup>83</sup> Also, coverage is expanded for pregnant women for the duration of their pregnancy and sixty days following delivery.<sup>84</sup> These women can have income levels up to 200% of the federal poverty level and qualify for coverage.<sup>85</sup> Additionally, a pregnant woman is considered a family of two for purposes of eligibility.<sup>86</sup>

Medicaid has improved access to care for many low-income people since its start in 1965.<sup>87</sup> Medicaid currently funds 16% of all personal health spending in the United States.<sup>88</sup> Previously, Medicaid services were provided on a fee-for-service basis in which Medicaid was directly billed for all procedures.<sup>89</sup> In 1995, New Jersey Medicaid began moving Medicaid clients from a traditional fee-for-service health insurance program into managed care HMO plans through Amerigroup NJ, Healthfirst NJ, Horizon NJ Health, and UnitedHealth Care Community Plan.<sup>90</sup> This means that Medicaid-eligible individuals are enrolled into an HMO plan instead of having

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<sup>81</sup> *N.J. Medicaid*, N.J. DEP'T. OF HUMAN SERVS DIV. OF MED. ASSISTANCE & HEALTH SERVS, <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/pregnant/> (last visited May 22, 2012).

<sup>82</sup> *See id.* The amount of money at each percentage of the federal poverty level depends on the number of individuals in the family. *See id.* Therefore, a family of two can make more money than a single individual and still fall within the requirements of Medicaid eligibility. *See id.*

<sup>83</sup> *See Carey & Villegas, supra note 20.*

<sup>84</sup> *N.J. Medicaid, supra note 81.*

<sup>85</sup> *Id.*

<sup>86</sup> *See id.* Because of the 200% threshold and the fact that a pregnant woman is considered a family of two, a pregnant woman living alone qualifies for Medicaid coverage during her pregnancy and for the sixty days following delivery of the child if she makes under \$2,428.33 a month. *See 2010 Poverty Guidelines: All States (Except Alaska and Hawaii) and D.C., CTR FOR MEDICAID SERVS., available at* <http://chfs.ky.gov/NR/rdonlyres/60830211-1431-4396-BB6D-991BA9D8EC23/240928/2010PovertyGuidelines.pdf> (last visited May 22, 2012).

<sup>87</sup> *See Kaiser Commission on Medicaid Facts: Medicaid and the Uninsured, supra note 79.*

<sup>88</sup> *Id.* It is important to note though that many scholars believe that Medicaid spends more than private insurance because it covers a sicker population. *See Diane Rowland, Medicaid: Issues and Challenges for Health Coverage of the Low-Income Population, 7 J. HEALTH CARE L. & POL'Y 106, 111-12 (2004).*

<sup>89</sup> *See N.J. Medicaid & Managed Care*, N.J. DEP'T OF HUMAN SERVS. DIV. OF MED. ASSISTANCE & HEALTH SERVS., <http://www.state.nj.us/humanservices/dmahs/info/resources/care/> (last visited February 9, 2011).

<sup>90</sup> *Id.*

2012]

COMMENT

1693

coverage provided directly from Medicaid. There are some services, however, which are still provided on a fee-for-service basis.<sup>91</sup>

In 1997, Congress created the State Children's Health Insurance Program as part of the Balanced Budget Act of 1997 to expand coverage to the gap between Medicaid and employment-based insurance.<sup>92</sup> This program provides "capped federal matching payments to states for coverage of uninsured, low-income children with incomes above . . . Medicaid standards."<sup>93</sup> Unlike Medicaid, SCHIP is funded through a block grant that is capped at a certain amount of federal funds.<sup>94</sup> The federal government pays for a higher share of spending under SCHIP than under Medicaid, with the "enhanced federal match" being "30% higher under SCHIP than Medicaid."<sup>95</sup> States "may use their SCHIP funds to create or expand a separate child health program, expand Medicaid, or use a combination of both types of programs."<sup>96</sup>

In New Jersey, the state has created the program "Family Care."<sup>97</sup> Within the State, Medicaid is also sometimes referred to as "Family Care" in an attempt to avoid the stigma associated with "Medicaid."<sup>98</sup> Family Care is technically a distinct program, funded, like Medicaid, jointly by the state and federal government, although in different proportions.<sup>99</sup> Family Care is not actually Medicaid, although practically, for those covered by Family Care or Medicaid, they appear to be the same thing. Family Care serves as a way to expand the number of individuals that qualify for coverage. Children whose families make up to 350% of the federal poverty level can receive coverage.<sup>100</sup>

<sup>91</sup> See *Kaiser Commission on Medicaid and the Uninsured*, THE KAISER FAMILY FOUND. (Feb. 2010), available at <http://www.kff.org/medicaid/upload/8046.pdf>.

<sup>92</sup> See Cindy Mann et al., *Historical Overview of Children's Health Care Coverage*, 13 THE FUTURE OF CHILD 31 (2003), available at [http://www.princeton.edu/futureofchildren/publications/docs/13\\_01\\_02.pdf](http://www.princeton.edu/futureofchildren/publications/docs/13_01_02.pdf).

<sup>93</sup> *Id.* at 35.

<sup>94</sup> *Id.* at 38.

<sup>95</sup> *Id.*

<sup>96</sup> *Id.*

<sup>97</sup> See *What Is It?*, N.J. FAMILY CARE, <http://www.njfamilycare.org/pages/whatitis.html> (last visited Apr. 10, 2011).

<sup>98</sup> Some scholars believe that certain people will avoid taking advantage of benefits to which they are entitled because of a stigma associated with the idea of a welfare program. See Arik Levinson & Sjamsu Rahardja, *Medicaid Stigma* (2004), available at <http://www9.georgetown.edu/faculty/aml6/pdfs%26zips/stigma.pdf>.

<sup>99</sup> See Mann et al., *supra* note 92.

<sup>100</sup> See *Income Eligibility and Cost*, N.J. FAMILY CARE, <http://www.njfamilycare.org/pages/whatItCosts.html> (last visited Feb. 5, 2011).



Outside of public programs, individuals in the United States have private insurance or are uninsured. Health care in the United States is often viewed as a huge failure.<sup>101</sup> The United States spends more than any other country when it comes to medical expenses but has little to show for it.<sup>102</sup> In 2005, the United States spent more than double the median per capita expenditure of the Organization for Economic Co-operation and Development (OECD)<sup>103</sup> countries on health care. Despite the incredible spending, the United States has worse-than-expected life expectancies, with only one OECD country coming in below the United States.<sup>104</sup> With such high costs for care, health insurance is a necessity in the United States.<sup>105</sup> However, only sixty-one percent of the non-elderly have employer-sponsored insurance and eighteen percent of the population is uninsured.<sup>106</sup> Even for those with insurance, health care associated costs can still be prohibitive. The United States is one of only a few countries with deductibles on core benefits and no limit on annual out-of-pocket spending.<sup>107</sup> With so many problems, it is not hard to see why health care reform has been a subject of dissatisfaction and a target of

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<sup>101</sup> The United States spends more money per person than every other country and a greater percentage of the national income is spent on health care than every other United Nations member state except East Timor. WORLD HEALTH ORGANIZATION, WORLD HEALTH STATISTICS (2009), available at [http://www.who.int/whosis/whostat/EN\\_WHS09\\_Full.pdf](http://www.who.int/whosis/whostat/EN_WHS09_Full.pdf). In an analysis of money spent on healthcare and outcomes measured in life expectancy, the United States has the worst performance, outspending every other country for three fewer years of life expectancy. Many of the countries with the highest life expectancies actually spend far less than the United States. Gerard F. Anderson & Bianca K. Frogner, *Health Spending In OECD Countries: Obtaining Value Per Dollar*, 27 HEALTH AFFAIRS 1718, ex. 3 (Nov/Dec. 2008), available at <http://content.healthaffairs.org/content/27/6/1718/F2.large.jpg>. The United States is also the only wealthy industrialized nation that does not ensure all citizens have coverage. *Health Insurance in the United States*, CLAIMAT MANAGED HEALTHCARE DATA, <https://www.claimat.com/kc-Health-Insurance-in-the-United-States.php> (last visited May 17, 2012).

<sup>102</sup> Catherine Hoffman & Julia Paradise, *Health Insurance and Access to Health Care in the United States*, 1136 ANNALS N.Y. ACAD. SCI., 149–60 (2008).

<sup>103</sup> The Organization for Economic Co-operation and Development is comprised of thirty-four industrialized nations. See *List of OECD Member Countries*, ORG. FOR ECON. CO-OPERATION AND DEV., [http://www.oecd.org/document/58/0,3746,en\\_2649\\_201185\\_1889402\\_1\\_1\\_1\\_1,00.html](http://www.oecd.org/document/58/0,3746,en_2649_201185_1889402_1_1_1_1,00.html) (last visited May 22, 2012).

<sup>104</sup> Anderson & Frogner, *supra* note 101 at 1722–23 & ex. 3.

<sup>105</sup> See Hoffman and Paradise, *supra* note 102, at 149.

<sup>106</sup> See *id.* at 150.

<sup>107</sup> Cathy Shoen et al., *How Health Insurance Design Affects Access to Care and Costs, By Income, In Eleven Countries*, 29 HEALTH AFFAIRS 2323, 2324–25 (Dec. 2010), available at <http://content.healthaffairs.org/content/29/12/2323.html>.

2012]

COMMENT

1695

political reform.

## V. THE ACA

It is important to note that with the implementation of the ACA, Medicaid and Family Care are explicitly left in place.<sup>108</sup> The ACA actually expands Medicaid coverage<sup>109</sup> to include non-disabled adults without dependent children.<sup>110</sup> It also substantially increases Medicaid funding to the states, completely covering the cost of new Medicaid enrollees for the first three years and then covering most of their costs thereafter.<sup>111</sup> One of the most prominent features of the ACA is the creation of the American Health Benefit Exchange (Exchange). A Health Exchange is essentially a place to “shop” for health insurance.<sup>112</sup> The ACA requires states to set up these new markets.<sup>113</sup> The federal government provides grants to states to establish these Exchanges as long as the states comply with regulations set forward in the Bill.<sup>114</sup> If a state fails to set up an exchange by January 1, 2013, as required by the Bill, then the Federal

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<sup>108</sup> See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 2101, 2201, 124 Stat. 119 (2010) (Each of these sections leave the Children’s Health Insurance Programs in place and provide incentives to continue to enroll at current levels).

<sup>109</sup> Carey & Villegas, *supra* note 20. The Bill will lift restrictions on Medicaid, and all individuals who make under 133% of the federal poverty level will be able to qualify for coverage. This will greatly expand coverage to a number of childless adults who have often been excluded. *Id.*; see also *Kaiser Commission on Medicaid Facts: Medicaid and the Uninsured*, *supra* note 79. However, it is important to note that the Supreme Court limited the ability of Congress to condition receipt of funds for existing Medicaid programs on the State’s compliance with the new Medicaid expansions under the ACA. See *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2601-03 (2012).

<sup>110</sup> Under Medicaid currently, non-disabled adults without dependent children are categorically excluded from Medicaid unless the state gets a waiver or uses only state money to cover them. See *Kaiser Commission on Medicaid Facts: Medicaid and the Uninsured*, *supra* note 79. Although states are allowed to include several other classes of people not mandated by federal law, the class of non-disabled adults with no dependent children is not an optional category for Medicaid coverage and cannot be included under current law. See Rowland, *supra* note 82, at 111.

<sup>111</sup> From 2014 through 2016 the federal government will completely cover the cost of those made eligible for Medicaid by expansions in the ACA. The federal share will phase down, leveling out at 90% for 2020 and thereafter. See *Kaiser Commission on Medicaid Facts: Medicaid and the Uninsured*, *supra* note 79.

<sup>112</sup> See Grier, *supra* note 19.

<sup>113</sup> See *id.*

<sup>114</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2793, 124 Stat. 119, Sec. 2793 (2010) (codified in scattered sections of Internal Revenue Code and in 42 U.S.C.).

Government has the ability to “establish and operate an Exchange within the State and . . . take such actions as are necessary to implement such other requirements.”<sup>115</sup> The purpose of the Exchange is to set up a system that facilitates the purchase of Qualified Health Plans (QHP).<sup>116</sup> There will also be a Small Business Health Options Program, referred to in the Bill as “SHOP Exchange,” to assist qualified small business employers in facilitating the enrollment of their employees in a QHP.<sup>117</sup> Each of the QHPs will cover the cost of childbirth-related expenses.<sup>118</sup> The ACA, however, explicitly allows for states to opt out of allowing the sale of QHPs that include abortion coverage.<sup>119</sup> Further, if a state does sell a QHP with abortion coverage, that state must pay for such coverage.<sup>120</sup>

In these Exchanges, individuals will be able to shop for insurance through a government-subsidized market.<sup>121</sup> Subsidies will also be available to essentially guarantee that no qualifying individual pays more than 9.8% of his or her income on health insurance

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<sup>115</sup> *Id.* § 1321.

<sup>116</sup> *Id.* § 1311.

<sup>117</sup> *Id.*

<sup>118</sup> The ACA requires that Qualified Health Plans (QHP) be sold through the Exchanges. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1302, 124 Stat. 119 (2010). To be a QHP, certain services must be covered. *Id.* This includes the cost of childbirth-associated expenses. *Id.*; see also *Patient Protection and Affordable Care Act of 2009: Health Insurance Exchanges*, NAT’L ASS’N OF INS. COMM’RS (Apr. 20, 2010), [http://www.naic.org/documents/committees\\_b\\_Exchanges.pdf](http://www.naic.org/documents/committees_b_Exchanges.pdf) (QHPs must include “essential health benefits” and the Essential Health Benefit Requirements include maternity and newborn care.); *Focus on Health Reform*, THE KAISER FAMILY FOUND. (Apr. 2010), available at <http://www.kff.org/healthreform/upload/7908-02.pdf> (“[T]his uniform benefit package, referred to as the essential health benefits . . . must include at least the following general services . . . maternity and newborn care.”).

<sup>119</sup> It should be noted that in New Jersey there is currently a bill pending before the legislature to have the state affirmatively opt out of allowing QHPs to be sold in the exchange if they include abortion coverage, except for those in compliance with the Hyde Amendment. See Assemb. 890, 215th Leg. (N.J. 2012), available at [http://www.njleg.state.nj.us/2012/Bills/A1000/890\\_I1.PDF](http://www.njleg.state.nj.us/2012/Bills/A1000/890_I1.PDF). It seems unlikely that this bill, if passed, would survive scrutiny in the New Jersey courts because every QHP in every state will cover the cost of childbirth-related expenses. The New Jersey Supreme Court has already held that it is an equal protection violation to provide coverage for the cost of childbirth but not an abortion where medically necessary. See *Right to Choose v. Byrne*, 450 A.2d 925 (N.J. 1982). In addition, the State uses a broader definition of medically necessary than the Hyde Amendment. See *supra* note 10 and accompanying text.

<sup>120</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1311(d)(3)(B), 124 Stat. 199 (2010); *infra* note 172 and accompanying text.

<sup>121</sup> Grier, *supra* note 19.

costs.<sup>122</sup> These subsidies will be calculated on a sliding scale so that the less money an individual makes, the more assistance the government provides.<sup>123</sup> The government expects that approximately twenty-five million people will shop<sup>124</sup> for insurance coverage in Exchanges.<sup>125</sup> Of these twenty-five million, approximately nineteen million are likely to be eligible for financial aid or government-subsidized coverage.<sup>126</sup>

The Exchange is for individuals who make more than Medicaid qualifying levels of income but may need assistance paying for health insurance. To demonstrate the effect of the ACA, this Comment will translate terms into actual amounts of income. Using the Medicaid standard of 133% of the federal poverty level, a single individual currently qualifies if he or she makes up to \$14,404 per year.<sup>127</sup> The amount increases as the family size increases.<sup>128</sup> For example, a family of four qualifies for Medicaid if the family makes up to \$29,326.50 per year.<sup>129</sup> Currently in New Jersey, approximately 452,900 people, or 5.3% of the population, have income levels that fall under 133% of the federal poverty level.<sup>130</sup> The ACA has a very complicated formula but essentially individuals may qualify for government-subsidized insurance based on a sliding scale of their income, with qualifying individuals making up to 400% of the federal poverty level.<sup>131</sup> This means that individuals who make up to \$44,000<sup>132</sup> per year, or a family of four making \$88,200<sup>133</sup> will qualify for government-subsidized insurance. The aim of the Exchanges is to ensure that those who earn up to four times the federal poverty level will not have to spend

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<sup>122</sup> *Id.*

<sup>123</sup> *Id.*

<sup>124</sup> There are additional reasons that an individual may shop in the Health Care Exchange, which are beyond the scope of this Comment.

<sup>125</sup> Grier, *supra* note 19.

<sup>126</sup> *Id.*

<sup>127</sup> See 2010 Poverty Guidelines: All States (Except Alaska and Hawaii) and D.C., CTR FOR MEDICAID SERVS., available at <http://chfs.ky.gov/NR/rdonlyres/60830211-1431-4396-BB6D-991BA9D8EC23/240928/2010PovertyGuidelines.pdf> (last visited May 22, 2012).

<sup>128</sup> *See id.*

<sup>129</sup> *See id.*

<sup>130</sup> State Medicaid Fact Sheets: New Jersey & United States, THE KAISER FAMILY FOUND., <http://www.statehealthfacts.org/mfs.jsp?rgn=32&rgn=1> (last visited May 22, 2012).

<sup>131</sup> Grier, *supra* note 19.

<sup>132</sup> *See id.*

<sup>133</sup> Phil Galewitz, *Consumers Guide to Health Reform*, KAISER HEALTH NEWS (Apr. 13, 2010), <http://www.kaiserhealthnews.org/Stories/2010/March/22/consumers-guide-health-reform.aspx>.

more than approximately 10% of their total income on health insurance expenses.<sup>134</sup> According to the projected estimates by the United States Census Bureau, between 2006 and 2010, the average household size in New Jersey was 2.69 individuals<sup>135</sup> with a median household income of \$69,811.<sup>136</sup> Based on these numbers, a family of three—very close to the average household size—making exactly the median salary for the state will qualify for government subsidies to help pay their insurance premiums. In theory then, the average New Jersey family will qualify for some form of subsidies. Further, considering that New Jersey has higher income levels than most of the nation,<sup>137</sup> an even higher percentage of individuals throughout the country will qualify for these subsidies.

Under Medicaid, states have the option to exclude abortion coverage.<sup>138</sup> This is also true of the Qualified Health Plans.<sup>139</sup> In New Jersey, after *Right to Choose v. Byrne*,<sup>140</sup> it is a violation of the State Constitution to exclude abortion coverage for individuals who qualify for Medicaid.<sup>141</sup> But does that mean that it is a violation of New Jersey's Equal Protection guarantee to exclude abortion coverage in the Qualified Health Plans sold in the Exchanges? Implicit in the holding of *Byrne* was the financial situation that the women faced, a much tougher situation than the women who will buy insurance through the Exchange.<sup>142</sup> In any event, whether a challenge to an

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<sup>134</sup> See *id.*

<sup>135</sup> See *State and County Quick Facts: New Jersey*, U.S. CENSUS BUREAU (Jan. 17, 2012), <http://quickfacts.census.gov/qfd/states/34000.html>.

<sup>136</sup> See *id.* It is important to note that this is far higher than the national median household income of \$51,914. *Id.*

<sup>137</sup> See *id.* (The New Jersey median household income is \$69,811 compared to the national median household income of \$51,914).

<sup>138</sup> *Focus on Health Reform: Summary of Health Care Reform Bill*, THE KAISER FAMILY FOUND. (Apr. 15, 2011), <http://www.kff.org/healthreform/upload/8061.pdf>.

<sup>139</sup> *Id.*

<sup>140</sup> 450 A.2d 925 (N.J. 1982).

<sup>141</sup> It is also important to note that abortion coverage is also provided for individuals who qualify for Family Care. Whether this is done under the assumption that *Right to Choose* also applies to individuals on Family Care because of New Jersey's system where Family Care essentially embraces Medicare, or simply as a matter of policy is difficult to unearth. However, according to a brochure for Family Care eligible individuals who enroll in an HMO provided through AmeriGroup, abortion services are covered for all members. See AMERIGROUP N.J. INC., COMMUNITY CARE MEMBER HANDBOOK 14, 25, available at [https://www.myamerigroup.com/English/Member%20Handbooks/NJ/NJNJ\\_CAID\\_MHB\\_ENG.pdf](https://www.myamerigroup.com/English/Member%20Handbooks/NJ/NJNJ_CAID_MHB_ENG.pdf).

<sup>142</sup> Single women would qualify for Medicaid coverage with a yearly income of roughly \$14,000. On the other hand, a single person will qualify to purchase

2012]

COMMENT

1699

exclusion of abortion coverage would stand depends on whether the Exchanges constitute state action. Without such, this is simply a private insurer excluding abortion coverage in lower cost plans, which does not necessarily implicate Equal Protection concerns. For this reason, it is necessary to explore New Jersey's history with state action.

A. *State Action*

Courts have found state action when it comes to Medicaid even when administered by private organizations,<sup>143</sup> but that does not necessarily mean that they will automatically find state action when it comes to Exchanges. The problem is that the Exchanges are not insurers themselves, but rather they contract with private insurers and provide government subsidies for private health insurance plans.<sup>144</sup> Ideally, the Exchanges would promote transparency and accountability and assist in spreading risk because those with high medical needs will have several options to choose from.<sup>145</sup> But whether or not this all adds up to state action, sufficient to require an expansion of *Right to Choose*, is an issue that requires a more thorough analysis because although the states are required to run the Exchanges, the Federal Government provides all of the subsidies.

Under the U.S. Constitution, to determine whether state action exists, "the inquiry must be whether there is a sufficiently close nexus between the state and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the state itself."<sup>146</sup> The Supreme Court has noted that the state's involvement "may not be immediately obvious, and a detailed inquiry may be

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subsidized insurance through the Exchange if he or she makes up to approximately \$44,000. See *supra* notes 127–137 and accompanying text.

<sup>143</sup> See generally, *Novak v. Ind. Family & Social Servs. Admin.*, No. 1:10-cv-0677-RLY-DML, 2011 WL 1224813, at \*6 (S.D. Ind. Mar. 30, 2011) (finding IBM to be a state actor when processing Medicaid claims); *Snodgrass v. Doral Dental of Tenn.*, No. 3:08-0107, 2008 WL 2718911, at \*4 (M.D. Tenn. July 10, 2008) (finding state action where private management company administered state's dental Medicaid program).

<sup>144</sup> See *Focus on Health Reform*, *supra* note 21. *But cf.* Cappy McGarr, *A Texas-Sized Health Care Failure*, N.Y. TIMES, Oct. 5, 2009, <http://www.nytimes.com/2009/10/06/opinion/06mcgarr.html> (explaining that Texas and California attempted to implement exchanges with the hope of advancing these policy goals but the market was too restricted and it ultimately resulted in higher premiums).

<sup>145</sup> See *Focus on Health Reform*, *supra* note 21.

<sup>146</sup> *Jackson v. Metro. Edison Co.*, 419 U.S. 345, 351 (1974) (internal citation omitted).

required in order to determine whether the test is met.”<sup>147</sup>

In 1991, the New Jersey Supreme Court observed that “our principles of state constitutional analysis . . . are substantially the same” as the federal constitutional analysis for equal protection.<sup>148</sup> The words of the New Jersey Constitution, however, do not suggest that rights and privileges are limited to protections only against the government.<sup>149</sup> Despite the court’s recognition that “the fundamental nature of a constitution is to govern the relationship between the people and their government, not to control the rights of the people vis-à-vis each other,”<sup>150</sup> the New Jersey Supreme Court has been very lenient on requiring state action to bring a constitutional claim. For example, in *Committee For a Better Twin Rivers v. Twin Rivers Homeowners Association*,<sup>151</sup> the New Jersey Supreme Court held that even in the absence of state action, it must determine whether the acts of a homeowner’s association violated its members’ free speech rights.<sup>152</sup> And again in *Peper v. Princeton University Board of Trustees*,<sup>153</sup> the State Supreme Court held that private university employees could bring equal protection actions despite the absence of state action.<sup>154</sup> Several states have interpreted their own state constitutions to weaken or even eliminate any requirement of state action in several contexts, including equal protection.<sup>155</sup> Therefore, even assuming a lack of state action, it is still possible that a court would allow an equal

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<sup>147</sup> See *id.* (citing *Burton v. Wilmington Parking Auth.*, 365 U.S. 715, 723 (1961)).

<sup>148</sup> See *Drew Associates of N.J., L.P. v. Trivisano*, 584 A.2d 807, 812 (N.J. 1991) (internal citation omitted) (noting the difference from the federal “tier” analysis but finding that state constitutional doctrine dealing with Equal Protection claims is substantially the same).

<sup>149</sup> See N.J. CONST. art. I, para. 1 (“All persons are by nature free and independent, and have certain natural and unalienable rights, among which are those of enjoying and defending life and liberty, of acquiring, possessing, and protecting property, and of pursuing and obtaining safety and happiness.”).

<sup>150</sup> *Comm. for a Better Twin Rivers v. Twin Rivers Homeowners Ass’n*, 929 A.2d 1060, 1071 (N.J. 2007) (quoting *Southcenter Joint Venture v. Nat’l Democratic Policy Comm.*, 780 P.2d 1282, 1286 (Wash. 1989)) (internal quotation marks omitted).

<sup>151</sup> 929 A.2d 1060, 1071 (N.J. 2007).

<sup>152</sup> See *id.* at 1072.

<sup>153</sup> 389 A.2d 465 (N.J. 1978).

<sup>154</sup> *Id.*

<sup>155</sup> See Ivo Becica, *Privacy—State Constitutional Privacy Rights Against Private Employers: A “Hairy” Issue In Alaska*, 37 RUTGERS L.J. 1235, 1238 & n.25 (2006), available at [http://org.law.rutgers.edu/publications/lawjournal/issues/37\\_4\\_Comments/Becica.pdf](http://org.law.rutgers.edu/publications/lawjournal/issues/37_4_Comments/Becica.pdf) (noting New Jersey’s holding in *Peper*, 389 A.2d at 476–78 where the court allowed an action for equal protection violation with no requirement of state action under the State Constitution).

protection claim under the ACA to go forward. However, because of the possibility that state action may be required, an examination of the role of the state is still warranted.

The ACA provides some guidelines for creating the Exchange that provide insight into the role of the state. The Bill assigns specific duties to the state and others to the federal government.<sup>156</sup> The Bill explicitly requires each state to establish an American Health Benefit Exchange by January 1, 2014.<sup>157</sup> The Federal Government's role is largely to ensure that the states comply in setting up the Exchanges and to provide assistance in doing so.<sup>158</sup> After the Exchanges have been established, the burden is on the state to make sure that they continue to operate effectively.<sup>159</sup> For example, under § 1311(d)(5)(A), "the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations."<sup>160</sup>

The states have a significant amount of leeway in determining how to set up the Exchange. The N.J. legislature initially considered several alternatives but narrowed their choices to two serious contenders in the 2012 session. The first bill proposed the establishment of an independent nonprofit entity to manage the

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<sup>156</sup> See, e.g., Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1311(a), 124 Stat. 119 (2010) (codified in scattered sections of the Internal Revenue Code and 42 U.S.C.) (requiring the states to create an operational Exchange by January of 2014 that meets certain requirements and also requiring oversight by the Secretary).

<sup>157</sup> See *id.* at § 1311(b).

<sup>158</sup> For example, § 1311(a)(1) appropriates money to the Secretary to make awards to the states. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1311(a)(1), 124 Stat. 119 (2010) (codified in scattered sections of the Internal Revenue Code and 42 U.S.C.). "For each fiscal year, the Secretary shall determine the total amount that the Secretary will make available to each state. . . ." *Id.* at § 1311(a)(2). "The Secretary shall provide technical assistance to States to facilitate participation of qualified small business in such States in SHOP Exchanges." *Id.* at § 1311(a)(5). "The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans." *Id.* at § 1311(c)(1). "The Secretary shall develop a rating system that would rate qualified health plans. . . ." *Id.* at § 1311(c)(3). "The Secretary shall develop an enrollee satisfaction survey system. . . ." *Id.* at § 1311(c)(4). Also, if a State fails to set up an exchange by the required time, the Secretary has the responsibility to establish and operate the Exchange within that state and take all actions necessary to implement other requirements. *Id.* at § 1321.

<sup>159</sup> See Patient Protection and Affordable Care Act §§ 1311(a)(1), 1311(c)(1), 1311(c)(4), 1312.

<sup>160</sup> See *id.* § 1311(d)(5)(A).



Exchange.<sup>161</sup> The second bill proposed that the Department of Banking and Insurance manage the Health care Exchange.<sup>162</sup> After much consideration, the legislature passed the second bill, establishing the Exchange within the Department of Banking. Before the bill was signed into law, however, Governor Chris Christie exercised his veto power.<sup>163</sup> Christie's main reason for the veto was the pending challenge before the Supreme Court at the time.<sup>164</sup> Christie said in a statement, "Because it is not known whether the Affordable Care Act will remain, in whole or in part, it would be imprudent for New Jersey to create an exchange at this moment in time before critical threshold issues are decided with finality by the Court."<sup>165</sup> Since Christie's veto, the Supreme Court upheld the ACA in large part.<sup>166</sup> Therefore, New Jersey is required to have approval from Washington on the State's healthcare Exchange plan by January 1, 2013 or the federal government can step in and take over the Exchange.<sup>167</sup>

In order to meet this deadline, on June 28, after the Supreme Court's decision on the ACA, the same bill that Christie vetoed, establishing the Exchange within the Department of Banking, was reintroduced in this session of State Senate.<sup>168</sup> A few days later the identical bill was introduced in the Assembly.<sup>169</sup> The bill that would establish a separate non-profit entity to operate the exchange has not yet been reintroduced.

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<sup>161</sup> S. No. 551, 215th Leg. (N.J. 2012), available at [http://www.njleg.state.nj.us/2012/Bills/S1000/551\\_I1.PDF](http://www.njleg.state.nj.us/2012/Bills/S1000/551_I1.PDF).

<sup>162</sup> Assemb. No. 2171, 215th Leg. (N.J. 2012), available at [http://www.njleg.state.nj.us/2012/Bills/A2500/2171\\_R2.HTM](http://www.njleg.state.nj.us/2012/Bills/A2500/2171_R2.HTM).

<sup>163</sup> *Governor Chris Christie Vetoes 'Health Exchange Bill' Tied to Federal Health Care Reform Law*, NJ.COM (May 10, 2012), [http://www.nj.com/news/index.ssf/2012/05/gov\\_chris\\_christie\\_vetoes\\_heal.html](http://www.nj.com/news/index.ssf/2012/05/gov_chris_christie_vetoes_heal.html).

<sup>164</sup> *Governor Chris Christie Prudently Vetoes Health Care Exchange Legislation While Fundamental Issues Still Unresolved by U.S. Supreme Court*, STATE OF NEW JERSEY GOVERNOR CHRIS CHRISTIE (May 10, 2012), <http://www.nj.gov/governor/news/news/552012/approved/20120510a.html>.

<sup>165</sup> *Id.*

<sup>166</sup> See *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012); see also *supra*, note 17.

<sup>167</sup> See Patient Protection and Affordable Care Act § 1321; *Christie Nixes Healthcare Exchange Bill*, POLITICO PRO (May 10, 2012), <http://www.politico.com/news/stories/0512/76179.html>.

<sup>168</sup> S. No. 2135, 215th Leg. (N.J. 2012), available at [http://www.njleg.state.nj.us/2012/Bills/S2500/2135\\_I1.PDF](http://www.njleg.state.nj.us/2012/Bills/S2500/2135_I1.PDF).

<sup>169</sup> Assemb. No. 3186, 215th Leg. (N.J. 2012), available at [http://www.njleg.state.nj.us/2012/Bills/A3500/3186\\_I1.PDF](http://www.njleg.state.nj.us/2012/Bills/A3500/3186_I1.PDF).

If the Department of Banking is established as the operator of the Exchange, a finding of state action is almost guaranteed since a State Department will be operating the Exchange.<sup>170</sup> Although the bill establishing a nonprofit to operate the Exchange seems to have phased out, it is worth noting that if a nonprofit were established, a finding of state action becomes more difficult, but certainly not impossible. Although the nonprofit will be created by a statute, that does not necessarily, by itself, warrant a finding of state action.<sup>171</sup> If this bill were adopted, New Jersey would have a state-created nonprofit operating as a private entity and receiving subsidies from the federal government. The state of New Jersey would essentially be assuming a completely passive role. Under *Peper*, however, it might still be possible to bring a claim. The most likely way to find state action under this bill would be if the State mandates that additional services be covered in addition to those required by the ACA. The ACA allows states to require that qualified health plans cover additional services, but the State must assume the cost of paying the subsidies for that part of the coverage; federal funds may not be used.<sup>172</sup> This would more likely bring the Exchange into the ambit of state action because the State would be controlling, mandating, and funding certain aspects of the Exchange.<sup>173</sup> If a state requires several additional services and provides the subsidies for those services, it

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<sup>170</sup> The Department of Banking and Insurance is a state-operated agency. See *Departments & Agencies*, THE OFFICIAL WEBSITE FOR THE STATE OF NEW JERSEY, <http://www.state.nj.us/nj/gov/deptserv/> (last visited Feb. 9, 2011).

<sup>171</sup> For example, Horizon Blue Cross Blue Shield is not considered a state actor but is operating as a product of legislation. See *Company History*, HORIZON BLUE CROSS BLUE SHIELD NEW JERSEY, [http://horizon-bcbnsj.com/aboutus/company\\_information/history.html](http://horizon-bcbnsj.com/aboutus/company_information/history.html) (last visited May 18, 2012).

<sup>172</sup> See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1311(d)(3)(B), 124 Stat. 199 (2010) (codified in scattered sections of the Internal Revenue Code and 42 U.S.C.). The way that the subsidized premiums work, the state would be responsible for the portion of the premium which covers the state-mandated coverage. *Id.* The State may either make payments directly to an individual enrolled in a qualified health plan offered in the state or they can make payments directly to the health plan in which the individual is enrolled. *Id.* This has significance because if the suggestion of this Comment is adopted, all medically necessary (as defined by New Jersey) abortions will need to be covered by the Qualified Health Plans sold in New Jersey and New Jersey must assume the full cost of subsidizing these plans.

<sup>173</sup> There is still an argument, however, that this does not make the Exchange a state actor because many industries are heavily regulated but do not qualify as state actors. For example, airline industry and pharmaceutical companies are considered private actors but are subject to heavy government regulation. Together with the regulation, funding, and establishment by the state, however, it may be likely that a finding of state action would be warranted with the Exchanges.

would be hard to argue that there was not state action, regardless of whether a state organization actually operates the Exchange. On the other hand, if a state is largely noncompliant with the ACA and the federal government steps in to oversee the functions, then it might be hard to argue that state action actually does exist in any meaningful way under those circumstances.<sup>174</sup>

There is no indication, however, that New Jersey will not comply with the requirements of the ACA and it seems much more likely that it will adopt one of the proposals to establish the Exchange within the state. The previous veto by Chris Christie was made for the stated reason of the pending challenges to the bill. Now that these issues have been resolved, New Jersey appears to be back on track to implement the Health Exchange. Given the statements made surrounding his previous veto, there is no indication that Christie would refuse to implement the Exchange now that the ACA has been deemed constitutional.

Additionally, given New Jersey's history of allowing equal protection claims to continue even in the absence of state action, it seems unlikely that New Jersey, faithful to its established case law, could possibly find that a lawsuit should be dismissed for a lack of state action regardless of how the Exchange is established. Even if a court were to find that state action was lacking through the Exchange, that may not be detrimental to a state equal protection claim.<sup>175</sup>

## VI. POTENTIAL CHALLENGES

The holding of *Right to Choose v. Byrne*, requires that if Medicaid-eligible women receive coverage for the costs of childbirth, then they must also receive coverage for medically necessary abortions to be in compliance with the New Jersey Constitution.<sup>176</sup> In 2014, the state will face a situation where many more individuals will be provided with

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<sup>174</sup> It is also important to note that a role of state action would be important to the subject of filing a grievance. Currently if an individual has a dispute with Medicaid or Family Care there is an established process through which the individual can file a grievance, and then there is always the option to bring suit. See *HMO Appeals and Complaints*, LSJ LAW., <http://www.lsnjlaw.org/english/healthcare/hmosmanagedcare/appeals/> (last visited Aug. 6, 2012). Under the Exchanges, however, if there is no state action, then what will be the means of recourse? It would seem that the only option would be to file a lawsuit against the federal government. This is largely undetermined and yet to be seen.

<sup>175</sup> See *supra* Part V.A.

<sup>176</sup> See *supra* note 69 and accompanying text.

government-subsidized insurance.<sup>177</sup> Although the state government is not subsidizing the program, New Jersey's role is likely enough for an individual to make a valid claim under the New Jersey Constitution.<sup>178</sup> As mentioned above, the QHPs that individuals will purchase through the Exchange will all cover the costs of childbirth and the costs of federally recognized "necessary" abortions, exactly as Medicaid did before the challenge in *Right to Choose*.<sup>179</sup> Therefore, the state of New Jersey will essentially encounter the exact same problem that it faced in *Right to Choose*, but in a context that the Justices certainly did not contemplate in 1982.

In *Right to Choose*, the court was implicitly relying on the fact that the women making the challenge were indigent.<sup>180</sup> It is important to remember, however, that at the time of the decision, government-funded health care was only widely available to the indigent, not the general population.<sup>181</sup> In a lengthy footnote, the court explained why the challenged statute failed even the rational basis test, but in doing so the court alluded again to the fact that the women challenging the statute were not capable of paying for the abortion in any other way:

For many indigent women, the denial of Medicaid funds, as a practical matter, forecloses the option of obtaining a medically necessary abortion. More affluent women need not avail themselves of public funds for necessary medical procedures. Through private resources or third-party payors, they can protect their health without recourse to Medicaid. Only those least able to bear the financial burden will be forced into childbirth at the expense of their health.<sup>182</sup>

The court here was obviously concerned with the fact that these

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<sup>177</sup> Grier, *supra* note 19.

<sup>178</sup> See *supra* Part V.A.

<sup>179</sup> See *supra* Part III.

<sup>180</sup> The court wrote, "[the State] concedes that, for a woman *who cannot afford* either medical procedure, the statute skews the decision in favor of childbirth at the expense of the mother's health." *Right to Choose v. Byrne*, 450 A.2d 925, 934–35 (N.J. 1982) (emphasis added). "[T]he State may not use its treasury to persuade a *poor* woman to sacrifice her health by remaining pregnant." *Id.* at 936 (emphasis added). "The Statute affects the right of *poor pregnant women* to choose between alternative necessary medical services." *Id.* (emphasis added).

<sup>181</sup> In the 1980s, only Medicaid and Medicare were available. The State Children's Health Insurance Program was not even created until 1997. See CONG. BUDGET OFFICE, THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (2007), available at <http://www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf>.

<sup>182</sup> *Right to Choose*, 450 A.2d at 935 n.6 (emphasis added).

women have no other option.<sup>183</sup> The court also referred to more “affluent” women not needing recourse to Medicaid.<sup>184</sup> While it is true that more affluent could not turn to Medicaid, that does not mean that they had the ability to pay for it themselves or that they had a third-party payor (insurance) that covered the procedure. Medicaid was only available to the poorest of women; not all women above the line for Medicaid eligibility had private resources for the procedure.<sup>185</sup> Legislators recognized that individuals who fall outside the threshold for Medicaid eligibility still have trouble funding the cost of their own medically necessary procedures and enacted the ACA to deal with that problem.<sup>186</sup>

Additionally, in the quote above, the court referenced insurance companies paying for the procedure. The court essentially assumed that people who had their own insurance policies would have such coverage. However, people who will purchase insurance through the Exchange will receive a Qualified Health Plan that does not include subsidized costs for abortion procedures. Therefore, unlike the sentiment from the footnote, which suggests that people with insurance do not need to worry about the cost of an abortion procedure,<sup>187</sup> every person who is covered by insurance through the Exchange will not have the option to have a third-party payor cover the cost of her procedure, unless the state mandates this and pays for

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<sup>183</sup> *See id.*

<sup>184</sup> *Id.*

<sup>185</sup> One of the main objectives of the massive health care reform, however, was to make health care more affordable. *See Summary of New Health Reform Law*, THE KAISER FAMILY FOUND., <http://www.kff.org/healthreform/upload/8061.pdf>. Note also that the name of the New Health Care Bill is the Patient Protection and *Affordable Care Act* (emphasis added). Although different surveys vary on the number of people uninsured for the entire year of 1998, the lowest number that has been accepted is 21.1 million, with the highest number at 31.1 million. *See How Many People Lack Insurance and For How Long*, CONG. BUDGET OFFICE vii (May 2003), <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/42xx/doc4210/05-12-uninsured.pdf>. The lowest number of those uninsured at any time during the year was 56.8 million and 59 million individuals. *Id.* at 1, 3.

<sup>186</sup> When President Barack Obama signed the Health Care Reform into law he stated, “And we have now just enshrined, as soon as I sign this bill, the core principle that everybody should have some basic security when it comes to their health care.” Statement by President Barack Obama Upon Signing H.R. 3590, 2010 U.S.C.C.A.N. S6, 2010 WL 3200955 (Mar. 23, 2010).

<sup>187</sup> It is important to note that, according to the Guttmacher Institute, 87% of private health care plans currently cover abortion services. *Memo on Insurance Coverage of Abortion*, GUTTMACHER INST. (July 22, 2009), <http://www.guttmacher.org/media/inthenews/2009/07/22/index.html>. Because of the substandard plans that cover many people, however, only 46% of Americans have abortion services covered in their health insurance plans. *Id.*

2012]

COMMENT

1707

it.<sup>188</sup> Thus, “affluent” women referred to in the court’s footnote<sup>189</sup> who qualify for government subsidized insurance will essentially be left to fund their medically necessary abortions with their own resources. Consequently, the first time that a pregnant woman whose income falls between 200% and 400% of the federal poverty level requires an abortion for her health, it is certainly plausible that she will bring an equal protection challenge if she is denied funding for the procedure.

Some might argue that women purchasing insurance through the Exchange do not fall within the holding of *Right to Choose* because the holding was made in the context of the indigent and many of the women who will be purchasing insurance through the Exchange would not be considered indigent. But, despite the fact that the court was examining a class of indigent women in *Right to Choose*, it is important to remember that it was also only looking at a *system* that only provided medical care for the indigent. The court said that the state “may not jeopardize the health and privacy of poor women by excluding medically necessary abortions from *a system providing all other medically necessary care* for the indigent.”<sup>190</sup> Therefore, much of the court’s language was phrased in terms of medical care for the poor, because it was examining a *system* that provided medical care to that class of individuals. The court, in other parts of the opinion, used much broader language to explain the holding:

A woman’s right to choose to protect her health by terminating her pregnancy outweighs the State’s asserted interest in protecting a potential life at the expense of her health. Therefore, we hold that the restriction of funding to abortions necessary to save the life of the mother violates the New Jersey Constitution.<sup>191</sup>

Thus, it is not necessarily an accurate conclusion to say that the court’s decision can only apply if the individual is indigent.<sup>192</sup> The whole purpose of expanding medical coverage is that many individuals do not have the means to pay for their own procedures,

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<sup>188</sup> See *supra* note 173 and accompanying text.

<sup>189</sup> See *Right to Choose v. Byrne*, 450 A.2d 925, 935 n.6 (N.J. 1982); *supra* note 182 and accompanying text.

<sup>190</sup> *Right to Choose*, 450 A.2d at 937 (emphasis added).

<sup>191</sup> *Id.*

<sup>192</sup> It is interesting to note also that “indigent” is a very vague term. Black’s Law Dictionary defines indigent as simply “a poor person.” See BLACK’S LAW DICTIONARY (9th ed. 2009).

even when they are making four times the federal poverty level.<sup>193</sup> The court in *Right to Choose* wrote its decision in a very specific context, which did not necessarily contemplate such a drastic change in health care, but that does not mean the holding cannot be adapted to the new system. New Jersey, and similarly situated states, need a way to deal with this issue when these changes take effect in 2014.

#### VII. IMPLEMENTING A SOLUTION

The best way to resolve this issue of abortion coverage for women purchasing government-subsidized health insurance is for the legislature to step in. If the State waits for a challenge, the court will likely hold in favor of the challengers<sup>194</sup> and then the State will have to struggle with implementation.<sup>195</sup> In 2014, if a pregnant woman who purchased her insurance through the New Jersey Exchange requires an abortion to protect her health is denied funding and subsequently prevails in a claim against the State, what is the result? Does she get full coverage for her abortion? Is she entitled to a subsidy from the State for the portion of her premium that can be allocated to abortion coverage? Should there be a sliding scale that determines what percentage is paid to the woman based on her income? And finally, once the method is determined, how would it operate practically? Instead of having the court struggle with these questions, it is best for the legislature to step in and resolve the issue before the problem arises.

At first glance, the most obvious way to resolve the issue would be to implement a sliding-scale system in which people pay for a portion of the procedure equivalent to the portion of subsidies that they receive. For example, under this system, if an individual is

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<sup>193</sup> This implicates the incredibly high costs of health care in the United States. *See supra* Part IV.

<sup>194</sup> The focus of this paper has been on the fact that the holding of *Right to Choose*, although decided in the context of indigent women, is not necessarily limited to such women, especially given the social changes and policy reasons accompanying health care reform. *See supra* Parts III.B, III.C and IV. Therefore, it appears that to be faithful to current law, the holding of *Right to Choose* should extend to all women who qualify for government-subsidized insurance. It would be a violation of Equal Protection not to fund the abortions necessary for the health of these women while providing subsidized insurance coverage for any costs associated with childbirth.

<sup>195</sup> Further, it should be noted that much of this solution was written under the assumption that coverage is constitutionally required under *Right to Choose*.<sup>195</sup> Even if it is not constitutionally required, however, the legislature should still implement such a scheme as a matter of policy.

2012]

COMMENT

1709

receiving 40% subsidies for the cost of her insurance, then the state would pay for 40% of the procedure would be paid for by the state. This seems like it would save the state money since it is not responsible for the entire cost of the procedure.

This type of a system, however, would run into some serious problems. First, and most importantly, abortion procedures may still be cost-prohibitive. In 2009, the cost of a non-hospital abortion with local anesthesia at ten weeks gestation averaged \$451.<sup>196</sup> Abortions after the first trimester, though, had a median rate of \$1,500.<sup>197</sup> Consider the same woman from above, receiving a 40% subsidy. This woman would be required to pay an out-of-pocket expense of 60%. If she must have a procedure at the median cost for a second trimester abortion, her out-of-pocket cost would be \$900. For a woman with income levels low enough to receive a 40% subsidy, a \$900 out-of-pocket cost for a procedure is probably not something for which she has the financial means.

In addition to the problem of cost-sharing and the fact that this solution is really no solution at all, there are serious administrative problems with such a system. If the system had to sort out how much of a subsidy every single woman received and then match that percentage with a state subsidy for abortion procedures, the state would be wasting time and resources on a costly administrative nightmare.

The best solution is to cover the entire cost of the procedure for all women. The system could mimic the administrative guidelines that Medicaid and Family Care already use.<sup>198</sup> Since this system is already in place, we know it is administratively feasible. Some people might argue, though, that covering the complete cost for all women up to 400% is providing more of a benefit for people who need it less. An element of cost-sharing, however, still exists in the form of premiums, which makes it much fairer.<sup>199</sup> Premiums are still

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<sup>196</sup> *The Economics of Second Trimester Abortions: Market Demand*, BIG THINK (Jan. 23, 2012), <http://bigthink.com/dollars-and-sex/the-economics-of-second-trimester-abortions-market-demand?page=all>.

<sup>197</sup> *Id.*

<sup>198</sup> Medicaid is already required to keep funds separate to pay for what New Jersey deems a necessary abortion after the decision in *Right to Choose*. See discussion *supra* Parts II–III.

<sup>199</sup> As income levels rise, premiums and copayments also rise. See *Income Eligibility and Cost*, N.J. FAMILY CARE, <http://www.njfamilycare.org/pages/whatItCosts.html> (last visited Feb. 5, 2011).



determined on a sliding scale.<sup>200</sup> The entire point of paying a premium for your health insurance is so that when you require a procedure for your health, the cost is not excessive. Premiums are determined based on an individual's income and therefore the individual is already paying an amount determined by his or her ability to pay.<sup>201</sup> It is important to remember also that the class of women at issue in this Comment only includes those whose abortions are necessary for their health, but for whom federal funds are not available because the individual does not fall into one of the exceptions that the Hyde Amendment created. Therefore, the class is very small.<sup>202</sup>

There are still other concerns that will also need to be addressed. It is very likely that providing any form of funding is likely to meet opposition, both from religious organizations and taxpayer associations.<sup>203</sup> Politicians concerned about fiscal problems might oppose this funding.<sup>204</sup> Family Planning Clinics are not high on the list of concerns as New Jersey attempts to battle its budget crisis.<sup>205</sup> These clinics that rely heavily on state aid have recently taken a huge

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<sup>200</sup> *Id.*

<sup>201</sup> *Id.*

<sup>202</sup> *See supra* Part I (discussing the scope of the class of women involved).

<sup>203</sup> In *Right to Choose*, a nonprofit organization formed to oppose abortion, a nonprofit association of students opposing the war in Vietnam, and a nonprofit taxpayers association entered the action as Defendant-Intervenors. *Right to Choose v. Byrne*, 450 A.2d 925, 929 (N.J. 1982). Several amicus briefs were also submitted on behalf of both sides. *Id.* at 927 (listing parties that had submitted amici curiae briefs).

<sup>204</sup> New Jersey currently has a budget shortfall of approximately \$8.71 billion dollars. *See State Budget Update*, NATIONAL CONFERENCE OF STATE LEGISLATURES, 18 (July 2009), <http://www.ncsl.org/documents/fiscal/StateBudgetUpdateJulyFinal.pdf>. Governor Chris Christie entered office facing an almost 11 billion dollar deficit which he battled by laying off 1,300 state workers, closing state psychiatric institutions, cutting 820 million dollars in aid to public schools, and providing nearly half a billion dollars less in aid to towns and cities. David M. Halbfinger, *New Jersey Governor Proposes Deep Spending Cuts*, N.Y. TIMES, Mar. 16, 2010, <http://www.nytimes.com/2010/03/17/nyregion/17budget.html>. He also suspended property tax rebate programs. *Id.*

<sup>205</sup> Family Planning Clinics provide free services to individuals who make less than the federal poverty level. At these clinics, individuals can receive gynecological exams, breast and cervical cancer screenings, birth control, screenings and treatment for sexually transmitted infections, counseling services, pregnancy testing, prenatal care or referral, screenings for high blood pressure, anemia, and diabetes. *See* Mary Jo Patterson, *Family Planning Clinics Feel Christie's Cuts*, WOMEN'S HEALTH MATTERS (Aug. 23, 2010), <http://www.njspotlight.com/stories/10/0822/2045/>. The clinics are also a large provider of abortion services. *Id.*

2012]

COMMENT

1711

cut in funding.<sup>206</sup> New Jersey's fifty-eight Family Planning Clinics went from receiving 7.5 million dollars to zero dollars for the 2011 fiscal year.<sup>207</sup> While New Jersey may not be in a good position to take on additional funding responsibilities, with the elimination of family planning aid and the passage of Health Care Reform, it seems that the way to eliminate some of the issues associated with family planning cuts<sup>208</sup> and still remain faithful to the New Jersey law as established in *Right to Choose* is to cover the cost of necessary abortions (as defined by New Jersey) for all women buying insurance in the Exchange. It is important to remember also, when it comes to fiscal concerns, that the scope of the abortions that the state will be responsible for paying is quite limited.<sup>209</sup> Under this framework, New Jersey would be responsible for funding abortions that fall outside of federal "medically necessary abortions" but within New Jersey's definition of medically necessary. Essentially this means that the state will be responsible only for abortions necessary to preserve the *health* of the mother where her life is not in danger.

#### VIII. CONCLUSION

The New Jersey Constitution has been interpreted to contain several important guarantees that the court addressed in *Right to Choose v. Byrne*. The court held that a Medicaid-eligible woman, who needs an abortion to protect her health, cannot be denied access to those funds under the New Jersey Constitution, despite the limitations placed on the use of federal funds by the Hyde Amendment. The passage of the ACA introduced complicated issues about funding for abortion in the states that have mandated abortion coverage in expanded situations under their State Constitutions. The circumstances in *Right to Choose* are analogous to the situation the state will be presented with in 2014 when the Health Care Exchanges become operational. Determining what the outcome of such a

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<sup>206</sup> *See id.*

<sup>207</sup> *See id.* New Jersey is the only state to completely eliminate family-planning funding altogether. *Id.*

<sup>208</sup> Approximately 70% of the individuals that use family planning clinics are uninsured. *Id.* Another 20% are covered by Medicaid. *Id.*

<sup>209</sup> The funding for these abortions would come from New Jersey's General Fund. Under the PPACA, however, "the issuer of a plan to which subparagraph (A) applies shall deposit all payments described in subparagraph (B)(i)(I) into a separate account that consists solely of such payments and that is used exclusively to pay for services other than services other than services described in (1)(B)(i)." Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1303(b)(2)(C)(i), 124 Stat. 119 (2010).

challenge would be in New Jersey begins with a determination of whether or not there is state action. It is likely that, no matter how much of a role the state actually plays in the Exchange, there will be an affirmative finding of state action, given New Jersey's case law.

Instead of waiting for a challenge from an individual after she is denied funds for her abortion, the legislature should step in and structure the program so that it can control how it will operate. Under the ACA, it is permissible for states to require additional services to supplement those provided through a QHP, but the State must fund the cost of that procedure. The legislature would need to require that plans include coverage for abortions necessary for the health of the mother and then fund the cost for those procedures where federal funds cannot be used. Since there would be several problems with a cost-sharing system, which splits the cost of the procedure based on a sliding scale, the best way to administer the coverage would be through complete coverage that mirrors the Medicaid/Family Care method of payment already in place and functioning. Despite potential backlash for extending funding for medically necessary abortions, it is the better policy decision and it maintains the New Jersey Supreme Court's interpretation of the New Jersey Constitution.