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NO TAXPAYER FUNDING FOR ABORTION ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON THE CONSTITUTION

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

ON

H.R. 3

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NO TAXPAYER FUNDING FOR ABORTION ACT

TUESDAY, FEBRUARY 8, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON THE CONSTITUTION,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to call, at 4:05 p.m., in room 2141, Rayburn House Office Building, the Honorable Trent Franks (Chairman of the Subcommittee) presiding.

Present: Representatives Franks, Pence, Chabot, King, Jordan, Nadler, Quigley, Conyers, and Scott.

Also Present: Representatives Goodlatte and Jackson Lee.

Staff Present: (Majority) Paul Taylor, Subcommittee Chief Counsel; Sarah Vance, Clerk; (Minority) Heather Sawyer, Counsel; and Veronica Eligan, Professional Staff Member.

Mr. FRANKS. The Subcommittee will come to order.

Good afternoon to all of you. Pursuant to notice, the Subcommittee on the Constitution meets today to consider H.R. 3, the "No Taxpayer Funding for Abortion Act." This is the very first Constitution Subcommittee hearing in this, the new 112th Congress, and it is such a privilege to be the new Chairman of the Subcommittee and to offer a heartfelt welcome to all of the Members, the witnesses, and the observers.

Let me take a little side note here. Rule XI of the House rules provides that the Chairman of the Committee may punish breaches of order and decorum by censure and exclusion from the hearing. Presently we have people standing and it makes the order not in order in the hearing room. So members of the audience must behave in an orderly fashion. I say that respectfully, but otherwise they will be removed from the hearing room. So I hope you all will sit down.

Daniel Webster once said, Hold on, my friends, to the Constitution and to the Republic for which in stands, for miracles do not cluster and what has happened once in 6,000 years may never happen again. So hold on to the Constitution for if the American Constitution should fall, there will be anarchy throughout the world.

Our Founding Fathers wrote the words of our Constitution down for us because they did not want us to forget their true meaning, or to otherwise fall prey to those who would deliberately undermine or destroy it. This has always been the preeminent reason why we write down documents or agreements or declarations or constitutions in the first place: To preserve their original meaning and intent.

Protecting the lives of innocent Americans and their constitutional rights is why those of us in this room are all here, and indeed this is why Congress itself exists. The phrases in the Fifth and 14th Amendments capsulate our entire Constitution when they proclaim that no person shall be deprived of life, liberty or property without due process of law.

Those words are a crystal clear reflection of the Proclamation and the Declaration of Independence that declares that all men are created equal and endowed by their Creator with certain unalienable rights, those being life, liberty, and the pursuit of happiness. Those words are the essence of the America, and our commitment to them for more than two centuries has set America apart as the flagship of human freedom in the entire world. And yet unspeakable suffering and tragedy have occurred whenever we have strayed from those words.

Our own United States Supreme Court ruled that millions of men, women, and children were not persons under the Constitution because their skin was black. It took a horrible Civil War and the deaths of over 600,000 Americans to reverse that unspeakable tragedy. And we saw the same arrogance in 1973 when the Supreme Court said the unborn child was not a person under the Constitution. And we have since witnessed the silent deaths of now over 50 million innocent little baby boys and baby girls who died without the protection the Constitution gave them and without the protection this Congress should have given them.

H.R. 3 is a bipartisan bill that takes a step to turn America away from that tragedy. The bill forms part of the new majority's pledge to America, codifying the Hyde amendment by permanently prohibiting taxpayer funding of abortion across all Federal programs. In addition, the bill protects health care workers' rights of conscience so that they cannot be coerced to participate in abortion procedures as a condition their employment.

The Capitol Police are in the process of restoring order here and we are going to go ahead and continue and would ask them to continue.

The Speaker of the House, John Boehner, directed that this bill receive the designation H.R. 3 as "one of our highest legislative priorities." H.R. 3 is intended to continue the same policy as the Hyde amendment. The Hyde amendment prohibits taxpayer funding of abortion except in cases of rape, incest, or to save the life of the mother.

Contrary to discussion in the press, this bill with not be a departure from the decades of implementation of the Hyde amendment policy. Sponsors of the bill are reviewing clarifying language for amending H.R. 3 to assure lawmakers that funding policy as it relates to cases of rape will not be altered by this bill.

The second part of this bill provides necessary protection for health care workers who will not perform or refer for abortions as a matter of conscience. Those who believe that a pregnancy is a circumstance which presents with two patients, the mother and the unborn child, cannot in good conscience do harm to that unborn child and therefore should not be coerced into performing abortions as would be required under the current health care system.

Now, it is said that government is what it spends. Planned Parenthood alone aborts over a quarter of a million unborn babies every year, all the while it receives hundreds of millions of dollars in Federal, State or local taxpayer funds. This legislation is really about whether the role of America's government is to continue to fund a practice that takes the lives of over 1 million little Americans every year.

Even some of those who do not consider themselves pro-life strongly object to their taxpayers going to pay for abortion—their dollars.

Now I believe the intensity of this debate has something to do with our collective conscience. Perhaps it is because ultrasound technology has begun to demonstrate to all reasonable observers both the humanity of the victim and the inhumanity of what is done to them.

We are beginning to realize as Americans that somehow we are bigger than abortion on demand and that 50 million dead children is enough. We are beginning to ask the real question, does abortion take the life of a child? If it does not, then all of this here today is a non-issue. But if it does, then those of us sitting here in the chambers of freedom are in the midst of the greatest human genocide in the history of humanity.

Thomas Jefferson said that the care of human life and its happiness and not its destruction is the chief and only object of good government. And ladies and gentlemen, using taxpayer dollars to fund the killing of innocent, unborn children does not liberate their mothers. It is not the cause for which those lying out under the white stones in Arlington National Cemetery died, and it is not good government.

Abraham Lincoln called upon all of us to remember America's Founding Fathers and, "Their enlightened belief that nothing stamped with the divine image and likeness was sent into the world to be trodden on or degraded and imbruted by its fellows. He reminded those he called posterity that when in the distant future some man, some factions, some interests should set up a doctrine that some were not entitled to life, liberty, and the pursuit of happiness that "their posterity"—that's us, ladies and gentlemen—"their posterity might look up again to the Declaration of Independence and take courage to renew the battle which their fathers began."

May that be the commitment of all of us today. I look so forward to hearing from the witnesses, and I now recognize the Ranking Member of the Subcommittee, Mr. Nadler, for his opening statement.

[The bill, H.R. 3, follows:]

I

112TH CONGRESS
1ST SESSION

H. R. 3

To prohibit taxpayer funded abortions and to provide for conscience protections, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 20, 2011

Mr. SMITH of New Jersey (for himself, Mr. LIPINSKI, Mr. AKIN, Mr. ALEXANDER, Mr. AUSTRIA, Mrs. BACHMANN, Mr. BACHUS, Mr. BARLETTA, Mr. BARTLETT, Mr. BARTON of Texas, Mr. BENISHEK, Mr. BILIRAKIS, Mr. BISHOP of Utah, Mrs. BLACKBURN, Mr. BONNER, Mr. BOUSTANY, Mr. BRADY of Texas, Mr. BROOKS, Mr. BROUN of Georgia, Mr. BUCHANAN, Mr. BURGESS, Mr. BURTON of Indiana, Mr. CANSECO, Mr. CARTER, Mr. CASSIDY, Mr. CHABOT, Mr. CHAFFETZ, Mr. COFFMAN of Colorado, Mr. COLE, Mr. CONAWAY, Mr. COSTELLO, Mr. CRAVAACK, Mr. CRAWFORD, Mr. CRENSHAW, Mr. CRITZ, Mr. DAVIS of Kentucky, Mr. DESJARLAIS, Mr. DIAZ-BALART, Mr. DONNELLY of Indiana, Mr. DUFFY, Mr. DUNCAN of South Carolina, Mr. DUNCAN of Tennessee, Mrs. EMERSON, Mr. FITZPATRICK, Mr. FLAKE, Mr. FLEMING, Mr. FORBES, Mr. FORTENBERRY, Ms. FOXX, Mr. FRANKS of Arizona, Mr. GARDNER, Mr. GARRETT, Mr. GERLACH, Mr. GIBBS, Mr. GINGREY of Georgia, Mr. GOWDY, Ms. GRANGER, Mr. GRAVES of Missouri, Mr. GRIMM, Mr. GUTHRIE, Mr. HALL, Mr. HARPER, Mr. HARRIS, Mrs. HARTZLER, Mr. HENSARLING, Mr. HERGER, Mr. HUELSKAMP, Mr. HUNTER, Mr. HURT, Ms. JENKINS, Mr. JOHNSON of Illinois, Mr. JONES, Mr. JORDAN, Mr. KELLY, Mr. KING of New York, Mr. KING of Iowa, Mr. KINGSTON, Mr. KINZINGER of Illinois, Mr. KLINE, Mr. LAMBORN, Mr. LANDRY, Mr. LANKFORD, Mr. LATOURETTE, Mr. LATTA, Mr. LEE of New York, Mr. LOBIONDO, Mr. LONG, Mr. LUETKEMEYER, Mr. DANIEL E. LUNGREN of California, Mr. MANZULLO, Mr. MARCHANT, Mr. MARINO, Mr. MCCARTHY of California, Mr. MCCAUL, Mr. MCCLINTOCK, Mr. MCCOTTER, Mr. MCHENRY, Mr. MCINTYRE, Mr. MCKINLEY, Mrs. MCMORRIS RODGERS, Mrs. MILLER of Michigan, Mr. GARY G. MILLER of California, Mr. MILLER of Florida, Mr. MULVANEY, Mr. MURPHY of Pennsylvania, Mr. NEUGEBAUER, Mrs. NOEM, Mr. NUNNELEE, Mr. OLSON, Mr. PAUL, Mr. PENCE, Mr. PETERSON, Mr. PITTS, Mr. POMPEO, Mr. POSEY, Mr. PRICE of Georgia, Mr. RAHALL, Mr. RIBBLE, Mr. RIGELL, Mr. ROE of Tennessee, Mr. ROGERS of Kentucky, Mr. ROKITA, Mr. ROSKAM, Ms. ROS-LEHTINEN, Mr. ROSS of Arkansas, Mr. ROYCE, Mr. RYAN of Wisconsin, Mr. SCALISE, Mr. SCHILLING, Mrs. SCHMIDT,

Mr. AUSTIN SCOTT of Georgia, Mr. SCOTT of South Carolina, Mr. SENSENBRENNER, Mr. SHIMKUS, Mr. SHULER, Mr. SHUSTER, Mr. SIMPSON, Mr. SMITH of Texas, Mr. STUTZMAN, Mr. SULLIVAN, Mr. TERRY, Mr. THOMPSON of Pennsylvania, Mr. TURNER, Mr. WESTMORELAND, Mr. WHITFIELD, Mr. WILSON of South Carolina, Mr. WOLF, Mr. WOODALL, Mr. YOUNG of Florida, Mr. GOHMERT, Mr. WITTMAN, Mr. CANTOR, Mr. BOREN, Mr. GOODLATTE, Mr. MCKEON, Mr. ROGERS of Michigan, Mr. CALVERT, Mrs. ELLMERS, Mr. ADERHOLT, Mr. TIBERI, and Mr. SAM JOHNSON of Texas) introduced the following bill; which was referred to the Committee on the Judiciary, and in addition to the Committees on Energy and Commerce and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

---

A BILL

To prohibit taxpayer funded abortions and to provide for conscience protections, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "No Taxpayer Funding for Abortion Act".

SEC. 2. PROHIBITING TAXPAYER FUNDED ABORTIONS AND PROVIDING FOR CONSCIENCE PROTECTIONS.

Title 1 of the United States Code is amended by adding at the end the following new chapter:

"CHAPTER 4—PROHIBITING TAXPAYER FUNDED ABORTIONS AND PROVIDING FOR CONSCIENCE PROTECTIONS

"SEC. 301. PROHIBITION ON FUNDING FOR ABORTIONS.

"No funds authorized or appropriated by Federal law, and none of the funds in any trust fund to which funds are authorized or appropriated by Federal law, shall be expended for any abortion.

"SEC. 302. PROHIBITION ON FUNDING FOR HEALTH BENEFITS PLANS THAT COVER ABORTION.

"None of the funds authorized or appropriated by Federal law, and none of the funds in any trust fund to which funds are authorized or appropriated by Federal law, shall be expended for health benefits coverage that includes coverage of abortion.

"SEC. 303. PROHIBITION ON TAX BENEFITS RELATING TO ABORTION.

"For taxable years beginning after the date of the enactment of this section—

"(1) no credit shall be allowed under the internal revenue laws with respect to amounts paid or incurred for an abortion or with respect to amounts paid or incurred for a health benefits plan (including premium assistance) that includes coverage of abortion,

"(2) for purposes of determining any deduction for expenses paid for medical care of the taxpayer or the taxpayer's spouse or dependents, amounts paid or incurred for an abortion or for a health benefits plan that includes coverage of abortion shall not be taken into account, and

"(3) in the case of any tax-preferred trust or account the purpose of which is to pay medical expenses of the account beneficiary, any amount paid or distributed from such an account for an abortion shall be included in the gross income of such beneficiary.

"SEC. 304. LIMITATION ON FEDERAL FACILITIES AND EMPLOYEES.

"No health care service furnished—

"(1) by or in a health care facility owned or operated by the Federal Government; or

"(2) by any physician or other individual employed by the Federal Government to provide health care services within the scope of the physician's or individual's employment,

may include abortion.

1 **"SEC. 305. CONSTRUCTION RELATING TO SEPARATE COV-**
2 **ERAGE.**

3 "Nothing in this chapter shall be construed as pro-
4 hibiting any individual, entity, or State or locality from
5 purchasing separate abortion coverage or health benefits
6 coverage that includes abortion so long as such coverage
7 is paid for entirely using only funds not authorized or ap-
8 propriated by Federal law and such coverage shall not be
9 purchased using matching funds required for a federally
10 subsidized program, including a State's or locality's con-
11 tribution of Medicaid matching funds.

12 **"SEC. 306. CONSTRUCTION RELATING TO THE USE OF NON-**
13 **FEDERAL FUNDS FOR HEALTH COVERAGE.**

14 "Nothing in this chapter shall be construed as re-
15 stricting the ability of any non-Federal health benefits cov-
16 erage provider from offering abortion coverage, or the abil-
17 ity of a State or locality to contract separately with such
18 a provider for such coverage, so long as only funds not
19 authorized or appropriated by Federal law are used and
20 such coverage shall not be purchased using matching
21 funds required for a federally subsidized program, includ-
22 ing a State's or locality's contribution of Medicaid match-
23 ing funds.

24 **"SEC. 307. NON-PREEMPTION OF OTHER FEDERAL LAWS.**

25 "Nothing in this chapter shall repeal, amend, or have
26 any effect on any other Federal law to the extent such

law imposes any limitation on the use of funds for abortion or for health benefits coverage that includes coverage of abortion, beyond the limitations set forth in this chapter.

"SEC. 308. CONSTRUCTION RELATED TO STATE OR LOCAL LAWS.

"Nothing in this chapter or any other Federal law shall be construed to require any State or local government to provide or pay for any abortion or any health benefits coverage that includes coverage of any abortion.

"SEC. 309. TREATMENT OF ABORTIONS RELATED TO RAPE, INCEST, OR PRESERVING THE LIFE OF THE MOTHER.

"The limitations established in sections 301, 302, 303, and 304 shall not apply to an abortion—

"(1) if the pregnancy occurred because the pregnant female was the subject of an act of forcible rape or, if a minor, an act of incest; or

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

1 **"SEC. 310. APPLICATION TO DISTRICT OF COLUMBIA.**

2 "In this chapter:

3 "(1) Any reference to funds appropriated by
4 Federal law shall be treated as including any
5 amounts within the budget of the District of Colum-
6 bia that have been approved by Act of Congress pur-
7 suant to section 446 of the District of Columbia
8 Home Rule Act (or any applicable successor Federal
9 law).

10 "(2) The term 'Federal Government' includes
11 the government of the District of Columbia.

12 **"SEC. 311. NO GOVERNMENT DISCRIMINATION AGAINST**
13 **CERTAIN HEALTH CARE ENTITIES.**

14 "(a) NONDISCRIMINATION.—A Federal agency or
15 program, and any State or local government that receives
16 Federal financial assistance (either directly or indirectly),
17 may not subject any individual or institutional health care
18 entity to discrimination on the basis that the health care
19 entity does not provide, pay for, provide coverage of, or
20 refer for abortions.

21 "(b) HEALTH CARE ENTITY DEFINED.—For pur-
22 poses of this section, the term 'health care entity' includes
23 an individual physician or other health care professional,
24 a hospital, a provider-sponsored organization, a health
25 maintenance organization, a health insurance plan, or any
26 other kind of health care facility, organization, or plan.

"(c) REMEDIES.—

"(1) IN GENERAL.—The courts of the United States shall have jurisdiction to prevent and redress actual or threatened violations of this section by issuing any form of legal or equitable relief, including—

"(A) injunctions prohibiting conduct that violates this section; and

"(B) orders preventing the disbursement of all or a portion of Federal financial assistance to a State or local government, or to a specific offending agency or program of a State or local government, until such time as the conduct prohibited by this section has ceased.

"(2) COMMENCEMENT OF ACTION.—An action under this subsection may be instituted by—

"(A) any health care entity that has standing to complain of an actual or threatened violation of this section; or

"(B) the Attorney General of the United States.

"(d) ADMINISTRATION.—The Secretary of Health and Human Services shall designate the Director of the Office for Civil Rights of the Department of Health and Human Services—

1 "(1) to receive complaints alleging a violation of
2 this section;
3 "(2) subject to paragraph (3), to pursue the in-
4 vestigation of such complaints in coordination with
5 the Attorney General; and
6 "(3) in the case of a complaint related to a
7 Federal agency (other than with respect to the De-
8 partment of Health and Human Services) or pro-
9 gram administered through such other agency or
10 any State or local government receiving Federal fi-
11 nancial assistance through such other agency, to
12 refer the complaint to the appropriate office of such
13 other agency.

14 **"SEC. 312. HEALTH BENEFITS COVERAGE DEFINED.**

15 "In this chapter the term 'health benefits coverage'
16 means the package of services covered by a managed care
17 provider or organization pursuant to a contract or other
18 arrangement.".

○

Mr. NADLER. Thank you, Mr. Chairman. I first want to note that this is our first Subcommittee hearing of the 112th Congress and your first as Chairman. I want to congratulate you. Although our jurisdiction includes some of the most difficult issues before the Congress, some of which have historically been very contentious, I look forward to working with you in the spirit of comity to give what we both know are strong and sincerely held views the fair hearing that they deserve.

Having chaired this Subcommittee for two Congresses and having served as the Ranking Member for several Congresses before that, I appreciate what a challenge this Subcommittee can be and I look forward to working with you.

Today's hearing concerns what may be the most difficult and divisive issue we will have the opportunity to consider: A woman's right to make decisions about her own body. Whether to become pregnant, whether to continue a pregnancy, or whether to terminate it has long been a right protected by the Constitution. Whether or not people think that is a good idea or a fair reading of the Constitution or morally correct, it remains the law of the land.

Congress has for more than three decades used economic coercion to try to prevent women from exercising their constitutionally protected choice by prohibiting use of Federal funds for abortions, the only legal health care procedure subject to such a ban. Until now that coercion was directed against the poor and against women dependent upon the government for health care, military personnel and their dependents, prison inmates, and Federal employees. We have thus developed a two-tiered system in which people with means have the right to choose but members of vulnerable populations do not.

Now comes the No Taxpayer Funding for Abortion Act, H.R. 3, which is really misnamed, because it has very little to do with taxpayer funding for abortions, it goes way beyond that question and places government in the middle of private choices by families and businesses about how they wish to spend their own health care dollars. This legislation represents an entirely new front in the war against women and their families.

After 2 years of hearing my Republican colleagues complain that government should not meddle in the private insurance market or in private health care choices, I was stunned to see legislation so obviously designed to do exactly that.

It seems that many Republicans believe in freedom, provided no one uses that freedom in a way they find objectionable. That is a strange understanding of freedom. Even more stunning, this bill contains a huge tax increase on families, businesses, and the self-employed if they spend their own money—let me repeat that, their own money on insurance that covers abortions or abortion services.

The power to tax is the power to destroy and here the taxing power is being used quite deliberately to destroy the right of every American to make private health care decisions free from government interference. A Republican tax increase, Republican support for government intrusion into private health care choices—I am supposed to say you heard it here first, but if you read the bill you saw it there first.

I am equally surprised to find out that my Republican colleagues think that a tax exemption or credit is a form of government funding. What happened to all the about the rhetoric about its being our money, or does that apply only in certain circumstances? Will we now have to call every tax exemption or credit a form of government funding for the recipient? I am sure there will be many businesses, charities, and religious denominations that will be alarmed to find out that they are receiving government subsidies.

I also join many other Americans in being absolutely horrified—well, before I get to that, let me say that among others who should be horrified are all the churches, and synagogues and mosques that will now presumably have to give up their tax exemptions, because if tax exemptions are government subsidies then that is a direct establishment of religion and the logic is inexorable. Either a tax exemption is government funding, in which case we cannot give tax exemptions to churches and synagogues and mosques, or it is not, in which case this bill has no claim on anything.

I also join many other Americans being absolutely horrified that the sponsors of this bill seem not to know what rape and incest are. Rape, according to this legislation, is only "forcible" rape. Date rape drugs, sex with minors, with the mentally impaired are, at least according to the sponsors of this bill, not really rape anymore. Incest also is no longer incest. Instead it is now only incest with a minor that we have to be concerned about, which means I guess that incest with a high school senior doesn't count.

Have the extremes really taken such a hold on this debate that we cannot even agree to help children and teenagers who are the victims of predators? Is there no compassion left in this Capitol?

I have heard that the rape and incest provisions are going to be removed from this bill or modified because of the outcry they have raised. But first, we have not seen such an amendment yet. And second, what does this provision, even if amended, what does the provision in the first place say about the mindset and intent of the sponsors of the legislation?

There is also a provision in this bill that in the name of conscience of health care providers would allow any health care provider or institution to refuse to provide an abortion to a woman who would die if she doesn't get the abortion. They would be allowed to refuse to provide an abortion in the emergency room, even if the medical judgment is that without that abortion she would die. They would let that woman die right there in the emergency room and the government would be powerless to do anything to penalize that or to prevent it. In fact, if the government, under the provisions of this bill, insisted that the hospital not let the woman die, section 311 of the bill would allow the hospital to sue the government and in the case of a State or locality strip that community of all Federal funding until the jurisdiction relented and allowed women to die if they needed an abortion to prevent the death. That is the new definition it seems of pro-life.

So, Mr. Chairman, let's start off on the right foot. The No Taxpayer Funding for Abortion Act is not really about taxpayer funding; it is about government interfering with private healthcare decisions. It is not about protecting the innocent; it is about creating

appalling, even life threatening situations for women. It is a tax increase of historic proportions.

Finally, if passed, it would eliminate the private market for abortion insurance coverage. The chief sponsor of this legislation, the gentleman from New Jersey, Mr. Smith, has been very clear about his purpose. When he introduced this bill, he cited a study by the Guttmacher Institute that showed a decline in the rate of abortions of approximately 25 percent when funding is cut off. What that proves, if it proves anything, is that economic coercion works, and the remarks we have just heard from the Chairman made crystal clear that the unashamed purpose of this bill is to use economic coercion to prevent women and families from exercising their constitutional right to make a choice of abortion even with their own funds.

It is an unprecedented attack on women, on families, on their rights under the Constitution and, for that matter, on the private insurance market. Let's not pretend this bill has anything to do with government funding. It does not.

I yield back the balance of my time.

Mr. FRANKS. Thank you, Mr. Nadler. And without objection, other Members' opening statements will be made part of the record.

Mr. NADLER. Mr. Chairman, may I be recognized for a unanimous consent request?

Mr. FRANKS. Certainly.

Mr. NADLER. Thank you, Mr. Chairman. Mr. Chairman, I ask unanimous consent to place into the record testimony submitted by our colleague, the gentlewoman from the District of Columbia, Ms. Norton. The gentlewoman had requested that she be allowed to present testimony in today's hearing because there is a provision in the bill that specifically pertains to her district, the District of Columbia, and to no other, but we were told that the Chairman of the full Committee has denied that request. I am sorry. I regret that she was denied permission to testify, and I hope that this has been a misunderstanding and that in the future Members of Congress will be, as was the practice when I was Chairman of the Subcommittee, permitted on request to testify as witnesses, especially if it has something to do specifically with their own district. So I ask unanimous consent to place her statement and my statement in the record.

Mr. FRANKS. Without objection, your statement and hers will be placed in the record.

[The prepared statement of Mr. Nadler follows:]

CONGRESSMAN
JERROLD NADLER
8th Congressional District of New York

Nadler Opening Statement for Hearing on H.R. 3, The "No Taxpayer Funding for Abortion Act"

FOR IMMEDIATE RELEASE: Tuesday, February 8, 2011
CONTACT: Ilan Kayatsky, 202-225-5635

I first want to note that this is our first Subcommittee hearing of the 112th Congress, and your first as Chairman. I want to congratulate you. Although our jurisdiction includes some of the most difficult issues before the Congress, ones which have historically been very contentious, I look forward to working with you in a spirit of comity to give what we both know are strongly and sincerely held views the fair hearing that they deserve.

Having chaired this Subcommittee for two Congresses, and having served as the Ranking Member before that, I appreciate what a challenge this Subcommittee can be. I look forward to working with you.

Today's hearing concerns what just might be the most difficult and divisive issue we will have the opportunity to consider. A woman's right to make decisions about her own body, whether to become pregnant, to continue a pregnancy, or whether to terminate a pregnancy, has long been a right protected by the Constitution. Whether or not you think that is a good idea, or a fair reading of the Constitution, it remains the law of the land.

Congress has, for more than three decades, used economic coercion to prevent women from exercising that constitutionally protected choice. Until now, that coercion was directed against the poor, and women dependent on the government for health care: military personnel and their dependants, prison inmates, and federal employees. We have, thus, developed a two-tiered system, where people with means have the right to choose, and where vulnerable populations do not.

Now comes the "No Taxpayer Funding for Abortion Act," which is really misnamed, because it goes well outside the limits of taxpayer funding and places government in the middle of private choices by families and businesses about how they wish to spend their own health care dollars. This legislation represents an entirely new front in the war on women and their families.

After two years of hearing my Republican colleagues complain that government should not meddle in the private insurance market, or in private health care choices, I was stunned to see legislation so obviously designed to do just that. It seems that Republicans only believe in freedom provided no one uses that freedom in a way that Republicans find objectionable. It is a strange understanding of freedom.

Even more stunning, this bill contains huge tax increases on families, businesses, and the self-employed if they spend their own money - let me repeat that: their own money – on abortion coverage

or services. The power to tax is the power to destroy, and, here, the taxing power is being used to destroy the right of every American to make private health care decisions free from government interference.

A Republican tax increase? You heard it here first.

I am equally surprised to find out that my Republican colleagues think that a tax exemption or credit is a form of government funding. What happened to all the rhetoric about it being "our money?" Or does that only apply in certain circumstances. Will we now have to judge every tax exemption or credit as a form of government funding for the recipient? I'm sure that there will be many businesses, charities, and religious denominations that will be alarmed to find this out.

I also join many other Americans in being absolutely horrified that the sponsors of this bill seem not to know what rape and incest are.

Rape, according to this legislation is only forcible rape. Date rape drugs, sex with minors or with the mentally impaired are – at least according to the sponsors of this bill – not really rape anymore.

Incest is also no longer incest. Instead, it is now "incest with a minor," which means – I guess – that incest with a high school student doesn't count.

Have the extremes really taken such a hold on this debate that we can't even agree to help children and teenagers who are the victims of predators? Is there no compassion left in this place?

There is also a provision in this bill that would allow any health care provider or institution to refuse to provide an abortion to a woman whose life is in imminent peril. They could let that woman die right there in the emergency room and the government would be powerless to do anything. In fact, if the government insisted that the hospital not let the woman die, section 311 of the bill would allow the hospital to sue the government and, in the case of a state or locality, strip that community of all federal funding until the jurisdiction relented.

That's the new definition of "pro-life?"

So, Mr. Chairman, let's start off on the right foot: the "No Taxpayer Funding of Abortion Act" is not really about taxpayer funding; it's about government interfering with private health care decisions. It is not about protecting the innocent, it is about creating appalling, even life threatening situations, for women. It is a tax increase of historic proportions. Finally, if passed, it would eliminate the private market for abortion coverage.

The sponsor of this legislation, the Gentleman from New Jersey, has been very clear about his purpose. When he introduced this bill, he cited a study by the Guttmacher Institute that showed a decline in the rate of abortions by approximately 25% when funding is cut off. What that proves is that economic coercion works. This bill takes that to a whole new level by going after the private insurance and health care markets.

It is an unprecedented attack on women, families, and their rights under the constitution. Let's not pretend this is about government funding. I yield back.

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Jerrold Nadler has served in Congress since 1992. He represents New York's 8th Congressional District, which includes parts of Manhattan and Brooklyn

[The prepared statement of Ms. Norton follows:]

ELEANOR HOLMES NORTON
DISTRICT OF COLUMBIA

COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE
SUBCOMMITTEES:
CHAIRWOMAN
ECONOMIC DEVELOPMENT, PUBLIC BUILDINGS, AND EMERGENCY MANAGEMENT
AVIATION
WATER RESOURCES AND ENVIRONMENT

Congress of the United States
House of Representatives
Washington, D.C. 20515

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
SUBCOMMITTEES:
FEDERAL WORKFORCE, POSTAL SERVICE, AND DISTRICT OF COLUMBIA
INFORMATION POLICY, CENSUS, AND NATIONAL ARCHIVES

COMMITTEE ON HOMELAND SECURITY
SUBCOMMITTEES:
TRANSPORTATION SECURITY AND INFRASTRUCTURE PROTECTION
EMERGENCY COMMUNICATIONS, PREPAREDNESS, AND RESPONSE

Statement of Congresswoman Eleanor Holmes Norton
on H.R. 3, the No Taxpayer Funding for Abortion Act
House Committee on the Judiciary
Subcommittee on the Constitution
February 8, 2011

First, I want to strongly object to the Committee Majority's denial of my request to testify today, particularly in light of the fact that H.R. 3 singles out the local law and taxpayer funds of my district. I recognize that no Member panel was contemplated, but in my two decades in the Congress, I have never seen a Member turned away from testifying, and certainly not when her own district was targeted by a bill under consideration.

I strongly oppose the harsh anti-choice H.R. 3, the No Taxpayer Funding for Abortion Act, in its entirety, but I am specifically compelled to discuss an unprecedented provision of the bill, Section 310, "Application to District of Columbia." This provision is entirely unrelated to the purposes of the bill, which seeks not only to write the Hyde amendment into federal law and extend it permanently, but to go much further, threatening the health of millions of women. However, H.R. 3 goes haywire and crosses the line between autocracy and democracy to dictate to the self-governing District of Columbia that it may not spend its own local taxpayer-raised funds as it chooses.

The new House Republican Majority that rode into town on the wings of a promise for jobs has yet to introduce a jobs bill. Instead, they quickly reverted to type, giving top priority to controversial social issues. Two of their top bills are aimed uniquely at one local jurisdiction, the District of Columbia. One of these anti-home-rule bills, sponsored by the Speaker, targets the District with D.C.-only private school vouchers, although our residents have created a large, alternative public charter school system that almost half of our children attend and that is so successful, it has long waiting lists. To compound the injury, the new House Majority has included an outrageous provision in H.R. 3 that would federalize the District of Columbia for purposes of denying the city the right to spend its own local funds on abortions for low-income residents.

During the past four years, I worked to carry out the will of D.C. residents and our local government by successfully removing all of the accumulated appropriations riders that eliminated the District's right to decide how to spend its local funds on behalf of its residents, including for abortion for low-income women.

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H.R. 3, however, not only seeks to re-impose the ban on the District's use of its local funds for abortion, but also to make it permanent. This bill presents a new and expanded way to deny the residents of the District of Columbia their democratic rights. Unlike the prior prohibitions on the District's use of its local funds, Section 310 states that the "term 'Federal Government' includes the government of the District of Columbia." Declaring that the District is a part of the federal government for the purpose of abortion is an unprecedented violation of the District's right to self-government.

The District of Columbia is not a colony of the Congress. We refuse to submit the funds we alone raise and decisions about how to spend our own local funds to Members of the House. We will not let the Majority get away with supporting democracy everywhere on earth except its own nation's capital. The House Majority goes many steps too far when they introduce a bill with such potential harm to all women and then try to make it worse for the women of the District of Columbia by taking down part of the local government's authority in the process.

The new House Majority says it supports limiting the federal government's power and devolving that power to the states and localities. This bill does the opposite by using federal power to snatch local authority from the District of Columbia and its people. The time has come to practice what the House Majority preaches.

Mr. NADLER. I thank the gentleman.

Mr. FRANKS. Just to clarify the issue, Mr. Nadler, Chairman Smith has decided that as a general policy the Judiciary Committee and its Subcommittees will only have one panel of witnesses for each hearing and that the panel will consist of no more than four witnesses. The minority is able to select a witness. And if they would like to invite a Member to testify, that is certainly something they can do. The Chairman did not refuse Ms. Norton's abil-

ity to be here; she just had to be chosen as one of the minority witnesses.

There may be times when the Committee is not able to accommodate every individual who wishes to testify. However, the record always remains open for 5 legislative days for others to submit testimony if they wish. This is a bright line rule that is not meant to discriminate against any particular potential witness. It is meant to ensure that hearings are succinct enough so that Members are able to hear all of the witnesses and participate in a meaningful way.

Mr. NADLER. Mr. Chairman?

Mr. FRANKS. Mr. Nadler.

Mr. NADLER. Thank you. I simply would like to comment on that. I have never objected—I mean, some Committees in this Congress have three and four panels, I certainly have never objected and indeed I sometimes welcome that this Committee generally only has one panel. It makes life easier and more succinct. I am not objecting to that now.

However, when the minority only has only one witness, which has been the practice under the Democrats and Republicans and certainly that is not a change here, but in certain circumstances it presents a quandary. Here we have a bill dealing for the most part with a broad issue of taxpayer funding of everything that I talked about and a specific provision dealing with the District of Columbia. To say that the minority could have Ms. Norton as the witness to talk about D.C. is to say that we couldn't talk about the basic provisions of the bill. And if we choose to have one witness on the basis of the provisions of the bill, then Ms. Norton is denied the opportunity to talk about the specific application to her district. That is why when I was Chairman we—if a Member desired to testify, especially if there was something to do with his or her district, we would always provide a separate panel for that Member, and for partisan purposes you might say, all right, if it's a Republican we will have a Democrat testify about something, too. But you would allow that flexibility under the general rule. And I would hope in the future that flexibility would be attended to.

Mr. FRANKS. Thank you, Mr. Nadler.

If the witnesses would come forward and be seated. We have a very distinguished panel of witnesses today.

Each of the witnesses' written statements will be entered into the record in its entirety, and I ask that each witness summarize his or her testimony in 5 minutes or less. Now to help you stay within that time there is a timing light on your table. When the light switches from green to yellow, you will have 1 minute to conclude your testimony. When the light turns red, it signals that the witness' 5 minutes have expired.

Our first witness is Mr. Richard M. Doerflinger, associate director of the Secretariat of Pro-Life Activities, United States Conference of Catholic Bishops, where he has worked for over 30 years. His writings on medical ethics and public policy include contributions to the Journal of Law, Medicine & Ethics, Duquesne Law Review, the Kennedy Institute of Ethics Journal, the National Catholic Bioethics Quarterly, and the American Journal of Bioethics. The May 22nd, 2004 issue of National Journal featured Mr. Doerflinger

as one of the 12 experts whose ideas are shaping national debate on the use and abuse of biotechnology.

Our second witness is Cathy Ruse, Senior Fellow for Legal Studies at the Family Research Council's offices. Mrs. Ruse worked previously as FRC's Legal Director, as well as the Legal Counsel and Program Director for the National Center for Children and Families. We are proud to note that Mrs. Ruse—Ms. Ruse has served as Chief Counsel of this very Subcommittee. Wired Magazine has called her one of the most influential opinion shapers in the country.

Our third witness is Professor Sara Rosenbaum, the Harold and Jane Hirsh Professor of Health Law and Policy and Chair of the Department of Health Policy at George Washington University School of Public Health and Health Services. Professor Rosenbaum also directs the Hirsch Health Law and Policy Program and the Center for Health Services Research and Policy and holds appointments in the Schools of Medicine and Health Sciences and Law.

Now without objection, all Members will have 5 legislative days within which to submit materials for the record.

It is the practice of this Subcommittee to swear in the witnesses, so if you will all please stand and raise your right hand.

[Witnesses sworn.]

Mr. FRANKS. Thank you, and please be seated.

I now recognize our first witness, Richard Doerflinger, for 5 minutes.

Mr. DOERFLINGER. Thank you, Mr. Chairman.

Mr. FRANKS. Sir, would you turn on that microphone?

Mr. DOERFLINGER. Is this it?

Mr. FRANKS. Yes, sir. Thank you.

TESTIMONY OF RICHARD M. DOERFLINGER, ASSOCIATE DIRECTOR OF THE SECRETARIAT OF PRO-LIFE ACTIVITIES, UNITED STATES CONFERENCE OF CATHOLIC BISHOPS (USCCB)

Mr. DOERFLINGER. Thank you, Mr. Chairman, for this opportunity to present our views in support of the No Taxpayer Funding for Abortion Act. This bill will write into permanent law policy on which there has been strong popular and congressional agreement for over 35 years: The Federal Government should not use tax dollars to support or promote elective abortion. That principle has been embodied in the Hyde amendment and in numerous other provisions governing a wide range of domestic and foreign programs, and has consistently had the support of the American people.

Even courts insisting on a constitutional right to abortion have said that alleged right "implies no limitation on the authority of a State to make a value judgment favoring childbirth over abortion and to implement that judgment by the allocation of public funds."

In 1980, the U.S. Supreme Court said the Hyde amendment is an exercise of the "legitimate congressional interest in protecting potential life," adding: "Abortion is inherently different from other medical procedures because no other procedure involves the purposeful termination of a potential life." In our view the Court's only mistake here was the phrase "potential life." In our view, unborn

children are actually alive, until they are made actually dead by abortion.

While Congress's policy has been consistent for decades, its implementation in practice has been piecemeal, confusing and sometimes sadly inadequate. Gaps or loopholes have been discovered in this patchwork of provisions over the years, highlighting the need for permanent and consistent policies across the Federal Government.

Last year, Congress passed major health care reform legislation with at least four different policies on abortion funding, ranging from a ban on such funding in one section of the bill to a potential mandate for such funding in another.

If H.R. 3 had been enacted before that debate began, the debate would not have been about abortion. A major obstacle to support by Catholics and other pro-life Americans would have been removed, and the final legislation would not have been so badly compromised by provisions that place unborn human lives at grave risk.

H.R. 3 would prevent problems and confusions on abortion funding in future legislation. Federal health bills could be debated in terms of their ability to promote the goal of universal health care, instead of being mired in debates about one lethal procedure that most Americans know is not truly health care at all.

H.R. 3 would also codify the Hyde-Weldon amendment, a part of the annual Labor-HHS appropriations bills since 2004, and I would say one of many conscience provisions, beginning with the Church amendment in 1973, named after Senator Frank Church of Idaho, which has tried to protect the rights of health care providers not to be coerced into abortion.

The Hyde-Weldon amendment was recently reaffirmed, unanimously, as part of the House version of health care reform legislation in Congressman Waxman's Health Subcommittee. It was approved by voice vote without dissent, but sadly it did not survive in the final legislation.

Hyde-Weldon ensures that Federal agencies, and State and local governments receiving Federal funds, do not discriminate against health care providers because they do not take part in abortions. And I emphasize that because this is a modest bill that has the Federal Government essentially policing itself. It is government restraining itself from coercing abortion; it does not reach out into private actions.

It is long overdue for the Hyde-Weldon policy as well to receive a more secure status. Here also Congress's policy has been clear for 38 years, but the mechanism for achieving it has suffered from drawbacks and loopholes, including a failure even to specify where or how providers may go to have their rights enforced.

H.R. 3 writes this essential civil rights protection into permanent law, allows for modest and reasonable remedies to ensure compliance, provides for a private right of action, and designates the HHS Office for Civil Rights to hear complaints as well.

The need for more secure protection in this area is clear. The American Civil Liberties Union, for example, has been urging the Federal Government to force Catholic and other hospitals to violate their moral and religious convictions by providing what the ACLU

calls emergency abortions. By this it means all abortions to serve women's life or health, which it surely knows has been interpreted by the Federal courts to mean social or emotional well-being.

This is an obvious threat to access to life affirming health care. Catholic hospitals alone care for one in six patients in the United States each year and provide a full continuum of health care through more than 2,000 sponsors, systems, facilities and related organizations. They have been shown to provide higher quality and more effective care, including care for women, than anyone else in various studies.

If Congress wants to expand rather than eliminate access to lifesaving health care, including lifesaving health care for women and particularly for the poor and the underserved, it should be concerned about any effort to attack the rights of these providers and undermine their continued ability to serve the common good.

Just to give short answers to some questions raised about H.R. 3, with longer answers in our prepared text, H.R. 3 does not eliminate private coverage for abortion but specifically allows such coverage when purchased without Federal subsidy. It does not create an unprecedented policy of denying tax benefits to abortion, but follows the recently enacted Affordable Care Act in this regard, which I believe had some Democratic support. It is that Act which said use of tax credits for abortion is, "Federal funding of abortion." This simply follows the precedent.

This bill does not depart from precedent by saying that Federal law does not compel States to fund any abortions. In this regard as well, it follows a policy actively supported by the Democratic leadership in the last Congress and stated no less than three times in the Affordable Care Act.

Finally, its conscience clause does not place women's lives at risk. What places women's lives at risk, as we recently learned from the story of Dr. Gosnell in Philadelphia—but he is only the tip of the iceberg—what places women's lives at risk is the abortion industry itself as well as that same industry's attacks on the continued viability of the most effective providers of lifesaving care in the world.

My prepared text provides additional details, and I would be happy to answer questions. Thank you.

[The prepared statement of Mr. Doerflinger follows:]

Testimony of Richard M. Doerflinger
on behalf of the
U.S. Conference of Catholic Bishops
before the
Subcommittee on the Constitution
House Judiciary Committee
February 8, 2011

Hearing on H.R. 3, No Taxpayer Funding for Abortion Act

I am Richard M. Doerflinger, Associate Director of the Secretariat of Pro-Life Activities at the United States Conference of Catholic Bishops (USCCB). I want to thank this Subcommittee for allowing us to present our views in support of H.R. 3, the No Taxpayer Funding for Abortion Act.

A Permanent Ban on Abortion Funding: Long Overdue

H.R. 3 will write into permanent law a policy on which there has been strong popular and congressional agreement for over 35 years: The federal government should not use tax dollars to support or promote elective abortion.[1]

Since 1976 this principle has been embodied in the Hyde amendment to annual appropriations bills funding the Department of Health and Human Services (HHS), and in numerous similar provisions governing a wide range of domestic and foreign programs. It has consistently had the support of the American people. For example, reflecting a long history of public support for the Hyde amendment, a November 2009 CNN survey found that Americans oppose "using public funds for abortions when the woman cannot afford it" by a margin of 61 to 37%.[2] In December 2009 a Quinnipiac University poll found 72% opposition to "allowing abortions to be paid for by public funds under a health care reform bill." In a survey conducted for my organization by International Communications Research at about the same time, 67% (including 60% of those supporting health care reform legislation) opposed "measures that would

[1] In this testimony the phrase "elective abortion" refers to abortions that have long been ineligible for federal funding; in recent years this has included abortions except for cases of rape, incest, or danger to the life of the mother. The term is used here as shorthand for a longstanding federal policy, not as expressing a medical or moral judgment.

[2] This poll even found a majority against companies including abortion in private insurance plans involving no government money, 51% to 45%. See CNN/Opinion Research Corporation Poll of November 13-15, 2009, at http://i2.cdn.turner.com/cnn/2010/images/03/09/top17.pdf.

require people to pay for abortion coverage with their federal taxes." That survey also asked: "If the choice were up to you, would you want your own insurance policy to include abortion?" Only 24% said yes; 68% of U.S. adults, and *69% of women*, said **no**. Also saying **no** were 82% of those currently uninsured, presumably the primary target audience for health care reform.[3]

Even public officials who take a "pro-choice" stand on abortion have supported bans on public funding as a "middle ground" on this contentious issue – sometimes observing that it is not "pro-choice" to force others to fund a procedure to which they have fundamental objections. And even courts insisting on a constitutional "right" to abortion have said that this alleged right "implies **no limitation** on the authority of a State to make a value judgment favoring childbirth over abortion, and to implement that judgment by the allocation of public funds."[4] As the U.S. Supreme Court said in 1980:

> By subsidizing the medical expenses of indigent women who carry their pregnancies to term while not subsidizing the comparable expenses of women who undergo abortions (except those whose lives are threatened), Congress has established incentives that make childbirth a more attractive alternative than abortion for persons eligible for Medicaid. These incentives bear a direct relationship to **the legitimate congressional interest in protecting potential life**. Nor is it irrational that Congress has authorized federal reimbursement for medically necessary services generally, but not for certain medically necessary abortions. **Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life.**[5]

So secure is this legal and political consensus, in fact, that some have *assumed* it is already fully implemented at all levels of our federal government. For example, some wrongly argued during the recent debate on health care reform that there was no need for restrictions on abortion funding in the legislation, because this matter had already been settled by the Hyde amendment. However, the Hyde amendment itself is only a rider to the annual Labor/HHS appropriations bill, and thus governs only funds appropriated under that particular Act.

The fact is that Congress's *policy* has been remarkably consistent for decades, but the implementation of that policy in *practice* has been piecemeal, confusing and sometimes sadly

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[3] These and other recent polls are summarized in National Right to Life Committee, "Public opinion on 'health care reform' and abortion," January 6, 2010, at www.nrlc.org/ahc/AHCPollsSummary.pdf. For more on the ICR survey see USCCB News Release, "New Survey: Most Americans Want Health Care Reform, Oppose Abortion Coverage, Support Conscience Protection Laws," September 22, 2009, at www.usccb.org/comm/archives/2009/09-186.shtml.

[4] *Maher v. Roe*, 432 U.S. 464, 474 (1977) (emphasis added).

[5] *Harris v. McRae*, 448 U.S. 297, 325 (1980) (footnotes omitted, emphasis added). The Court's only error here was its use of the incoherent and undefined term "potential life." The unborn child is actually (not just potentially) human and alive, unless he or she is made actually (not just potentially) dead by abortion. Note that this court decision upheld the original Hyde amendment of Fiscal Year 1977, which allowed federal abortion funding only in cases of danger to the life of the mother; that policy was also in effect from 1981 to 1993.

inadequate. Federal funds are prevented now from funding abortion by riders to a number of annual appropriations bills, as well as by provisions incorporated into specific authorizing legislation for programs such as the Department of Defense, Children's Health Insurance Program, Title X family planning, and foreign assistance.

On occasion a gap or loophole has been discovered that does not seem to be addressed by this patchwork of provisions, highlighting the need for a permanent and consistent policy to be applied across the federal government:

- In 1979, Congressman Hyde learned that elective abortions were being funded for American Indians and Alaska Natives through the Indian Health Service (IHS). In response to his inquiries, IHS Director Emery Johnson, M.D., replied that while funding abortions was not specifically authorized by any law, the authorizing legislation for the IHS did permit expenditure of appropriated funds for the "relief of distress and conservation of health" of Indians. "All current requirements having been met, and procedures followed," he wrote, "we would have no basis for refusing to pay for abortions" (Letter to Rep. Henry Hyde, July 30, 1979). He added that IHS services were funded through a separate Department of the Interior appropriations bill, which had no provision like the Hyde amendment. The Reagan Administration later attempted to place an administrative restraint on this practice in 1982; Congress finally enacted legislative language as part of the IHS reauthorization bill in 1988, but even this language only references whatever policy the Hyde amendment places on HHS funds in a given year.

- In 1997, it was discovered that some states were using federal Medicaid funds not to reimburse directly for particular services, but to help pay premiums for overall benefits packages or capitation fees for health maintenance organizations (HMOs). Since the Hyde amendment only prohibited expending federal funds for abortion itself, some thought states might be free to subsidize elective abortions by using federal funds to help purchase overall health plans that cover abortion. A second sentence had to be added to the Hyde amendment, to forbid using federal funds for "health benefits coverage that includes coverage of abortion." This same policy of denying federal funds to health plans that cover abortion was also incorporated into the State Children's Health Insurance Program (SCHIP) and the Federal Employees Health Benefits Program (FEHBP), creating a consistent federal policy: Wherever federal and nonfederal funds are combined to purchase a health benefits package, that package may not cover elective abortions. That policy was consistently applied until 2010, when it was contradicted by the final version of the Patient Protection and Affordable Care Act (PPACA).

- In 1998, Congress became aware that Medicare was subsidizing abortions for non-elderly enrollees who were eligible for Medicare due to disability. Because federal funds appropriated through the Labor/HHS appropriations bill are combined with other funds such as premium payments and co-pays in the Medicare trust fund, which then reimburses for medical

services, some federal officials thought they could fund these abortions while claiming this was not a use of federally appropriated funds. After congressional inquiries, HHS Secretary Donna Shalala reversed this interpretation and said that Medicare would follow the Hyde criteria (Letter to Senate Assistant Majority Leader Don Nickles, June 22, 1998). This policy, that a trust fund receiving federal funds may not be used to help fund abortions (or to help fund a health plan that covers abortions), was incorporated into the Hyde amendment for Fiscal Year 1999 and has remained in effect ever since.

- The absence of a government-wide law against federal funding of abortion led most recently to the passage of major health care reform legislation that contains at least *four* different policies on this issue. Section 1303 of PPACA, on health plans in state exchanges, complies with the first sentence of Hyde (against direct and traceable funding of abortion procedures themselves) but violates Hyde's second sentence (against funding health plans that cover abortions). Section 1101, on state high-risk insurance pools, appropriates its own new funds outside the bounds of the Hyde amendment, and allows those funds to be used for abortions or not, depending on a changeable decision by the Secretary of Health and Human Services. Section 10503, on community health centers, omits any reference to Hyde, and allows its new funding to be governed by underlying mandates in the authorizing legislation for these centers – mandates that in other health programs have been interpreted by federal courts to *require* federal funding of abortion when not corrected by Hyde language. Finally, Section 4101, on school-based clinics, explicitly excludes abortion funding. All except the last of these disparate policies are incompatible with the Hyde amendment and similar longstanding federal policies; each of them is incompatible with all the others.[6]

Obviously the current patchwork of almost a dozen legislative provisions, most of which must be reapproved each fiscal year, has not always adequately served the will of Congress or the American people in preventing all forms of federal subsidy for abortion. However, at least until last year, Congress has always acted to address the immediate problem once it has understood that problem and had an opportunity to address it. It should do no less today. In fact, it should finally put a stop to this ungainly mechanism and simply apply the principle of the Hyde amendment across the federal government once and for all.

If a bill like H.R. 3 had been enacted before the health care reform debate began, that debate would not have been about abortion funding. A major obstacle to support by Catholics and other pro-life Americans would have been removed, and the final legislation would not have been so badly compromised by provisions that place unborn human lives at grave risk.

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[6] For more about this and other problems in the final version of PPACA see www.usccb.org/healthcare. The United States Conference of Catholic Bishops has declined advocating for or against repeal of PPACA in this Congress, focusing instead on advocating changes to address its key priorities of universal access to affordable care, respect for life and conscience, and fairness to immigrants. See USCCB letter to House of Representatives of January 18, 2011, at www.usccb.org/sdwp/Letter-hc-repeal112th-final.pdf.

The USCCB also supports the Protect Life Act, H.R. 358, to address these and other abortion-related problems in the health care reform law itself. The benefit of H.R. 3, however, is that it would prevent problems and confusions on abortion funding in future legislation. Federal health bills could be debated in terms of their ability to promote the goal of universal health care, instead of being mired in debates about one lethal procedure that most Americans know is not truly "health care" at all. Annual funding bills could be discussed in terms of how their budget priorities best serve the common good, instead of being endangered because some want to use them to reverse or weaken longstanding federal policy on abortion funding. This is a result that everyone in Congress should welcome.

Ensuring the Civil Rights of Health Care Providers

H.R. 3 would also codify the Hyde/Weldon amendment that has been part of the annual Labor/HHS appropriations bills since 2004. Hyde/Weldon ensures that federal agencies, and state and local governments receiving federal funds, do not discriminate against health care providers because they do not perform, provide or otherwise participate in abortions. It is long overdue for this policy, as well, to receive a more secure legislative status. In this regard the USCCB supports the Abortion Non-Discrimination Act (H.R. 361) as a free-standing bill to address this need; but it is very appropriate to address the problem in H.R. 3, as the Hyde/Weldon amendment has been an added subsection of the Hyde amendment itself for seven years.

As with the Hyde amendment's ban on abortion funding, the policy of the Hyde/Weldon amendment is both clear and widely supported. Hospitals, doctors and nurses should not be forced to stop providing much-needed legitimate health care because they will not participate in destroying a developing human life. In the ICR survey cited earlier, 63% of U.S. adults favored keeping in place federal laws that "protect doctors and nurses from being forced to perform or refer for abortions against their will." In an April 2009 survey by The Polling Company, Inc., 87% of American adults believed it is important (and 65% saw it as very important) to "make sure that healthcare professionals in America are not forced to participate in procedures and practices to which they have moral objections."[7]

Yet on this issue as well, the policy has been clear but the mechanism for achieving it has suffered from drawbacks and loopholes:

- The Hyde/Weldon amendment is only a Labor/HHS appropriations rider requiring renewal each year, giving no assurance to young doctors, nurses and students in the healing professions that if they enter these professions their fundamental rights will be respected.

[7] On the April 2009 survey see www.freedom2care.org/doc1.lib/200905011_Pollingsummaryhandout.pdf.

- This nondiscrimination policy only covers government entities receiving funds from the Labor/HHS appropriations bill, omitting many health programs. For example, the billions of dollars newly appropriated each year under PPACA are not covered.[8]

- Because this rider was crafted as a "limitation on funds" provision to avoid points of order, the only apparent remedy for stopping discrimination is to withhold all funds under the Labor/HHS Appropriations Act: no funds under the Act may be provided to a government entity that discriminates. This remedy is so sweeping that many see the threat of imposing it as unconvincing. Some state officials, for example, have implied that they may freely ignore the rights that Catholic health care providers should enjoy under the amendment, because no one will deny an entire state all its Medicaid and other health funds under the Labor/HHS bill.

- The amendment fails to state any mechanism by which a complaint may even be raised, whether in court or by appeal to HHS. The Bush administration had issued regulations to designate the HHS Office for Civil Rights to investigate complaints; but the Obama administration has proposed rescinding these regulations, and recently told a federal court that it will soon take final action on this proposal.[9] Moreover, the amendment does not provide for a private right of action allowing providers whose rights are being violated to file suit to vindicate their rights. Recently a federal appellate court ruled that a similar conscience law, commonly known as the Church amendment, does not allow such a suit to be heard in court because the law did not explicitly provide for one – and so a nurse who was forced under threat of dismissal to take part in a grisly late-term abortion at Mount Sinai Hospital in New York in 2009 has found herself without recourse, her complaint to HHS also having received no visible action thus far.[10]

H.R. 3 addresses these serious problems, by writing this essential civil rights protection into permanent law; allowing for measured and reasonable remedies to ensure compliance with the law; providing for a private right of action; and also designating the HHS Office for Civil Rights to hear complaints, an avenue that under H.R. 3 will be available separately and in parallel with the right to file suit in federal court.

The need for stronger protection in this area is clear. The American College of Obstetricians and Gynecologists, which supports "abortion rights," has issued and recently

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[8] The health care reform bill approved by the House of Representatives in November 2009 contained its own Hyde/Weldon provision, but this was not accepted by the Senate. The final PPACA legislation includes a weaker provision, barring only discrimination by qualified health plans against pro-life health care providers (Sec. 1303 (b)(4)); discrimination by governmental entities is not addressed.

[9] See Federal Defendants' Response to November 3, 2010 Show Cause Order, *State of Connecticut v. United States of America*, No. 3:09-cv-54-VLB (D. Conn. Dec. 1, 2010).

[10] See *Cenzon-DeCarlo v. Mount Sinai Hospital*, 626 F.3d 695 (2d Cir. 2010).

reaffirmed an ethics committee opinion that calls on pro-life physicians to refer for abortions in a wide array of circumstances, to perform abortions themselves when referral is not possible, and even to locate themselves near abortion practitioners to maximize access to abortion.[11] The American Civil Liberties Union has launched a campaign urging the federal government to force Catholic hospitals to violate their moral and religious convictions by providing "emergency" abortions (by which the ACLU means all abortions to serve women's life or "health," defined by federal courts to encompass social "wellbeing").[12] And many institutions apparently remain oblivious even to health care professionals' clearly established statutory rights, as when a medical center affiliated with the State University of New York at Stony Brook recently suspended eight nurses for stating that they would not assist in abortions.[13]

Some of the recent threats are overt efforts to suppress or eliminate health care that is guided by Catholic moral principles. This in itself is an obvious threat to access to life-affirming health care. Catholic hospitals care for 1 in 6 patients in the United States each year, and provide the full continuum of health care through more than 2,000 sponsors, systems, facilities, and related organizations, employing 725,000 individuals. Catholic and other religiously affiliated health care facilities provide higher quality and more effective care, including care for women, than any others.[14] If Congress wants to expand rather than eliminate access to life-saving health care, particularly for the poor and underserved, it should be concerned about any effort to attack the rights of these providers and undermine their continued ability to serve the common good.

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[11] ACOG Committee Opinion No. 385, "The Limits of Conscientious Refusal in Reproductive Medicine" (Nov. 2007, Reaffirmed 2010), at www.acog.org/from_home/publications/ethics/co385.pdf. The reference to "limits" here is misleading, as the opinion makes it clear that anything like a right to refuse participation in morally abhorrent procedures simply vanishes in the face of the overriding mandate to maximize abortions.

[12] The ACLU's July 2010 and December 2010 letters, urging HHS to suppress health care based on Catholic teaching, are available at www.aclu.org/reproductive-freedom/aclu-sends-second-letter-asking-government-investigate-potential-denials-emerge. The ACLU's claim that current federal laws already require all hospitals to provide abortions in some cases has been ably rebutted by the Becket Fund in its letter to HHS of August 19, available at www.becketfund.org/index.php/article/1355.html. Among other things, the ACLU claims that the federal Emergency Medical Treatment and Active Labor Act (EMTALA) creates a mandate for "emergency" abortions – yet EMTALA explicitly calls on emergency health care personnel to respond to any condition that places a pregnant woman or "her unborn child" in jeopardy, requiring them to stabilize the medical condition of both mother and child. 42 USC §1395dd(c).

[13] See "LI hospital issues abortion apology to nurses," *New York Post*, April 28, 2010, at www.nypost.com/p/news/local/li_hospital_issues_abortion_apology_LbmfsompphRJjakFbUtizN?CMP=OTC-rss&FEEDNAME.

[14] A recent study of 255 health systems found: "Catholic and other church-owned systems are significantly more likely to provide higher quality performance and efficiency to the communities served than investor-owned systems. Catholic health systems are also significantly more likely to provide higher quality performance to the communities served than secular not-for-profit health systems." David Foster, Ph.D., M.P.H., *Research Brief: Differences in Health System Quality Performance by Ownership* (Thomson Reuters, August 9, 2010), at www.100tophospitals.com/assets/100TOPSystemOwnership.pdf.

Answering questions about H.R. 3

A number of questions have been raised about H.R. 3, sometimes in the form of charges by groups committed to government support for abortion. These groups have abandoned their earlier slogan of "choice" and instead are committed to "access" – which means maximizing abortions, and using the coercive power of government to enlist the unwilling aid of taxpayers and health care providers who disagree with them. Answers are offered here for some of these questions.

Does H.R. 3 eliminate private coverage for abortion?

No, in fact Section 305 of the bill explicitly allows such coverage as long as it does not use federal subsidies. Those who want abortion coverage can use nonfederal money to purchase a plan that includes it; or they can receive a federal subsidy to purchase a plan that does not include it, then buy abortion coverage separately with nonfederal funds.

Critics claim that such separate abortion riders will not be offered or will be difficult to obtain. The experience in states that have generally prohibited abortion coverage except by optional rider rebuts this claim. Supplemental abortion coverage is available in these states – in some plans offered by large insurers, choosing this coverage requires a simple check-off. The problem is that almost no woman chooses abortion coverage, which is to be expected in light of the surveys showing that most women oppose it. Abortion coverage is included in so many plans now because it is imposed on women and men by employers and insurance companies without their consent and generally without their knowledge. (In the ICR poll cited earlier, 68% of those who had insurance simply *did not know* whether their plan covered abortion, though that same percentage would reject it if asked.)

What this legislation does is place abortion coverage more in the arena of *individual choice* for women – an outcome opposed by groups that once claimed to be "pro-choice" and "pro-woman." They prefer a status quo in which insurance companies or employers choose abortion coverage and impose it on others chiefly because it is cheaper for them than reimbursing for live birth.[15]

A more limited and subtle argument has been advanced by Prof. Sara Rosenbaum and colleagues at George Washington University.[16] They point out that the policy outlined here –

[15] John Nugent, CEO of Planned Parenthood of Maryland, says of abortion coverage that "the insurance companies think they should be offering it" because it's "cheaper to terminate an unwanted pregnancy rather than taking it to term." David Whelan, "Obamacare: Why Private Insurers Like Paying for Abortion," *Forbes* Blog, at http://blogs.forbes.com/sciencebiz/2010/01/07/obamacare-why-private-insurers-like-paying-for-abortion/.

[16] Sara Rosenbaum *et al.*, "Analysis of the Implications of the Stupak/Pitts Amendment for Coverage of Medically Indicated Abortions," The George Washington University Medical Center, November 16, 2009,at

denial of federal subsidies for health plans that include elective abortions – already affects many millions of people under Medicaid, the Federal Employees' Health Benefits Program, SCHIP and so on. By extending this policy to millions more (*e.g.*, to lower-income people who purchase their coverage on state exchanges), the new legislation when combined with existing laws may produce a "tipping point" where coverage without abortion becomes the usual norm for health insurance; coverage that includes abortion will be permitted but rare.

My response to this is that I hope it is correct. As the Supreme Court noted approvingly three decades ago, the purpose of a federal funding ban is to use the government's funding power to encourage childbirth over abortion. Abortion coverage, and therefore abortion, may become more rare, a result favored by all but the most committed advocates for abortion.

Does Section 303 of H.R. 3 create an unprecedented policy of denying "tax benefits" to abortion?

No, that issue was settled by PPACA. Members of Congress discussed whether the premium tax credits that help make health coverage affordable on state exchanges constitute federal funding, and decided in the affirmative. The provision forbidding direct use of these credits for abortion is even titled "Prohibition on the Use of Federal Funds" (Sec. 1303 (b)(2)).[17]

The PPACA debate drew attention to the issue of how our tax system treats abortion, and uncovered some remarkable facts. For example, the individual tax deduction for medical expenses can be directly used to help reduce the cost of an abortion performed for *any* reason (not just abortion coverage but payments for abortions themselves).[18] This seems a very explicit and direct statement that the government wants to help pay for your elective abortions. Now that this loophole allowing tax support for abortion has been discovered, H.R. 3 is addressing it.

Does Section 308 of H.R. 3 depart from precedent by saying that federal law does not compel states to fund any abortions?

No, on this point as well it simply follows the policy of PPACA. It specifically states that the new federal "essential health benefits" mandate may not require inclusion even of

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www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_FED314C4-5056-9D20-3DBE77EF6ABF0FED.pdf.

[17] This provision still violates the policy of the Hyde amendment by allowing use of these credits to purchase overall health plans that cover abortion. But it did establish the idea that abortions not eligible for funding under Hyde should also be ineligible for tax credits.

[18] "You can include in medical expenses the amount you pay for a legal abortion." Internal Revenue Service, Publication 502, *Medical and Dental Expenses (Including the Health Coverage Tax Credit)*, Dec. 9, 2008, page 5.

abortions that are eligible for funding under the Hyde amendment (Sec. 1303 (b)(1)(A)(i)). Two distinct provisions of the final law also explicitly allow states to exclude abortion coverage in all circumstances (Secs. 1303 (c)(1) and 1303 (a)(1)). The first two provisions mentioned here were first offered in subcommittee by Rep. Henry Waxman (D-CA) and Lois Capps (D-CA) in summer 2009; the third was developed by Senate Democrats and added to the Senate bill in a Manager's Amendment by Senate Majority Leader Harry Reid (D-NV). This policy of not *forcing* states to provide or fund any abortion coverage has become a point of consensus across partisan and ideological lines.[19]

Does H.R. 3's conscience clause place women's lives at risk?

Of course not. It simply continues the longstanding and consistent policy of federal law, beginning with the Church amendment of 1973, to allow health care providers to decline involvement in abortion in all circumstances.[20] That 38-year-long policy has not been responsible for any woman's death – on the contrary, as noted above, hospitals that perform no abortions provide the finest high-quality health care in the country. During this period abortion itself has caused the deaths of (at least) hundreds of women, chiefly women who were perfectly healthy until they placed themselves in the hands of an abortion provider. If Congress should be concerned about health care providers who endanger women's lives – and in this regard Dr. Gosnell, the infamous Philadelphia physician now facing eight murder indictments, is the tip of the iceberg -- it needs to start with the abortion industry itself.[21]

Conclusion

H.R. 3 is a well-crafted and reasonable measure to maintain longstanding and widely supported policies against active government promotion of abortion. It consistently applies to all branches of the federal government the principle that government can encourage childbirth over abortion through its funding power, and that it should not coerce anyone's involvement in abortion. It merits prompt and overwhelming support by this Congress.

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[19] At times when the Hyde amendment had a rape/incest exception prior to 1981, it also explicitly allowed states to decide whether to fund abortions eligible for federal funding. When the federal rape/incest exception was restored in 1993, unfortunately, that "state discretion" clause was omitted. This led to a constitutional crisis in states like Arkansas and Colorado whose constitutions barred state funding of abortion except in cases of danger to the life of the mother; those states were told they must ignore their own constitutions or be ejected from the Medicaid program, and at one point faced the prospect that their constitutional provision would be nullified entirely to allow unlimited abortion funding. That crisis should not be repeated now.

[20] For a compendium of many of these laws see USCCB Secretariat of Pro-Life Activities, "Current Federal Laws Protecting Conscience Rights," at www.usccb.org/prolife/issues/abortion/crmay08.pdf.

[21] See Melinda Henneberger, "Kermit Gosnell's Pro-Choice Enablers (Is This What an Industry That Self-Regulates Looks Like?)," *Politics Daily*, January 23, 2011, at www.politicsdaily.com/2011/01/23/kermit-gosnells-pro-choice-enablers-how-clinics-become-death-t/.

Mr. FRANKS. Thank you, Mr. Doerflinger. We now recognize Mrs. Ruse for 5 minutes.

TESTIMONY OF CATHY CLEAVER RUSE, SENIOR FELLOW FOR LEGAL STUDIES, FAMILY RESEARCH COUNCIL

Ms. RUSE. Thank you for inviting me to provide testimony this morning, this afternoon, on the No Taxpayer Funding for Abortion Act. And it is nice to be back, a little less work on this side of the dais but not much.

Thirty-five years ago something of a consensus was reached between those who support legal abortion and those who oppose it. Whatever our differences on the underlying question of legality, a majority of Americans came together and supported a proposition that the Federal Government should not subsidize abortions. That consensus took the form of the Hyde amendment in 1976, which limited abortion funding appropriated under Labor-HHS to cases where an abortion was necessary to save a mother's life and later the cases involving rape and incest.

The Supreme Court upheld the constitutionality of the Hyde amendment in *Harris v. McCrae* and in so doing made a sharp distinction between abortions and other medical procedures. In the words of the Court, no other procedure involves the purposeful termination of a potential life.

That abortion is scandalous to many is understandable. That it is exceptionally controversial in the United States is beyond dispute. For these reasons it is entirely appropriate that abortions not be subsidized in any way by the Federal Government. The No Taxpayer Funding for Abortion Act implements this legal and political consensus on a government-wide basis.

Over the years the Hyde amendment and others like it have been included in various appropriations bills renewed annually by Congress. What has been lacking is a single, simple law prohibiting government funding of abortion across the board wherever Federal dollars are expended.

We taxpayers paid for 425 abortions in fiscal year 2008 and 220 last year. Without the Hyde amendment and the patchwork of other appropriations writers, that number could skyrocket to as many as 675,000 government-financed abortions every year, according to the CBO.

Now two measures passed in the last Congress also threatened to escalate the number of government-funded abortions dramatically. The D.C. appropriations bill opened the door for Federal funding of any and every abortion in the District of Columbia, and the Patient Protection and Affordable Care Act, known popularly as ObamaCare, authorized Federal funding for elective abortions directly and through private health insurance plans. A detailed accounting of the abortion subsidies in ObamaCare is included in my written testimony.

Because these programs are directly appropriated and not subject to further appropriation under Labor-HHS, they are not subject to the Hyde amendment. As for the Executive order purporting to nullify abortions in ObamaCare, last month former White Chief of Staff Rahm Emanuel admitted that he "came up with an idea for an Executive order so that the abortion funding restrictions would not exist by law." On this he and I are in agreement with each other and also with Planned Parenthood, who issued a statement calling the Executive order a symbolic gesture.

It is axiomatic that when government subsidizes conduct, it encourages it. Our Tax Code is replete with pertinent examples. The Supreme Court in *Maher v. Roe* acknowledged the truth of this proposition in the context of abortion.

Most abortions in America are purely elective. Ninety-two percent of abortions every year are performed on healthy women with healthy babies, according to the Alan Guttmacher Institute. In light of this fact the abortion funding question is quite literally a matter of life and death for many thousands of American children.

Now, President Obama has urged Americans to find common ground on the controversial issue of abortion. Americans have come together, 67 percent of us, in what may be the only truly bipartisan agreement possible that whatever our differences on the issue of abortion we can agree that the Federal Government should not subsidize it. This is the common ground issue on abortion in America today. H.R. 3 would make that common ground statutory law.

Thank you.

[The prepared statement of Ms. Ruse follows:]

U.S. House of Representatives
Committee on the Judiciary
Subcommittee on the Constitution
Hearing on H.R. 3, the "No Taxpayer Funding for Abortion Act"

Testimony of Cathy Cleaver Ruse, J.D.
Senior Fellow for Legal Studies, Family Research Council

February 8, 2011

Introduction

Thank you for inviting me to provide testimony regarding H.R. 3, the "No Taxpayer Funding for Abortion Act," introduced by Representative Chris Smith (R-NJ) and Representative Dan Lipinski (D-IL).

Thirty-five years ago a consensus was reached between those who support legal abortion and those who oppose it. A majority of "Pro-life" and "Pro-choice" Americans came together in agreement that, whatever their differences on the underlying question of legality, the government should not subsidize abortions. This agreement was the Hyde Amendment of 1976, in which Congress amended the Labor, Health and Human Services (LHHS) appropriations act to limit the funding of abortion to cases where an abortion is necessary to save the life of the mother and later to abortions involving pregnancies from rape or incest.[1]

When a challenge to the constitutionality of the Hyde amendment reached the Supreme Court in 1980 in the case of *Harris v. McCrae*, the Court ruled that the government may distinguish between abortion and other procedures in funding decisions -- noting that "no other procedure involves the purposeful termination of a potential life" -- and affirmed that *Roe v. Wade* had created a limitation on government, not a government entitlement.[2] Three years earlier the Supreme Court had ruled that government refusal to fund abortion placed no restriction on the right to choose abortion. [3]

The "No Taxpayer Funding for Abortion Act" (H.R. 3.) implements this legal and political consensus on a government-wide basis, through the means of statutory law.

H.R. 3 does not impact in any way the legality of any abortion, nor does it strengthen or diminish the arguments on either side of the abortion divide. Rather, it simply codifies the long-standing principle that federal dollars should not be used to finance abortions or abortion coverage, a principle supported by an overwhelming majority of Americans: 67%, according to a recent

[1] The provision is named after U.S. Representative Henry Hyde (R-IL) who, as a freshman member of the House, first proposed the amendment. Rep. Hyde (1924-2007) served in the House from 1975-2007. The Hyde Amendment is sometimes misunderstood to mean only the prohibition of direct funding for abortions. In truth, the Hyde Amendment not only prevents federal funding to pay directly for abortions but also prevents federal funds from paying for health care plans that include abortion coverage. See Sections 507 and 508(a)-(c) of Division D of the Consolidated Appropriations Act, 2010 (P.L. 111-117).
[2] *Harris v. McCrae,* 448 U.S. 297, 325 (1980).
[3] *Maher v. Roe,* 432 U.S. 464, 475 (1977).

Quinnipiac University poll.[4] It also codifies the Hyde-Weldon conscience protection amendment renewed as part of the LHHS appropriations bill since 2004 to prevent government discrimination against healthcare providers, including doctors, nurses, and hospitals, because the providers do not provide, cover, or refer for abortions.[5]

Congress has the authority to pass the H.R. 3 under the Spending clause in Article 1, Section 8, Clause 1 of the U.S. Constitution.[6]

Over the years the Hyde Amendment has been included in amendments to various appropriations bills annually renewed by Congress, in each instance prohibiting the funding of abortions through a particular federally-funded program.[7] What has been lacking is a single, simple, law prohibiting government funding of abortion across the board, wherever federally-funded programs arise.

Moreover, two laws passed in the last Congress reversed course on the Hyde Amendment principle: the Patient Protection and Affordable Care Act (known popularly as "ObamaCare" and sometimes referenced herein as PPACA),[8] which allows federal funds directly to pay for abortions and to pay for health care plans which cover abortion, and the Financial Services Appropriations Act for 2010, which allows funding for all abortions in the District of Columbia with funds appropriated from Congress.[9]

Why Does Abortion Warrant a Funding Prohibition?

An induced abortion is the purposeful termination of the life of a human child before birth. As the Supreme Court stated in *Harris v. McCrae*, "no other procedure involves the purposeful termination of a potential life."[10]

The overwhelming majority of abortions in America are done on healthy women with healthy babies, according to research conducted by the Guttmacher Institute.[11] The Guttmacher research

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[4] Quinnipiac University Poll, page 7, January14, 2010.

[5] Hyde-Weldon is currently contained in Section 508(d) of Division D of The Consolidated Appropriations Act, 2010 (P.L. 111-117).

[6] Where Congress has the authority to tax and spend money for the general welfare, as a general matter it also has the authority to carve out exceptions to that spending.

[7] Examples include the Smith Amendment on Financial Services prevents federal funding for abortions under the Federal Health Employee Benefits Program, the Helms Amendment prevents funding abortions as a method of family planning in international aid, and restrictions on the funding for abortions through Medicaid and other government health programs such as the State Children's Health Insurance Plan.

[8] Patient Protection and Affordable Health Care Act, H.R. 3590, became law P.L. 111-148 on March 23, 2010.

[9] Passed as Division C of the Consolidated Appropriations Act, 2010 (P.L. 111-117).

[10] *Harris* at 325.

[11] L. B. Finer, L. F. Frohwirth, L. A. Dauphinee, S. Singh and A. M. Moore, "Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives," *Perspectives on Sexual and Reproductive Health* 37 (2005): 113, 114. (Sarah Rosenbaum, a fellow witness at today's hearing who opposes H.R. 3, is a member of this Institute's governing board). This survey shows women have abortions for the following reasons:

25 % "not ready for a(nother) child/timing is wrong"
23 % "can't afford a baby now"
19 % "have completed my childbearing/have other people depending on me/children are grown"
8 % "don't want to be a single mother/am having relationship problems"

reveals that 92% of all abortions today are done for reasons unrelated to the health of the mother, the health of the baby, or cases involving rape or incest.

In 2008 there were 1,212,350 abortions in the United States.[12] If the Guttmacher Institute is correct, 1,115,362 abortions in 2008 were done on healthy women to end the lives of healthy babies.

In fact, the United States has the highest abortion rate in the Western World.[13]

Every abortion is an act of violence. One abortion method on the rise is Mifepristone, or RU-486, a drug regimen ingested orally which starves a developing fetus of the hormone necessary for its survival. RU-486 can cause an abortion up to ten weeks of fetal development – well past the point when the baby's beating heart can be observed through ultrasound imagery.[14] Often a second drug is taken to expel the baby.[15] An RU-486 abortion is completed at home. Since it was approved by the Food and Drug Administration (FDA) a decade ago (under expedited review), 8 women have died in the United States due to infection and severe bleeding after taking RU-486, and over 1,300 women have suffered adverse events reported to the FDA.[16] Those who do not suffer serious medical complications still face the prospect of delivering a dead baby at home.

There are different methods of surgical abortion depending on the age of the developing child. The most common method used during the first twelve weeks of pregnancy uses suction aspiration, where a woman's cervix is dilated and a suction device is inserted to remove the child. A similar method called Dilation and Curettage (D&C) involves using a sharp instrument to scrape a living fetus from the mother's uterus. Later in gestation, the mother's cervix is dilated and forceps are inserted to dismember the child's body and remove it piece by piece; the child's skull may be crushed and the spine snapped.[17] Each of these abortion methods is extremely invasive.

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7 % "don't feel mature enough to raise a(nother) child/feel too young"
6% "other" (this category had no further explanation)
4% "would interfere with education or career plans"
4 % "physical problem with my health"
3 % "possible problems affecting the health of the fetus"
>0.5% "husband or partner wants me to have an abortion"
>0.5 % "was a victim of rape"
>0.5 % "became pregnant as a result of incest"

[12] See The Guttmacher Institute: http://www.guttmacher.org/pubs/fb_induced_abortion.html.

[13] *Sharing Responsibility: Women, Society and Abortion Worldwide* (New York: The Guttmacher Institute, 1999), p. 28, http://www.guttmacher.org/pubs/sharing.pdf.

[14] Moore, Keith L. and Persaud, T.V.N. *The Developing Human: Clinically Oriented Embryology*, 6th edition (Philadelphia: W.B. Saunders Co. 1998): 77, 350.

[15] There is no doubt that every RU-486 pregnancy termination is an abortion. RU-486 ends the life of an implanted embryo or fetus. According to all four major American medical dictionaries that is an abortion. C.M. Gacek, "Conceiving Pregnancy: U.S. Medical Dictionaries and Their Definitions of Conception and Pregnancy," 9 National Catholic Bioethics Quarterly (Autumn 2009): 542-57.

[16] Coralee G. Lemley, "Mifepristone U.S. Postmarketing Adverse Events Summary Through 1/31/2008" (Rockville, Md: U.S. Food and Drug Administration. Jan. 31, 2008).

[17] Warren M. Hern, M.D., *Abortion Practice* (Philadelphia: J.B. Lipincott Company, 1984), pp. 153-154. The conduct outlined in the recent grand jury report against abortion practitioner Kermit Gosnell of Philadelphia –

That abortion is scandalous to many is understandable; that it is exceptionally controversial in the United States is beyond dispute. For these reasons, it is entirely appropriate that abortions not be financed by the federal government.

The History of Funding Elective Abortion

In 1973 the federal government began funding abortion under the Social Security Act as part of its Medicaid program to provide health benefits to the poor. Congress passed the Hyde Amendment in 1977, and when it was upheld by the Supreme Court in 1980 in *Harris v. McCrae*, the LHHS Department stopped paying for abortions except those allowed by the Hyde Amendment. By that point, 300,000 abortions per year were being financed with federal dollars under Medicaid.[18]

In 1993 the Congressional Budget Office estimated that the federal government would pay for as many as 675,000 abortions each year without the Hyde Amendment and other measures in place at the time to prevent federal funding of abortion in federal programs.[19]

By contrast, in 2008 there were 425 abortions funded by the federal government and in 2009 there were 220 government-financed abortions.[20]

It's axiomatic that when government subsidizes conduct, it encourages it. Our tax code is replete with pertinent examples. The Supreme Court in *Maher v. Roe* acknowledged the truth of this proposition in the context of abortion when it equated government funding of an activity with government encouragement of that activity.[21]

When one considers that the overwhelming majority of U.S. abortions are purely elective – 92% of abortions are done on healthy women to terminate the lives of healthy babies, according to the Alan Guttmacher Institute – the abortion-funding question becomes, quite literally, a matter of life-and-death for many thousands of American children.

The Passage of "ObamaCare" and the Executive Order on Abortion Funding

Abortion rights proponents have never concealed their goal of government-financed abortion without restriction. In a "wish list" for government healthcare sent to the White House Transition Team, a number of organizations, including Planned Parenthood, stated:

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induction delivery of living babies and the cutting of their spinal cords with scissors -- is not dissimilar to some abortion methods; the main distinction being the location of the baby. "DA: Pa. abortion doc killed 7 babies with scissors", Associated Press, by Maryclaire Dale And Patrick Walters, Jan 19, 2010. http://news.yahoo.com/s/ap/20110119/ap_on_re_us/us_abortion_clinic_investigation.

[18] See Statement of the Department of Health, Education and Welfare, "Effects of Sec. 209, Labor-HEW Appropriations Bill, H.R. 14232," June 25, 1976; John Thomas Noonan, A Private Choice: Abortion in America in the Seventies (Toronto: Life Cycle Books, 1979): ch. 12, fn. 6.

[19] Robert D. Reischauer, Director, Congressional Budget Office, Letter to the Congressman Vic Fazio (D-Ca) (July 19, 1993).

[20] FY 2011 Moyer Report, submitted by the Office of the Assistant Secretary for Financial Resources, U.S. Department of Health and Human Services, February 2010, page 106.

[21] *Maher*, 432 U.S. at 475.

"Comprehensive benefits must include access to the full range of reproductive health services, including contraception, maternity care, and abortion care."[22] Indeed, President Obama himself, on the campaign trail in 2007, promised Planned Parenthood that the provision of "reproductive services" would be "at the heart" of his planned health care legislation.[23] The passage of "ObamaCare" substantially achieves this goal.

Prior to its passage by the full Congress, the House of Representatives voted in favor of legislation which included an amendment by former Rep. Bart Stupak (D-MI) to prohibit funding of abortion. The Senate bill, however, contained a variety of provisions that could fund and subsidize abortion. Ultimately former Rep. Stupak and others agreed to vote in favor of legislation including the text of the Senate bill in exchange for a promise that President Obama would sign an executive order purporting to nullify the Senate bill's abortion funding language.

White House Executive Order 13535 was signed on March 24, 2010, but by its own terms it fails to reach some of the abortion-funding provisions in "ObamaCare," such as the provision regarding pre-existing conditions. Nothing in the Executive Order limits funds under this section.

Moreover, an executive order is inherently limited: it binds only the executive branch, it can be rescinded at any time, and it does not and cannot change the authority of statutory law as applied to private individuals. "Executive orders cannot override statutory provisions," according to the Congressional Research Service. When executive orders conflict with duly-enacted statutes, a court-challenge can result in the nullification of the executive order.

Former White House Chief of Staff, Rahm Emanuel, admitted as much during an editorial board meeting with the Chicago Tribune. He told the Tribune editors, "I came up with an idea for an executive order to allow the Stupak Amendment *not to exist by law* but by executive order" (emphasis added).[24] The President's own Chief of Staff admits that abortion funding restrictions do not exist by law in ObamaCare.

Even the president of the Planned Parenthood Federation of America stated in a March 21, 2010 press release stated that the President's Executive Order on abortion funding was "a symbolic gesture."[25]

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[22] See Planned Parenthood Federation of America "Advancing Reproductive Rights and Health Care in a New Administration." Pg 17. http://www.nrlc.org/obamaabortionagenda/ObamaTransitionDoc.pdf November 2008.

[23] Remarks of Barack Obama before the Planned Parenthood Action Fund (July 17, 2007), available at http://www.politifact.com/truth-o-meter/promises/obameter/promise/519/reproductive-health-care-will-be-heart-health-care/. Video of Barack Obama making this promise is available here: http://www.youtube.com/watch?v=Cqww8jmizug.

[24] Rahm Emanuel, speaking to the Chicago Tribune Editorial Board, "Tribune Editorial Board meeting pt. 10-Women's issues, healthcare, candidates pasts, closing arguments." January 14, 2011. http://www.wgntv.com/news/elections/mayor/editorial/.

[25] "Statement of Cecile Richards, President of PPFA, on House Passing Historic Health Care Reform Bill", March 21, 2010. http://www.plannedparenthood.org/about-us/newsroom/press-releases/statement-cecile-richards-president-ppfa-house-passing-historic-health-care-reform-bill-32230.htm

Federal Funding of Abortion in "ObamaCare"

"ObamaCare" subsidizes abortion in private health plans and can pay directly for abortion in new health programs.[26] The funds under "ObamaCare" are directly appropriated, not subject to further appropriation through the LHHS appropriations bill, and are therefore not subject to the Hyde Amendment abortion funding restriction.

Here are some examples:

"ObamaCare" appropriates $5 billion for high risk pool programs without a restriction on funding abortion.[27] The Pennsylvania, Maryland, and New Mexico's high risk pool plans approved by the federal government did, in fact, contain coverage of elective abortion. Only after the news of government-financed abortions was reported in the press did the White House tell these states to remove abortion from the list of covered services.[28]

"ObamaCare" also authorized funding for community health centers,[29] and the enactment of the Health Care and Education Reconciliation Act[30] a week later increased the amount of funding for these community health centers to $12.5 billion. The money appropriated for community health centers can be used to pay for elective abortions directly, as these funds are not appropriated under LHHS and therefore not subject to the Hyde Amendment.[31]

"ObamaCare" appropriates $6 billion for loans and grants for the creation of non-profit health co-ops.[32] Because the funds would not be appropriated by the LHHS bill, they are not covered by the Hyde Amendment and can be used to pay for elective abortions.

"ObamaCare" provides tax credits for qualified health plans in each of the state exchanges.[33] Section 1303, as amended, permits qualified health plans to include coverage for elective abortions even if they receive tax credits or cost-sharing credits.[34] This directly conflicts with the principle of the Hyde Amendment and the restriction on subsidizing abortion through the Federal Employee Health Benefit Program (FEHBP).[35]

What's more, Section 1303, as amended, permits private insurance plans who receive federal subsidies to cover elective abortions. If they chose to cover elective abortions and receive

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[26] For a chart of details of the various abortion funding provisions in PPACA, see http://downloads.frcaction.org/EF/EF10C08.pdf.
[27] PPACA, Section 1101.
[28] On July 14, 2010, HHS Spokesperson Jenny Backus issued a statement saying that abortion would not be covered in the high risk pool program in Pennsylvania. Then after other states approved abortion funding, Nancy-Ann DeParle on July 29, 2010 blogged that abortion would not be covered by the high risk pool program http://www.whitehouse.gov/blog/2010/07/29/insurance-americans-with-pre-existing-conditions
[29] PPACA Section 10503.
[30] The Health Care and Education Reconciliation Act, 2010, H.R. 4872, became P.L. 111-152 on March 30, 2010 ("Reconciliation Act").
[31] Reconciliation Act, Section 2303.
[32] PPACA, Section 1322.
[33] PPACA, Section 1401 provides refundable tax credits and Section 1402 provides cost-sharing credits to purchase health plans.
[34] PPACA, Section 1303 as amended by Section 10104(c).
[35] Section 613, Division C of the Consolidated Appropriations Act, 2010 (P.L. 111-117).

federal subsidies, then every individual who is part of that plan is required to pay an abortion surcharge and the insurance company will take that surcharge payment and hold it in a special account. This accounting gimmick does nothing to cure the problem: it still allows federal dollars to be used to subsidize abortion coverage.

Secretary Kathleen Sebelius on December 22, 2009 said that "everyone in the exchange would pay" a "portion of their premium" for "abortion coverage."[36] (This would not be the case for plans purchased without abortion coverage.) The abortion surcharge is, arguably, an even more egregious violation of the Hyde Amendment principle.

"ObamaCare" also created a new government-controlled, multi-state plan to be run by the Director of the Office of Personnel Management that can include insurance plans with abortion coverage.[37] This multi-state plan is similar to the FEHBP for federal employees and will be operated by the Federal government, but without the FEHBP restriction on coverage of elective abortion.

The Impact of the "No Taxpayer Funding for Abortion Act"

On "ObamaCare"

H.R. 3 does not strike down "ObamaCare" or specifically amend it. Instead, H.R. 3 amends Title 1 of the U.S. Code so that all existing law will be subject to an abortion-funding limitation.

Section 301 prevents funds appropriated by the federal government to be used for abortions. Section 302 prevents federal funds from being used to pay for health plans that include abortion. Taken together, along with Section 303, these provisions will stop government funding of abortions under "ObamaCare" and will prevent tax credits for premiums paid to health plans that cover abortions. Direct payments for abortions under the high risk pool program and in the community health centers will be prohibited, and tax credits will not be given to subsidize health plans with abortion coverage whether in private plans in the state exchanges, in plans created under the co-op program, or in the multi-state plan run by the government.

H.R. 3 does not ban abortion coverage in private insurance or prevent individuals from purchasing abortion coverage. Section 305 states explicitly that individuals, localities, or even states are not prevented from purchasing health care insurance packages with abortion coverage or separate abortion coverage so long as federal funding does not pay for such coverage. Section 306 states explicitly that insurance providers and others are not prevented from offering insurance packages with abortion coverage or separate abortion coverage so long as federal funding is not involved.

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[36] See "Sebelius Praises Abortion Accounting Trick in Senate Bill," Real Clear Politics Video (last modified December 22,2009) in which Secretary Sebelius states: "That would be an accounting procedure, but everybody in the exchange would do the same thing, whether you're male or female, whether you're 75 or 25, you would all set aside a portion of your premium that would go into a fund, and it would not be earmarked for anything, it would be a separate account that everyone in the exchange would pay....|I|t's really an accounting that would apply across the board and not just to women, and certainly not just to women who want to choose abortion coverage." http://www.realclearpolitics.com/video/2009/12/22/sebelius_praises_abortion_accounting_trick_in_senate_bill.html

[37] PPACA, Section 1334 as amended by Section 10104(q).

On the Tax Code

The reduction of taxation is a form of government subsidy. H.R. 3 Section 303 applies the principles of the Hyde Amendment to the tax code.

Section 303(1) prohibits individuals from receiving any tax credits, including under "ObamaCare," for the payment of premiums on health insurance plans that cover abortion. It also prohibits small businesses owners from obtaining tax credits under "ObamaCare" for the cost of health care plans which cover abortion.[38] Individuals and small businesses will be able to obtain tax credits on the purchase health plans that do not include abortion coverage.

Section 303(2) applies to tax deductions for abortion or for health plans that include abortion coverage (for those who may deduct the cost of their medical expenses because that cost exceeds 10% of their income). The Internal Revenue Code does not specify which expenses are eligible for deduction, yet the IRS has, without congressional authorization, listed "abortion" as a deductible medical expense in its official publication on medical expenses.[39] Section 303(2) would correct this abortion subsidy.

Section 303(3) applies to tax-preferred trusts, such as medical savings accounts, health savings accounts, and other tax-favored health plans.[40] Because IRS Publication 969 which governs these types of health accounts allows reimbursement for "qualified medical expenses" based on Publication 502, abortions are currently tax-preferred medical expenses. Section 303(3) would exclude abortion as a qualified medical expense.

H.R. 3 does not affect the employer tax deduction, which allows employers to deduct the cost of their contributions to an employee's health insurance plan as a business expense. Nor does H.R. 3 affect the employee exclusion, which allows an employee to exclude the cost of his employer's contribution to his health care insurance plan from his gross income.[41]

On the District of Columbia

Because H.R. 3 codifies the Hyde Amendment principle as a matter of federal law, it will affect federal funding in the District of Columbia. Article 1 of the Constitution grants Congress control over all District legislation, including funding. Last year the Omnibus Appropriations Act[42] which allocates funds to the District removed the provision restricting the funding of elective

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[38] PPACA, Section 1421, as amended by Section 10105(e), provides a small business tax credit for certain employers to cover up to 35% of the cost health care plans from 2010 through 2013, and up to 50% of the cost of health plans after 2014 for two consecutive years.

[39] Section 213(d) of the IRS code allows individuals who itemize to deduct medical expenses over 10% of their income, but does not specify what services can be deducted. IRS Publication 502 for 2010 "Medical and Dental Expenses" lists services which can be deducted. See page 5 (http://www.irs.gov/pub/irs-pdf/p502.pdf).

[40] See IRS Publication 969 for 2010 "Health Savings Accounts and Other Tax-Favored Health Plans," page 8 (http://www.irs.gov/pub/irs-pdf/p969.pdf).

[41] The "employer tax deduction" found in IRS Code I62(a) allows employers to write off the cost of their contribution to their employees' health plans as well as other business expenses. The "employee tax exclusion" found in IRS Code 106(a) allows employees to exclude from taxable income the amount their employer contributes to their health care premiums.

[42] Section 814 of Division C of The Consolidated Appropriations Act, 2010 (P.L. 111-117).

abortions, a provision which had been renewed each year since 1996. Section 814 of Division C changed this provision to prevent only "Federal" funds from being used for abortion, a fictitious distinction: all funds received and spent by the District are appropriated by the federal government. H.R. 3 would restore the prohibition on taxpayer funding for elective abortion in the nation's Capitol.

On Conscience Protection

H.R. 3 makes permanent the conscience protection language found in the Hyde-Weldon Amendment renewed each year in the LHHS appropriations bill. The Hyde-Weldon Amendment prevents the federal government, and any state and local government receiving federal funds, from discriminating against a health care entity because they refuse to provide, pay for, provide coverage of, or refer for abortions. Since "ObamaCare" appropriates funds directly, bypassing the LHHS bill, these funds are not bound by the Hyde-Weldon conscience protections. Moreover, "ObamaCare" included a weaker nondiscrimination provision which only prevents health "plans" in the exchanges from discriminating against "providers" or "facilities" unwilling to participate in abortion. It does not prevent the Federal government, or state or local governments, from committing such discrimination. H.R. 3 would codify the Hyde-Weldon provision, restoring conscience protections for health care workers to the status quo.

H.R. 3 also adds remedies not contained in the Hyde-Weldon Amendment due to continued attempts to undermine it and other conscience laws. For example, while the Church Amendment prevents government-funded discrimination, a lawsuit filed by a nurse forced to participate against her will in a late-term abortion was summarily dismissed recently by a federal circuit court which ruled that § 300a-7(c) of the Church Amendment does not confer a private right of action to enforce it.[43] Further, the conscience protection regulations implemented by President George W. Bush to enforce conscience laws, and provide relief for those who have been discriminated against, were rescinded by the current Administration.[44] These cases coupled with passage of abortion funding provisions in "ObamaCare" raise serious concerns about the conscience rights of health care entities who do not want the government to discriminate against them due to their views on abortion.

H.R. 3 solves this problem by providing judicial relief against government discrimination. Those who believe their conscience rights regarding abortion have been violated will be able to file claims to the Office of Civil Rights at the Department of Human Services.

Conclusion

President Obama has urged Americans to find common ground on the controversial issue of abortion. For over three decades Americans have come together in what may be the only truly bi-partisan agreement possible: That whatever our differences on the underlying question of legality, we agree that the federal government should not subsidize abortions with taxpayer dollars. This is *the* common ground on abortion in America. H.R. 3 would make that common ground statutory law.

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[43] *Cenzon Decarlo v. Mount Sinai Hospital*, Docket No. 10-0556-cv. (November 23, 2010).

[44] The Department of Health and Human Services issued a proposed rule to rescind the conscience regulations, on March 10, 2009. 45 CFR Part 88.

Mr. FRANKS. Thank you, Mrs. Ruse. We now recognize Professor Rosenbaum for 5 minutes.

TESTIMONY OF SARAH ROSENBAUM, HAROLD AND JANE HIRSH PROFESSOR, HEALTH LAW AND POLICY, AND CHAIR, DEPARTMENT OF HEALTH POLICY, THE GEORGE WASHINGTON UNIVERSITY SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES

Ms. ROSENBAUM. Thank you very much for inviting me here today to appear before you. I would like to make three points in my testimony. I have submitted a longer statement for the record. The first has to do with the baseline from which we are working in considering H.R. 3. The second has to do with the changes in the bill. The third has to do with the impact of these changes.

Insofar as the baseline is concerned, I think it is very important to understand what the Affordable Care Act does and does not do. The Affordable Care Act, where tax credits are concerned, allows women to obtain tax credits, to use those tax credits to buy insurance products, and if they choose to do so, to use their own money to buy additional coverage for abortion. If they make that choice and use their additional funds, their own funds, to buy abortion coverage, the tax credits remain completely available for the abortion product.

I emphasize this because it underscores the unprecedented nature of the bill. The bill would actually for the first time move the Hyde amendment far beyond where we have known it for the past 30 years directly into the Tax Code. Its reach in the Tax Code is extremely broad under this bill. It reaches deductions, and credits, it reaches advance tax credits even when those tax credits have to be repaid at a later date. It reaches health savings accounts, it reaches flexible spending accounts, it reaches money that we as individuals put aside for our medical care needs. It even potentially reaches employers and employer deductions for insurance because of a critical ambiguity in the drafting of the bill. It is unclear actually where the bill stops.

The impact of the bill insofar as its tax policies are concerned is enormous. The first fallout is on the Internal Revenue Service ("IRS"), which heretofore has not played a role in implementation of the Hyde amendment. The IRS is going to have to implement extremely complex provisions of the Tax Code that regulate tax favored health benefit plans and medical care payments. The IRS will have to issue a raft of implementing policies. The Internal Revenue Service will need to define rape, potentially forcible rape, incest, potentially incest involving minors as opposed to incest not involving minors, physical conditions endangering life and physical conditions that don't endanger life. The IRS will have to clarify what evidentiary standards will be required for individual claimants and employers who choose to buy products or make expenditures that wander into any of these areas.

There also will have to be a claims reviews process. For example, is a spontaneous abortion or a miscarriage an allowable expenditure under a flex fund? Does it for some reason cross the line? What will be the appeals procedures?How will plans be audited to make sure that their coverage stops at the allowable points under the statute?

The fallout on plans is equally serious. My own analysis, both of this bill and previous bills that attempted to do similar things in

terms of the impact on the insurance industry, leads me to conclude that what we will see in fact is a complete exodus of health plans from the abortion coverage market. I realize that may be the long-term goal here, but of course because there are not a lot, but a small number of very serious medically indicated abortions, this would be an enormous problem.

The third fallout of course is on the women themselves, not only because they can no longer secure coverage for medically indicated abortions, but because the typical practice in a health plan is to exclude not only specific procedures required under law, but follow-on procedures and treatments that are related to the original excluded treatment. So to use an easy example, a woman who needs an abortion because she has eclampsia, that is, stroke level hypertension, and who then needs subsequent treatment for the hypertension could find that she in fact is disqualified for the treatment of that hypertension because of the hypertension arose as the result of a condition that led to an excluded abortion. So there is no stopping point.

I would finally note that were the conscious clause provisions of this law to be enacted, it would begin the first great unraveling of EMTALA and the absolute duty on the part of hospitals to provide lifesaving treatment regardless of the underlying medical condition.

[The prepared statement of Ms. Rosenbaum follows:]

United States House of Representatives
Committee on the Judiciary
Subcommittee on the Constitution

Hearing on H.R. 3
No Taxpayer Funding for Abortion Act

Sara Rosenbaum, J.D.
Harold and Jane Hirsh Professor, Health Law and Policy
Chair, Department of Health Policy
George Washington University School of Public Health and Health Services

February 8, 2011

Mr. Chairman and Distinguished Members of the Subcommittee;

Thank you for extending me this opportunity to testify today on this important bill. My testimony focuses on the provisions of H.R. 3 that relate to the tax treatment of health insurance and health care expenditures and to its non-discrimination provision.

H.R. 3 carries important implications for private health care spending that carries tax-favored status.

H.R. 3 dramatically expands the Hyde Amendment's long-standing concept of what constitutes public funding in an abortion context. In doing so, H.R. 3 reaches a wide range of policies related to the tax-favored treatment of private health care expenditures by individuals and employers. The measure achieves this result essentially by imposing a federal coverage exclusion on certain types of medically necessary procedures that can be covered under a health benefit plan or paid for with private funds, as a condition of favorable tax treatment under the Internal Revenue Code.

The Code has long promoted access to health care through provisions that incentivize private health payments by individuals and employers toward the cost of medically necessary care, including the purchase of health benefit plans. Products and activities so incentivized include health insurance products, third party administered plans, health care products that encourage saving for health care expenditures and out-of-pocket payments. Under H.R. 3, health benefit products whose coverage includes benefit exclusions linked to certain procedures would no longer be eligible for favored treatment. Individuals and employers who purchase such products, even without knowledge of their design or practices, would be required to conform to the new federal exclusion.

The exclusion would take effect in the first taxable year following enactment, rather than in the first plan year or following a phase-in time allowing the IRS to develop compliance procedures. No provision would be made for grandfathering existing plans

or benefit arrangements. Noncompliance would result in exclusion of the product from the market, as well as liability on the part of affected individuals and employers for recoupment of the tax value of their expenditures. Depending on the excluded procedures and the value of any benefit plan involved, this recoupment amount could be in the thousands – or tens of thousands – of dollars for individuals. Employers could face far larger recoupments.

The Internal Revenue Service presumably would be charged with administering this new federal exclusion. Oversight would necessitate the development of a system that can police the contents of every health benefit services product sold through the tax-preferred market in order to assure that no product covers excluded procedures. In addition, oversight would require a recoupment process covering prohibited individual and employer expenditures.

For more than 30 years, the Hyde Amendment has focused on public spending by the federal government, including expenditures through appropriated funds as well as the government's expenditures for health benefits offered to federal employees. If enacted into law, H.R. 3 would dramatically expand the concept of public expenditure in order to reach laws governing tax treatment of private health expenditures. Specifically H.R. 3 would add a new Chapter 4 to Title I of the U.S. Code. As amended, Chapter 4 (§303) would create a federal exclusion related to the tax treatment of a range of medical care products:

- It would bar tax-favored expenditures in the form of tax credits made available to qualified small employers that select health benefit plans for their employees if those plans cover excluded abortions;
- It would bar tax-favored expenditures in the form of tax credits made available to qualified individuals who purchase a health insurance or health benefit product if those products cover excluded abortions. This bar appears to apply to all credits, even credits that, as in the case of the Affordable Care Act, are not extended unconditionally but must be recouped in the case of individuals whose incomes rise;
- It would bar individuals from deducting from their incomes the cost of premiums for policies covering prohibited abortions;
- It would bar individuals from claiming a deduction from personal income for uncovered medical expenses related to excluded but medically necessary abortions;
- It would bar individuals from using tax-preferred savings accounts that allow them to marshal their own incomes to pay for the cost of medically necessary but excluded abortions.

Furthermore, the language of H.R. 3 is sufficiently vague – and unaccompanied by any clause limiting the deduction to a deduction taken by the taxpayer – so that read in its broadest form, H.R. 3 conceivably could empower the IRS to reach a deduction taken by an employer who sponsors and contributes to the cost of an employee health benefit plan as a component of overall employee compensation. Section 303(2) (whose sweeping title is "Tax Benefits Relating to Abortion") provides in pertinent part that "*any*" deduction

for . . . "a health benefits plan that includes coverage of abortion shall not be taken into account." [emphasis added] Read literally, §303(2) applies to *any* deduction taken for products that cover excluded procedures, regardless of whether such products were purchased intentionally or without knowledge on the part of the employer. Threatened with the loss of deductibility for expenses related to employer-sponsored health plans, employers might cease to provide health benefits as a form of compensation, at least until they could switch to a product certified by the IRS.

As I have noted, not only does the measure impose a federal coverage exclusion for certain medically necessary procedures, but its effect is immediate and without regard to whether such products have been purchased intentionally or without knowledge of their design. Understanding the full scope of coverage under a health benefit plan is a near-impossibility because of the sheer sweep of the meaning of coverage.[1] Indeed, under the Employee Retirement Income Security Act, health plan administrators have no duty to disclose every covered or excluded procedure.[2] Because H.R. 3 leaves no time for individuals, employers, or the health insurance and health benefits industries to come into compliance, no time would be provided to adjust either product design or purchasing practices.

The potential amount of funding in play as a result of these broad changes in the tax-favored treatment of private medical care purchases is enormous. The Congressional Research Service reports that in 2007, tax-favored expenditures exceeded $310 billion when private health insurance, out-of-pocket payments, and other private expenditures were taken into account.[3]

A separate matter is how the private insurance and health benefits industries would react to this federal health coverage exclusion. We have considered this question previously in the context of the Stupak Amendment introduced and passed by the House of Representatives during the 2009-2010 health reform debate.[4] The vast majority of typical products sold in the employer market appear to cover medically indicated abortion services.[5] Because products that violate the exclusion would no longer qualify for favorable tax treatment, the industry can be expected to scramble quickly to come into compliance. Where the exclusion is as complex and fact-driven as that laid out in H.R. 3, compliance poses great difficulties. What evidence would be needed to document a rape, for example? Would the IRS provide guidance on allowable -- versus excluded -- procedures related to rape? What evidence would be required to justify coverage related to incest? What information would a claimant have to submit? What information would

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[1] Rand Rosenblatt, Sylvia Law and Sara Rosenbaum, *Law and the American Health Care System* (Foundation Press, NY, NY 1997)

[2] See, e.g., *Jones v Kodak Medical Assistance Plan*, 169 F. 3d 1287 (10th Cir. 1999)

[3] CRS Memorandum to Senator Tom Coburn (December 1, 2009)

[4] S. Rosenbaum, L. Cartwright-Smith, R. Margulies, S. Wood, and D. Mauery, *An Analysis of the Implications of the Stupak/Pitts Amendment for Coverage of Medically Indicated Abortions* (George Washington University School of Public Health and Health Services, Department of Health Policy, 2009) **http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/index.cfm?mdl=pubSearch&evt=view&PublicationID=FED314C4-5056-9D20-3DBE77EF6ABF0FED**

[5] The Guttmacher Institute reports that 87% of employer-sponsored plans cover some level of medically indicated abortion procedures. Guttmacher Institute Media Center, Memo on Private Insurance Coverage of Abortions (January 19, 2011)

be relevant during the review or an appeal of a coverage denial? What evidence would justify an abortion involving a "physical disorder, physical injury, or physical illness that would, as certified by a physician, place the pregnant female in danger of death"?

To be sure, the insurance and health benefits industries might look to the coverage experiences of public insurers such as Medicaid. However, a far easier and completely legal strategy for private insurers and plan administrators would be simply to exclude coverage of all abortions from their coverage products, whatever the clinical or factual evidence, rather than risk a violation of the federal exclusion that in turn would result in the loss of tax-favored treatment for the entire product. This result is particularly likely given the fact that under the terms of H.R. 3, the risk of violation is not limited to coverage designs that include federally excluded procedures. Loss of tax-favored status could result from an erroneous claims determination in a single case, since H.R. 3 links its exclusion to any plan that "includes coverage of abortion" without regard to whether the coverage is pursuant to plan design or a single claims decision.

Furthermore, given the nature of insurance coverage and health benefits arrangements, the industry's response could not end at specific excluded procedures. An insurance exclusion relates not only to specific abortion procedures but also to downstream treatments for conditions that arise from excluded procedures.[6] Thus, an insurer or health benefit product, including tax preferred trusts and accounts, would rightfully exclude not only the initial medically indicated abortion procedure but any payment for procedures required to treat complications arising from the initial procedure, such as a medically necessary abortion followed by extended treatment for the results of sepsis.

The Prohibition Against Government Discrimination Against Certain Health Care Entities Is Incomplete

H.R. 3 would codify into permanent law existing nondiscrimination provisions and would tie these newly codified provisions to governmental and private enforcement powers. As written however, the measure would apply only to discrimination against health care entities that do not provide, pay for, provide coverage of, or refer for abortions. Notably absent from the new provision is any protection for health care entities that do in fact provide, pay for, provide coverage of, or refer for abortions that are completely lawful. The absence of such a protection is important in my view given the potential for discriminatory conduct against entities that pay for or provide legal abortions. In the absence of equal protection, a health plan would be free to exclude from its network a physician who provides lawful abortions or a hospital that is willing to provide a life-saving abortion. If a truly enforceable prohibition against discrimination over abortion-related activities is to be added to permanent federal law, the prohibition should be expanded to cover the full range of public practices that might be discriminatory, not only to a selected sub-group.

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[6] *Kenseth v Dean Health Plan,* 610 F. 3d 1652, (7th Cir. 2010)

Mr. FRANKS. Thank you, Professor. I thank all of you for your testimony. And I will now begin the questioning by recognizing myself for 5 minutes. I will start with you, Mr. Doerflinger.

Absent the enactment of H.R. 3, what does a health care provider risk if the provider obeys his or her conscience and refuses to perform an abortion?

Mr. DOERFLINGER. Well, I don't want to overstate this, Mr. Chairman, because in my view H.R. 3 basically codifies and makes more permanent protection that has long been in law. The problem is that—and this was illustrated in one case in New York very recently—the existing conscience laws aren't very clear on what it is you do to actually protect your rights. So a nurse by the name of DeCarlo at Mount Sinai Medical Center in New York recently found that although she was forced to participate in a late term abortion, after having her statement accepted initially by the hospital staff that she would not be required to assist in these abortions, she was forced anyway. She was given the job of reassembling the body parts on a table in the operating room to make sure they got all of the pieces of the baby. She has had nightmares ever since and had a terrible time. And she was told that she would be fired if she didn't do this. And what she found when she went to court was that because the Federal conscience laws don't have anything in them that say you have a private right of action to go to court, she had no recourse. All she could do is file a complaint with the Department of Health and Human Services. And a year and a half after the abortion she still has not heard from them.

The cases in which there continue to be efforts to get governmental bodies to discriminate against pro-life health care providers occur almost every week. There was a recent case here in my hometown, Montgomery County, in which Holy Cross Hospital seems to be on course now, approved by the State of Maryland, to build a new hospital in northern Montgomery County, because it made the best case for being able to provide excellent care to the women and men of the county. But there was a very serious effort by abortion activists to say you must not give this contract to Holy Cross Hospital, you must give it to someone else, even if their general health care proposal is not as good, because if you give it to Holy Cross, you will not have access to abortions through the hospital up there.

So these efforts to discriminate against health care providers on this basis occur all the time, and we are just trying to make sure the protection is actually there and is working.

Mr. FRANKS. Mr. Doerflinger, there was a controversy in 2007 and 2008 concerning the extent of conscience protections for health care workers, specifically changes in the ethics guidelines propounded by ACOG, American Congress of Obstetricians and Gynecologists, and changes in the certifying criteria for the certifying agency of OB/GYNs, that is ABOGs. There are all these acronyms. American Board of Obstetrics and Gynecology. And it caused physicians to question whether refusal to perform an abortion can result in decertification, ending their career actually. Would you explain this controversy and how it led to the conscience regulations put in place at the end of the Bush administration?

Mr. DOERFLINGER. Yes, the Ethics Committee opinion from the American College of Obstetricians and Gynecologists came out in 2007, but despite all the controversy it was reaffirmed by the organization in 2010. And what really sent a chill of fear across many OB/GYNs throughout the country who do not perform abortions is that very often the ethical principles articulated by ACOG become standards for certification as an OB/GYN by the partner organization, the American Board of OB/GYN.

And so this was one of the reasons why the Bush administration decided to try to clarify regulations to uphold these providers' rights, regulations which the Obama administration has proposed to rescind. But the ACOG document is breathtaking in its disregard for any OB/GYN whot doesn't want to do abortions. They say that these OB/GYNs must nonetheless be willing to refer for abortions. If there is no one to refer them to, they must do them themselves. And they even said that if you are an OB/GYN who does not do abortions, you should make sure you locate your practice near an abortion provider to make sure that it is easy for everybody to get from you to the abortion.

So one talks about the tail wagging the dog, this is the tick on the tail of the dog wagging the entire health care system, saying people have to disrupt their lives and livelihoods and change even where they practice to make sure they are as close as possible to an abortionist.

Mr. FRANKS. Well, I am not going try to get another question in here, my time is about gone. So I am going to yield to the distinguished gentleman Mr. Nadler for his questions.

Mr. NADLER. Thank you, Mr. Chairman.

Ms. Ruse, you take the position that the reduction of taxation is a form of government subsidy. Now this is flatly at odds with what your organization, the Family Research Council, stated about tax credits and deductions in the context of tuition for religious schools. If it isn't Federal—where you said there is no government spending on religion here, it's people's private money that they send to various student tuition organizations. If it isn't Federal funding when people use their private money to fund religion tuition at a parochial school and receive a tax deduction or credit for doing so, how is it Federal funding when people use their private money to pay for their medical care or insurance coverage?

Ms. RUSE. As a general proposition, tax reduction is a form of government subsidy.

Mr. NADLER. And by tax reduction, you mean like a tax credit or something?

Ms. RUSE. Correct, that's right. And I would just direct you to, and I will get you the citation if you need it, but ObamaCare itself makes this distinction. It calls, or makes this equation I should say, it calls tax credits for buying insurance on State exchanges, it calls those a creature of Federal funding. If you have an argument with me——

Mr. NADLER. Excuse me. I am asking you.

Ms. RUSE. Yeah.

Mr. NADLER. It seems inconsistent, either it is or it isn't. How can you say that for religious schools it is—it is not and for health insurance it is? How do you make that distinction?

Ms. RUSE. Well, I appreciated your opening statement where you said it is our money. And that is what the Republicans often say and I think that is accurate.

Mr. NADLER. In which case you shouldn't be arguing what you are arguing with respect to health care. If it is our money, then it is not a government subsidy, as you said in the Arizona—or your organization said in the Arizona case. If it is not our money and it is a government subsidy, then it is the contrary. Both things can't be true.

Ms. RUSE. And I would say your argument is with President Obama and his health——

Mr. NADLER. That may be, but I am asking you how you justify saying it is a government subsidy here but not there. Which is it and why is it different?

Ms. RUSE. As a general proposition tax reduction is a form of government subsidy, as a general proposition.

Mr. NADLER. But not with respect to religious schools?

Mr. Doerflinger, let me ask you. As a general proposition government tax exemptions, tax subsidies, or what you call government spending, you said it was a tax? What did you say? As a general proposition it is a form of government subsidy. If tax exemptions are a form of government subsidy, how do we justify tax exemptions for the Catholic church, the Jewish synagogue, the Protestant church or anybody else or any other government——

Mr. DOERFLINGER. I think the first reason churches are not taxable is simply that they don't make a profit or are nonprofit organizations.

Mr. NADLER. Wait a minute. They are exempt from—all right. What about the individual who gives money to the church that is not taxable?

Mr. DOERFLINGER. Right.

Mr. NADLER. Under your definition isn't that a government subsidy to the church?

Mr. DOERFLINGER. I think the Federal Government has made a policy decision a very long time ago that charities and churches——

Mr. NADLER. Excuse me, it is not a question of a policy decision, because if it is a public subsidy to the church, it is unconstitutional because of the establishment clause. So either if government—a tax credit to the individual contributing to the church is not a government subsidy, then these things aren't government subsidies. If it is a government subsidy, then you have got an establishment problem under the First Amendment, have you not?

Mr. DOERFLINGER. It is not unconstitutional to give public subsidies to a charitable or church organization, as long as you are serving a legitimate secular purpose.

Mr. NADLER. Excuse me. But wait a minute. You are—we are not talking about that.

Our policy, we, if you give a tax—I'm sorry, a contribution, when I give a contribution to my synagogue it is not for general purposes, it is for religious purposes.

Mr. DOERFLINGER. Right.

Mr. NADLER. And I take a tax deduction for that. Now under your definition that is a government subsidy of the synagogue of

the church and it should be therefore a violation of the First Amendment.

Mr. DOERFLINGER. That is not my definition, sir. I disagree with your basic premise, which is that all of these things are the same and it is all one thing.

Mr. NADLER. You are just trying to have your cake and eat it too, because either a tax exemption is a government subsidy or it is not. If it is not a government subsidy the whole point of this bill.

Mr. DOERFLINGER. I——

Mr. NADLER. Excuse me, I am talking. The point of this bill is wrong. If it is a government subsidy, then this bill may be right, but then we have to question—not just question but then tax subsidies, government subsidies for religious institutions are probably unconstitutional as violations of establishment clause of the First Amendment.

Professor Rosenbaum, do you agree with Ms. Ruse's position that H.R. 3 does not affect employer provided plans?

Ms. ROSENBAUM. I do not. For the reasons stated in my written testimony I find section 303(2) ambiguous. It specifically refers to any deduction covering not only medical care but health benefit plans and I think that the ambiguity is critical on this point.

Mr. NADLER. Thank you. I am told my time has expired.

Mr. FRANKS. Thank you, Mr. Nadler. And just to clarify the point, both tax preferred status and appropriations have been recognized in the courts as being allowed for a public good, and I think the consideration here is that abortion is not a public good. And so it really doesn't need to reach Mr. Nadler's point, which I think he has some elements to his point. It doesn't matter if it is a tax preferred status or not. The government should still have the right to shape the Tax Code in favor of a public good or against something that they consider not a public good.

With that, I would recognize the distinguish gentleman from Indiana, Mr. Pence, for his questions.

Mr. PENCE. Thank you, Mr. Chairman. And let me also join the Ranking Member in congratulating you on your appointment. As Chairman of the Subcommittee, I think you know that I can think of no one in the newly minted majority in Congress that I think is more appropriate to lead this Subcommittee than you. And I found your opening remarks powerful and eloquent and I wish to offer you my congratulations, as I do to all the Members in the majority and the minority on this Subcommittee.

Thanks for holding this hearing. I appreciate the opportunity to participate in a discussion of H.R. 3, and I commend Congressman Chris Smith for his leadership on this issue. As our witnesses have testified, with the passage of the Patient Protection and Affordable Care Act, the need for a permanent government wide prohibition on taxpayer funding for abortion has probably never been more important. Sadly, Congress last year traded in 30 years of statutory protections for taxpayers for a piece of paper signed by the most pro-abortion President since *Roe v. Wade*. The need to pass this legislation I believe is self-evident when we think about the extraordinary subsidies, both direct and indirect, in the "Patient Protection Affordable Care Act" for abortion across government spending.

Let me say I also think now is the time to end taxpayer funding not only for abortion but also for abortion providers. That is why I have authored a bill, the Title X Abortion Provider Prohibition Act, that would end all Title X family planning funding to abortion providers.

Specifically, Planned Parenthood is sadly back in the news today. A new undercover video has been released showing multiple violations by Planned Parenthood employees in New York to go along with scandalous videos from Planned Parenthood clinics in New Jersey and Virginia. The videos show Planned Parenthood employees presumably advising an undercover sex trafficker on how to secure secret abortions, STD testing and contraception for child prostitutes. And I just have to tell you, Mr. Chairman, as the father of two teenage girls I can not be dispassionate about video evidence of individuals facilitating the abuse of minor young women in this way.

We have introduced this legislation, and along with H.R. 3, I hope the Congress will take up the Title X Abortion Provider Prohibition Act.

Planned Parenthood received over $363 million in taxpayer dollars, principally through Title X; and in 2008 alone, they performed 324,008 abortions. With more than a million abortions performed annually in this country, abortion is a heart-breaking billion dollar industry that mostly benefits Planned Parenthood. Planned Parenthood is far and away the largest abortion provider in America, and they are also the largest recipient of Federal funding under Title X. And I believe the time has come for that to end.

With that said, let me direct a question to Mrs. Ruse whose testimony I found compelling, as I do appreciate her leadership on this issue across the country. You spoke about the CBO projection that without the protections of this legislation, there could be as many as 675,000 government-financed abortions in this country. With this growing video record of Planned Parenthood employees, is there any doubt in your mind that Planned Parenthood would be the largest recipient of abortion support if H.R. 3 was not enacted into law?

And I guess my specific question, Mrs. Ruse, is if we do not succeed in passing H.R. 3 and banning public funding of abortion across government systems broadly, would that not be a windfall specifically for Planned Parenthood?

Ms. RUSE. I think the word "windfall" is accurate. Last year, Planned Parenthood committed 324,008 abortions in the United States of America. If you open the doors to Federal funding, Federal subsidies of abortion in the way that ObamaCare will do it, there is no question that the chief recipient of those funds will be Planned Parenthood who is showing itself to be internally corrupt and unable to handle their finances, at a minimum, given what we know about what is happening in California. And more than that, aiding and abetting in the abuse of minors as these videos come out one after another.

And incidentally, those who try to minimize Planned Parenthood—the expose' on Planned Parenthood as a single situation or one bad egg, I just want to remind this Committee that these videos, these undercover videos have been coming out for the last 4

years. They have not gotten as much play as those recently, and come from over 10 States: Alabama, Indiana, New Jersey, New York, Virginia. It suggests there is a system-wide problem with Planned Parenthood and they do not deserve one million dollars a day of taxpayer dollars.

Mr. PENCE. I thank you. This hearing is obviously on H.R. 3 and on the issue of direct public subsidy for abortion, and so we will not in this hearing discuss how the hundreds of millions of dollars that flow into Planned Parenthood, organizations that operate as title 10 indirectly support the abortion efforts of Planned Parenthood, but I look forward to that hearing, Mr. Chairman, perhaps in another Committee.

I commend the members of this panel for your thoughtful comments.

I yield back the balance of my time.

Mr. FRANKS. I thank the gentleman, as always.

I now call on Mr. Quigley for 5 minutes.

Mr. QUIGLEY. Thank you, Mr. Chairman. Congratulations on your new post.

I hate to begin by respectfully disagreeing with you, but I would only suggest that the public good that private health insurance is providing health insurance, and the incentive is to encourage employers to provide health insurance to everyone possible. But let me, if I can, Mr. Doerflinger, I guess the fair question to your points is how far does this go? And since you are the one testifying, I think it is fair, with your personal beliefs or any particular church. I would suppose that—I know the church, I'm not sure about you, believes that the use of modern birth control, the pill, is morally wrong. So would you then say that we don't want to use tax subsidies, or you call funding, to health insurance companies that provide birth control pills for women?

Mr. DOERFLINGER. I think it is a very different moral issue, Congressman.

Mr. QUIGLEY. It is still the same directive from the Catholic Church, isn't it?

Mr. DOERFLINGER. Yes, but we are not against Federal funding of abortion because Catholic moral teaching is against it. We are against abortion because it is a violation of the most fundamental right. It is something rejected not only by Catholics, and many other religions, but by the Hippocratic Oath that gave rise to medicine as a profession.

It is against the considered moral judgment of millions of Americans who have no particular religious affiliation at all. And it has been seen in the past as a crime. Of course today, there is at least one abortion procedure that is a Federal crime. And it is the killing of children who in any, other context, are seen even in Federal law as persons who have a right to be protected from lethal harm, the Unborn Victim of Violence Act. There is an arbitrary exception for abortion.

Mr. QUIGLEY. Let's go to another example, embryonic stem cell research. Do you believe Congress should impose tax penalties on people who purchase insurance policies that cover medical cures derived from such research?

Mr. DOERFLINGER. I think that is a—well, let's say it is a very farfetched thing to have happen.

Mr. QUIGLEY. Respectfully, you don't think people's lives are saved with embryonic stem cell research?

Mr. DOERFLINGER. I'm sorry?

Mr. QUIGLEY. You don't think people's lives are saved with embryonic stem cell research?

Mr. DOERFLINGER. I don't think that the evidence exists to say that embryonic stem cells will ever be used in actual clinical treatment. They are far too uncontrollable. They cause far too many tumors when used in animals. You can't tell what they are going to do once they are in a human body. So I think it is an imaginary question. But let me answer that I think what we are concerned about here is the use of tax dollars, tax subsidies, tax support for something that actually takes life.

We are against Federal funding of embryonic stem cell research itself when it involves the taking of life of an embryonic human being. In some States, Pennsylvania is one, the killing of an embryo for experimental purposes is a felony, and yet the Federal Government is funding it.

Mr. QUIGLEY. Let me turn to the Professor. It appears that our issue here is primarily whether or not this is Federal funding. Can you elaborate, to a certain extent, on the policy implication once it is decided that, I guess it was the Supreme Court in Walz versus the Tax Commission, that the court upheld property tax exemptions for such property. Once that is crossed, what are the other implications legally for not for profits, not just religious?

Ms. ROSENBAUM. Well, I think they are, as has already been said, most eloquently by Mr. Nadler, the conversion of what has been tax advantaged private spending, which is understood in society as private spending, it is simply not subjected to certain otherwise applicable taxes, into an overt public financing of certain activities. It has profound implications.

It has profound implications to the extent to which, as has been noted, certain recipients of those exemptions are suddenly receiving public funding for certain purposes not permitted under the Constitution. But also, it has implications for the kinds of conditions that can be attached to entities that do receive exemptions. It becomes a much more government-intrusive process in which government is setting the terms and conditions, as in the case of H.R. 3, for the receipt of a tax exemption. In this case, an entity can only receive favorable tax treatment if it does not seek or provide medically necessary care, certain types of medical care.

Mr. QUIGLEY. I thank you.

Mr. FRANKS. I thank the gentleman. I now recognize the former Chairman of this Committee, Mr. Chabot.

Mr. CHABOT. Thank you, Mr. Chairman. I want to commend you as Mr. Pence did. I know you are going to be a great Chair of this Committee. I did have the honor to serve for 6 years. And I wanted to go to a Committee where we knew the problems would be a little bit easier to solve. I know this is a controversial Committee; it always has been. We are assured of success on the Committee that I'm going to be chairing. I am going to be chairing the Foreign Af-

fairs Committee's Subcommittee on the Middle East, so that is going to be interesting.

Mr. FRANKS. After this, it will be easy; won't it?

Mr. CHABOT. I think so. That's right. This hearing itself is showing evidence of that.

You know, I couldn't help, it was mentioned that—Ms. Ruse I think mentioned there were 329,000 abortions a year committed by Planned Parenthood. I happen to represent the first district of Ohio and the largest entity, governmental entity in that district is the city of Cincinnati, and abortions in this country almost wipe out the population of Cincinnati every year. It is just amazing when you think how many little boys and little girls don't ever experience the life that we have all had the opportunity to experience because of this procedure which is still allowed in this country.

I was struck, again, going back to my district, Cincinnati, I was reading the story in the Cincinnati Enquirer some weeks ago about this doctor, Dr. Kermit Gosnell in west Philadelphia, and the headline in there was "House of Horrors," and it certainly was. But I would argue that what goes on in these abortion clinics all over the country is certainly houses of horror and we shouldn't be funding it at all as far as I am concerned, but certainly not with tax dollars of people who don't want their tax dollars going to carry out that type of behavior.

Talking about that doctor, Dr. Gosnell, according to the grand jury report on the activities that were conducted by him at his clinic, and it was called the Women's Medical Society in west Philadelphia, on page 4 of the report, it says, and I'm quoting this, When you perform late term abortions by inducing labor, you get babies—live, breathing, squirming babies. By 24 weeks, most babies born prematurely will survive if they receive appropriate medical care, but that was not what the Women's Medical Society was about. Dr. Gosnell had a simple solution for unwanted babies: he killed them. He didn't call it that. He called it ensuring fetal demise. The way he ensured fetal demise was by sticking scissors into the back of the baby's neck and cutting the spinal cord. He called that snipping. Over the years, there were hundreds of snippings.

I would ask you, Professor Rosenbaum, do you think American taxpayers should have to pay for this kind of activity?

Ms. ROSENBAUM. Mr. Chabot, I don't really see the connection between what is absolutely a terrible, terrible story and the tax finance issue here.

Mr. CHABOT. Let me draw the connection then for you. If he was doing this outside the womb, if he had snipped those spinal cords within the womb, that would be perfectly legal in this country; wouldn't it? And should we use tax dollars to pay for that type of activity?

Ms. ROSENBAUM. I think your question suggests that this bill involves tax dollars.

The Hyde amendment is a very clear statement about the use of——

Mr. CHABOT. Reclaiming my time.

Mr. NADLER. Would the gentleman yield?

Mr. CHABOT. I only have a very short time here, and I have a couple of other points I would like to make.

Let me ask the other two witnesses, is that legal? Would that be legal in the first trimester, second trimester, that type of activity in abortion clinics, or are there restrictions relative to what they can do to destroy that child in the womb?

Ms. RUSE. Very likely, yes. The only procedure that currently is not legal is the partial birth abortion procedure. So unless he followed the steps outlined in the partial birth abortion procedure, and my reading of the grand jury report is that he was not taking those steps, then what he was doing would be perfectly legal if it was done just before delivering the baby.

Mr. CHABOT. I see my time has expired. I thank you, Mr. Chairman. I yield back.

Mr. FRANKS. I thank the gentleman. It should be noted the gentleman was a prime sponsor of the partial birth abortion, and will forever be a hero to me because of that.

I now yield to Mr. Conyers, the distinguished former Chairman of the Committee, and we're going to call him Ranking Member for now.

Mr. CONYERS. I thank you very much. My congratulations. I could observe that the view isn't quite as good from this end as it used to be when we were on the other side, but I'll get use to it again.

I also wanted to welcome Mike Pence to the Committee and appreciate his coming aboard. What he has got against the Planned Parenthood people I have yet to discover. They have done, I thought, a pretty good job, but he is bound and determined to defund them, and I think do a great disservice to a very effective organization that has brought help and assistance to women over the years.

Now, Mr. Chairman, we talked about the fact that Eleanor Holmes Norton was not permitted to testify. Was the author of this bill prevented from being a witness here today, too?

Mr. FRANKS. Mr. Conyers, that was discussed earlier. The author of the bill could have been the witness here if they had been chosen as the Democrat witness. It is the Committee structure of the panel for witnesses.

Mr. CONYERS. You didn't want the author of the bill to testify?

Mr. FRANKS. I would have had no problem with that whatsoever, sir.

Mr. CONYERS. Did he ask to testify?

Mr. FRANKS. I'm not sure he asked to testify. I think Ms. Norton asked to testify, and if she wanted to be the Democrat witness, that would have been all right.

Mr. CONYERS. But the author of the bill, who I presume is here today, we are in the first few weeks of the 112th Session, and this is a major piece of legislation, and he is not here.

Mr. FRANKS. Mr. Conyers, I have just been told that the author made the decision not to testify. We don't know the reasons.

Mr. CONYERS. Okay.

Well, let me ask Ms. Ruse this question: The title of this bill is No Taxpayer Funding For Abortion Act. Do you know of any Federal funding for abortion that goes on in this country presently?

Ms. RUSE. The potential funding of abortion and the potential subsidies of abortion are numerous. The debate last fall over the

Burris amendment in the Senate, opening up our military facilities to allow elective abortions to be done then, that would be impacted by H.R. 3. That is still an open question. We may see reversal of that policy. And as you know, under the Clinton administration, that policy was reversed and opened up to elective abortions on military hospitals. That is one example.

So these policies, that being just one example——

Mr. CONYERS. And you would object to that?

Ms. RUSE. Yes.

Mr. CONYERS. And if you knew of any others, you would object to them as well?

Ms. RUSE. Yes. I would object to the funding of or subsidizing of elective abortions with Federal funding, absolutely. That's right.

Mr. CONYERS. So you think this is an appropriate title of a bill then, No Taxpayer Funding For Abortion Act, because women in service may be able or might be able to get an abortion?

Ms. RUSE. Yes, that is one example.

Mr. CONYERS. Well, that is the only example that I know of. If you know of others, let me know.

Ms. RUSE. Well, the District of Columbia appropriations bill last Congress also opened up Federal funding for abortions in the District of Columbia. So that is currently an area that needs to be corrected by H.R. 3 by employing the long-standing principal of the Hyde amendment. And the District of Columbia often does have that appropriations rider applied. It was just taken off just a few months ago. So that would be corrected by H.R. 3.

Mr. CONYERS. All right. It is my impression that this is a misleading title of the bill, not Federal funds, D.C. taxpayers funds, not funds from Fed Treasury. That is just a staffer. You're the expert witness.

Let me turn to another consideration. Has my time expired?

One final question, Mr. Chairman, and thank you. Section 311 of this bill protects individuals who refuse to provide abortion services. As I read it, Ms. Ruse, this would mean that someone who refused to provide life-saving treatment and allowed a woman to die as a result might escape any consequences if that were to happen; is that your understanding?

Ms. RUSE. No, not at all. What this section of H.R. 3 does is simply codify the long-standing principle of the Church amendment which allows health care providers to decline to participate in abortions. That has been around for 38 years. In that history of the Church amendment, we have never seen a situation where women were dying at the hands of outside an abortion clinic because they weren't able to have an abortion.

Now, I would also like to mention that EMTALA has never been used to require an emergency provision of an abortion, with is the Emergency Medical Treatment Act. That has come up earlier in the meeting. So we have a long history of this conscience protection section. The only additional new part of it is allowing remedies, allowing someone who has been discriminated against, like this nurse, DeCarla, to have a cause of action. So that is the new part. But the conscience language itself is just codifying this long-standing policy.

Mr. CONYERS. I would like to have unanimous consent to put in some articles from The Nation Magazine, and the New York Review of Books as well.

Mr. FRANKS. Without objection.

I thank you, Mr. Conyers.

[The information referred to follows:]

Published on *The Nation* (http://www.thenation.com/)

Piling on Against Planned Parenthood

Sharon Lerner | February 2, 2011

The next videogate episode is out! This one [1] features Planned Parenthood worker Amy Woodruff advising a man posing as a sex trafficker on how to get health care for girls as young as 14 who, he implies, work for him as prostitutes. If the gotcha! is reminiscent of the deceptively edited tapes that cost Shirley Sherrod her job at the US Department of Agriculture or the separate fake pimp scandal that brought down the community organization Acorn, that's probably because it was produced by antichoice activist Lila Rose—the president of an organization, Live Action, who, since 2006 has collaborated with the mastermind of those previous episodes, James O'Keefe.

The widely viewed tape has brought about the expected fallout: the New Jersey Planned Parenthood affiliate where the video was taken has received threats, including one mentioning a bomb. Woodruff was promptly fired. (That action was predictable and appropriate, given that she violated Planned Parenthood policy by advising the fake pimp how to get the teenagers abortions, after he told her that they were sex workers in the country illegally. While Woodruff seems to be just a bad—and, perhaps, insecure—apple, her fawning treatment of the fake pimp also speaks to the sad fact that Planned Parenthood clearly also needs to ensure that clinic staff follow its policy for dealing with pimps, whether they're real or fake.) A Twitter war has even ensued, with the video being used alternately as evidence of a smear campaign or of the fact that somehow Planned Parenthood is "aiding and abetting Sex Trafficking of Minors," as RedState.com put it.

In keeping with the videogate genre, there isn't much that could reasonably be considered scandalous behind this latest tempest. After visiting at least twelve Planned Parenthood clinics in six states, Live Action's elaborate charade turned up just this one heavily edited video. You might expect more from Rose, a 22-year-old former student activist who is part of a wacko fringe that lumps pro-choicers in with Nazis [2]. (Activist Mark Crutcher, who runs a fake abortion clinic in Denton, Texas, and has himself waged fake phone call campaigns against Planned Parenthood, is one of her heroes.)

The problem is that, while you might want to laugh off Rose and her fake pimp as just a couple of creepy video pranksters, this latest stunt is prompting a

conservative pile-on that could have serious legislative impact. If wackos are leading the charge, unfortunately, some of them of them have seats in Congress.

Rep. Michele Bachmann linked to the Live Action video on her Facebook page on Tuesday, noting that "I am introducing a bill that would prohibit Planned Parenthood from receiving any future federal money directly or indirectly.... You must see this undercover video. This is horrifying!"

She's not being abstract. Her colleague, Rep. Mike Pence, recently introduced legislation that would deny federal dollars to Planned Parenthood and other organizations that receive family funds and also provide abortion. The Pence bill, which has 154 sponsors, has seen no action since it was introduced almost a month ago. But, yesterday, after the Live Action video came out, an antichoice coalition launched a website pushing it forward. The release of the video has prompted Pence to call for immediate action [3] on the bill. And now sources say it looks as though the amendment may be brought to a vote within the next two weeks.

ExposePlannedParenthood.com, a site sponsored by a number of anti-abortion groups, including Rose's Live Action, Students for Life of America, Family Research Council and Concerned Women for America, is designed so visitors can send direct e-mails to their legislators in support of the Pence bill. Meanwhile, the Family Research Council is planning a live webcast [4] for Thursday night headlining Lila Rose and, no doubt, also pushing for the legislation.

It's clearly a bad moment for Planned Parenthood. But while it can seem like they're getting it from all sides, the truth may be that what looks like a random pile-on is actually a coordinated campaign.

"We definitely see a connection between all of this activity," says Stuart Schear, vice president for communications for the Planned Parenthood Federation of America. "These organizations are working very much together with the legislative agenda of defunding Planned Parenthood in mind."

Planned Parenthood has had its funding threatened before. Pence introduced bills that would have cut off federal funding to the organization in 2007 and 2009, but this may be his lucky legislative session, judging from the extremely conservative post-election make-up of Congress.

Meanwhile, family planning is also facing new threats on the state level. New Jersey, the state where the Live Action video was shot, has already severely cut state money. Last year, Governor Chris Christie defunded fifty-eight family planning centers, and he is widely expected to veto legislation that would give

Christie, the story goes, cut the money because he's opposed abortion. In reality, of course, reduced access to contraception means only more unintended pregnancies—and more abortions. But, then again, if you think getting rid of family planning will cut down on abortions, you might also see why a video of one misguided woman who, for all we know, was trying to help some fictitious teenaged sex slaves, should bring an end to federal funding for our nation's biggest reproductive healthcare provider.

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EDITORIAL

The Two Abortion Wars: A Highly Intrusive Federal Bill

Published: January 29, 2011

The Two Abortion Wars: A Highly Intrusive Federal Bill

House Republicans are preparing to push through restrictions on federal financing of abortions far more extreme than previously proposed at the federal level. Lawmakers who otherwise rail against big government have made it one of their highest priorities to take the decision about a legal medical procedure out of the hands of individuals and turn it over to the government.

Their primary bill —the "No Taxpayer Funding for Abortion Act" — is so broad that it could block insurance coverage for abortions for countless American women.

The anti-abortion forces almost derailed health care reform last year over whether people could buy policies that cover abortion on new insurance exchanges. The compromise embedded in the reform law sets up a hugely complicated plan to segregate an individual's premium payments from the government subsidies. It is so burdensome that it seems likely to discourage insurers from offering any abortion coverage at all on the exchanges.

But anti-abortion lawmakers are not satisfied. The new bill, introduced by Christopher Smith, a New Jersey Republican, would bar outright the use of federal subsidies to buy any insurance that covers abortion well beyond the new exchanges.

The tax credits that are encouraging small businesses to provide insurance for their workers could not be used to buy policies that cover abortions. People with their own policies who have enough expenses to claim an income tax deduction could not deduct either the premiums for policies that cover abortion or the cost of an abortion. People who use tax-preferred savings accounts to pay medical costs could not use the money to pay for an abortion without paying taxes on it.

The only tax subsidy left untouched is the exclusion that allows workers whose premiums are subsidized by their employers to avoid paying taxes on the value of the subsidy. Many, if not most, employer-sponsored insurance plans cover abortions. There would have been a huge political battle if workers were suddenly told they had to pay taxes on the benefit or change their policies.

The Smith bill also would take certain restrictions on federal financing for abortions that now must be renewed every year and make them permanent. It would allow federal financing of abortions in cases of "forcible" rape but not statutory or coerced rape, and in cases where a woman is in danger of death from her pregnancy but not of other serious health damage. It would free states from having to provide abortions in such emergency cases.

A separate Republican bill would deny federal funds for family planning services to any organization that provides abortions. It is aimed primarily at Planned Parenthood's hundreds of health centers, which also provide many other valuable services. No federal money is used for the abortions. This is a reckless effort to cripple an irreplaceable organization out of pure politics.

Mr. FRANKS. I now recognize for 5 minutes the distinguished gentleman from Iowa.

Mr. KING. Thank you, Mr. Chairman. I welcome you also as Chairman of this Committee. I have had the privilege to serve on this Committee now starting my 9th year, and I am really glad to

see you here with the gavel. And I am also delighted to see my former colleague and now current colleague, again, Mr. Chabot, back on this Committee and back on the subject matter that he led so well on. I look back at those debates here in this Committee when we were dealing with the terminology called "dilation and extraction" which was a nice term for partial birth abortion.

And Steve Chabot laid that out in a very good and clear way, and it was one significant piece of progress that this Congress has made, and there haven't been many over the last decade or so. That was dilation and extraction. Now we have Federal funding for dilation and evacuation, which I have asked them to put this poster up here so we know what we are talking about. And I recognize we have experts on the law here, but we are dealing with human lives. I would ask if each of you have reviewed this process that I will call dismemberment abortion. If each of you, and I would ask on the record, starting with Mr. Doerflinger, are you familiar with this dismemberment abortion?

Mr. DOERFLINGER. From the point of view of a nonmedical professional, yes, sir.

Mr. KING. Ms. Ruse?

Ms. RUSE. My answer is the same.

Mr. KING. And Professor Rosenbaum?

Ms. ROSENBAUM. It would be the same.

Mr. KING. You all are familiar with this procedure where the tool is used to dismember the baby and pull the parts of the baby apart, in utero dismemberment, and as they count the pieces up piece by piece, if it looks like you get down to the point where often the head is so well formed and the bone is so well structured that it has to be crushed and then pulled out, collapsed and then suctioned to make sure that the bone fragments don't bring about a high degree of hemorrhaging. For me I can't see much difference between partial birth abortion and dismemberment abortion, but we are here talking about legalities, talking about a complicated, convoluted tax policy that might be prohibitive for us to prohibit Federal funding for a procedure like this, this dismemberment abortion.

I know the positions of Mr. Doerflinger and Mrs. Ruse, but Professor Rosenbaum, you have not addressed this from a standpoint other the complications of the taxes. I would just ask: Should government fund a procedure like this?

Ms. ROSENBAUM. Again, I would have to respond that I am not prepared today to answer this question. I was focused on a bill that is dealing with what I don't consider to be government funding.

Mr. KING. But Professor, you understand that——

Ms. ROSENBAUM. If I could just finish. As far as I can tell, there is no public funding for this procedure right now, except in those situations in which one of the three very limited categories has been satisfied under Federal law. So my answer would be we are not publicly funding these procedures now, and the bill before us is not a public funding bill.

Mr. KING. I have before me data that shows about 142,800 of these dismemberment abortions taking place in America just last year by the Guttmacher Institute. We could go into the disagreement we might have, but I would ask you, you are aware that if

your testimony has impact here, then it might bring about this procedure that we are looking at now, and more of it funded by Federal tax dollars. So I am going to ask you then: Do you have a moral position on this or is it just a legal one on taxes?

Ms. ROSENBAUM. I prefer actually to keep my moral positions out of this hearing. I have very strongly held religious and moral views on many things.

In terms of today's hearing, as I said, I don't think I see any example of public financing for this procedure except in the excepted circumstances.

Mr. KING. Since you don't, if we could resolve that there is Federal funding for abortions in this country, and there has been testimony to that effect by Mr. Doerflinger in particular, and I think also by Ms. Ruse, if we establish that point, are you in a position to change your position?

Ms. ROSENBAUM. I truly am having trouble following the question.

Mr. KING. Let me go another route. You have reviewed this procedure. Could you step into an operating room and witness it?

Ms. ROSENBAUM. I am a law professor, so I presume I would never be in an operating room to see it.

Mr. KING. You can't answer that question then whether you could observe it or not. I'm going to also understand that if I asked you if you could actually conduct that procedure, you would answer the same way. But I won't ask you that question, Professor. I just make this point, that this is a ghastly, gruesome and ghoulish procedure, and it is dismemberment abortion. And I have known people who could not vote for a death penalty because they couldn't conduct it themselves, and they take that moral position. I understand that psychology.

But when we look at something we are asking taxpayers to fund against their will that is so ghastly, so gruesome and so ghoulish that we can't abide even looking at it or watching it, or watching a full video of it or listening to the sounds that go on there, and we are funding it and compelling taxpayers to fund this kind of a dismemberment abortion, I think that illustrates what we are up to here, and we should go to all steps to stop Federal dollars from going to abortion.

I thank you, and I yield back.

Mr. FRANKS. I thank the gentleman.

I would now yield to Mr. Scott of Virginia.

Mr. SCOTT. Thank you, Mr. Chairman, and I join the others in congratulating you on your new position and look forward to working with you.

Mr. Doerflinger, Professor Rosenbaum talked about the tax deduction and the wording seems a little unclear. Is it your belief that the tax deduction should still go to the health policy but just not that portion that pertains to abortion? Or should the entire policy lose its deductibility if it includes abortion coverage?

Mr. DOERFLINGER. Congressman, this is one of the problems I had with trying to be helpful to Mr. Nadler. I think there are a lot of different ways in which the Tax Code gets implicated in this, and there are some cases that are much more straightforward than others. I think with regard to the premium tax credits in the Af-

fordable Care Act, the policy that was put in place was that premium tax credits will not go directly to an abortion procedure itself, but they will go to an overall health plan that includes such abortions without limit. And then there will be a little accounting procedure within the plan to try to keep the Federal and private funds separate. My problem with that is that——

Mr. SCOTT. Just in terms of the bill, is it your intent that the entire, if someone has a policy that includes abortion coverage, should the employer lose the entire deductibility of the whole policy or just that portion that pertains to the abortion coverage?

Mr. DOERFLINGER. Congressman, my understanding from the analysis of this bill by the Congressional Research Service is that it does not cover the employer deduction.

Mr. SCOTT. Well, whatever deduction we are talking about, tax benefits, credits, are we just talking about the abortion portion or the entire policy?

Mr. DOERFLINGER. There are two questions: One is whether this is Federal funding, and somebody has to draw a nonarbitrary line.

Mr. SCOTT. The answer is it is not clear.

Mr. DOERFLINGER. The second question is whether, if we consider that it does cross the line into being a subsidy, whether you ban the subsidy just for abortion itself or for a plan that includes it. That policy decision was made many years ago in the Hyde amendment. The Federal employees health benefit——

Mr. SCOTT. We are here talking about the legislation. Professor Rosenbaum, you mention that there is a lack of clarity as to whether the whole policy would lose its deductibility, or whether just the portion attributable to abortion coverage would not be deductible; is that right? You said it is unclear?

Ms. ROSENBAUM. No, actually I think it is very clear that the entire policy, whatever is affected under this bill, the entirety would lose its deductibility, its tax advantage. What is not completely clear to me because of the term "any deduction" is whether the deductibility applies only to individual taxpayer deductions, or in fact, could at some point be interpreted to reach employer deductions. But I do believe that the deduction would be struck in its entirety if the product sold is a product that includes one of the prohibited abortion procedures, hence the extraordinarily difficult problems for the IRS in determining when the deductibility standard would be met.

Mr. SCOTT. The question I had was whether that was the intent and we couldn't get an answer, so it must be unclear.

Mr. Doerflinger, should government funds be used for capital punishment?

Mr. DOERFLINGER. My organization is against capital punishment. I think if you are going to have capital punishment, it pretty much has to be tax funded. But we are against that. We believe in the abolition of the death penalty.

Mr. SCOTT. Good. Should we work together, you and me, to prohibit government funds to be used for capital punishment?

Mr. DOERFLINGER. Unless the intent is to put it out into the private sector, yes.

Mr. SCOTT. Could you explain the exception for rape, why that is there?

Mr. DOERFLINGER. This recent debate about rape and forcible rape?

Mr. SCOTT. No. Why there is an exception?

Mr. DOERFLINGER. Why there is an exception? I think you would have to get that answer from someone who supports it. I can understand why some people want that exception. They want to be able to say that if the woman had no part in the decision to have sex, to get pregnant, then she should not have to bear this child that was part of no decision by her. My problem with that is, although that is a horrible thing, and there are a lot of things that the health care system and the government should do for women who have been victims of rape. I can't help thinking that there is another person involved now who has also has a right to live. I have met some kids who were conceived in rape. They and their mothers are great people and they are glad it was not an abortion.

But I think the recent debate about forcible rape was simply an effort on the part of the sponsors to prevent the opening of a very broad loophole for federally funded abortions for any teenager. The objection to that, which I thought was very interesting and helpful and clarifying, the objection to that was by people saying it doesn't mean that. Rape already means forcible. So if you say forcible rape, that is redundant and courts are going to read that as requiring some level of violence or brutality that goes beyond rape itself.

When Congresswoman Wasserman Schultz objected to the phrase "forcible rape," she said: "Rape is when a woman is forced to have sex against her will. That is whether she is conscious, unconscious, mentally stable, not mentally stable."

I think that is a pretty good definition, and I think that the Subcommittee could sort of stipulate in legislative history that is what we all mean. We are talking about cases where force is used or women have been subjected to this against their will, and move on.

Mr. CHABOT. I would like to thank Mr. Scott and thank all of our witnesses for their testimony today on this very crucial issue to humanity itself.

Mr. QUIGLEY. Mr. Chairman, a procedural question, if I could?

Mr. FRANKS. Yes.

Mr. QUIGLEY. In your opening statement, I believe you talked about perspective changes that you intended for the legislation. I believe you talked about what was just mentioned, that was rape. If I missed it, I'm apologizing, as it relates to incest as well?

Mr. FRANKS. I know that there are ongoing deliberations and they are trying to deal with at least the rape question. I can't speak to the incest question, but I am sure that will be part of their thought process. And I would invite you to be involved in that process.

Mr. QUIGLEY. Absolutely.

Mr. FRANKS. Without objection, all Members will have 5 legislative days to submit to the Chair additional written questions for the witnesses, and we will forward and ask the witnesses to respond as promptly as they can so that their answers may be made part of the record.

Without objection, all Members will have 5 legislative days within which to submit any additional materials for inclusion in the record.

With that, again, I thank the witnesses and I thank the Members and observers. This hearing is adjourned.

[Whereupon, at 5:36 p.m., the Subcommittee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

Prepared Statement of the Honorable Mike Quigley, a Representative in Congress from the State of Illinois, and Member, Subcommittee on the Constitution

Statement by Rep. Mike Quigley

Subcommittee on the Constitution
Hearing on: H.R. 3, the "No Taxpayer Funding for Abortion Act"
February 8, 2011

Thank you Mr. Chairman, for holding this hearing today to discuss and vet the many provisions of H.R. 3.

This hearing is particularly important because I believe most Americans are not aware of the provisions contained in H.R. 3 and what they would mean for their families.

This hearing will give us the opportunity to reveal and debate the extreme and in many cases harmful proposals within this bill.

For starters, we cannot be misled by this bill's name – No Taxpayer Funding for Abortions – H.R. 3 does not simply prevent public funding for abortions.

H.R. 3 goes far beyond banning federal funds for abortion care, and represents a radical departure from the status quo.

This bill is an unprecedented government overreach into women's private health insurance decisions and into the pockets of small businesses and families across America.

First, and I believe most importantly, this bill aims to dictate women's most intimate health decisions by limiting their access to coverage and reproductive care.

H.R. 3 intends to ban abortion coverage on the new health insurance exchanges.

The bill's authors claim they are only banning such coverage for individuals receiving government subsidies, but such a ban will have a chilling effect on abortion care for all women.

According to the George Washington school of public health it could "eliminate coverage over time for all women, not only those whose coverage is derived through a health insurance exchange."

This means women will not be able to buy health coverage that includes abortion with their own money - a significant departure from the status quo, where 87 percent of plans offer coverage that includes abortion.

The bill's sponsors want to take away women's ability to make their own decisions about coverage, and let the government and insurance companies make their decisions for them.

H.R. 3 also overreaches by raises taxes on millions of families and small businesses who want to keep the comprehensive coverage they currently have and pay for with their own money.

For example, a restaurant in my district in Chicago that has 40 half-time employees would be eligible for a Health Tax Credit under the new health law.

But under H.R. 3, if that restaurant offered comprehensive health coverage, including abortion care, they would pay $28,000 more in taxes.

The tax provisions of this bill also aim to redefine what constitutes "federal funding."

The sponsors of the bill are trying to argue that the tax credits and deductions taken on plans that include abortion are somehow federal funding,

Yet the Supreme Court has distinguished federal funding from the indirect benefits gained through the tax code.

This separation allows religious organizations to obtain tax benefits without violating the First Amendment Establishment clause.

If tax credits and deductions aren't considered federal funding for religious organizations, why should they be considered federal funding for comprehensive health insurance?

But I would argue that equally important to what is *in* the bill, is what is *not* in the bill.

The sponsors of H.R. 3 originally included a provision that would have redefined rape and incest.

They wanted to redefine rape as only "forcible" rape, therefore excluding women who are unconscious, mentally disabled, or forced into sex by threat or coercion.

And they wanted to redefine incest to apply only to those who are minors, as if somehow women over 18 who survive incest don't count.

They wanted to give insurance companies the authority to decide whether a woman has been raped or a victim of incest.

The bill's sponsors claim they are withdrawing this offensive language – but let's remember: 173 Members of Congress signed their names onto the original bill that would have redefined rape and incest.

This language reveals what the sponsors of this bill truely think of women.

They think women can't make their own decisions about their reproductive health.

They think women can't make their own decisions about their lives.

This language reveals the bill's sponsors' mindset, and it shows how far they will go if we let them.

I look forward to exploring and discussing the many provisions of H.R. 3 today,

And I hope our debate will shine a light on the true intentions of the bill's sponsors and real and harmful ramifications this bill would have on millions of small businesses, families, and most of all women.

Addendum to the Prepared Statement of Cathy Cleaver Ruse,
Senior Fellow for Legal Studies, Family Research Council

U.S. House of Representatives
Committee on the Judiciary
Subcommittee on the Constitution
Hearing on H.R. 3, the "No Taxpayer Funding for Abortion Act"

Additional Testimony of Cathy Cleaver Ruse, J.D.
Senior Fellow for Legal Studies, Family Research Council

February 14, 2011

The reduction of taxation can be a form of government subsidy; the Congressional Budget Act of 1974 (P.L. 93-344) requires that the federal budget list all "tax expenditures" and defines these to include "exclusions, exemptions or deductions from gross income." As a general matter, however, the Family Research Council does not regard broad tax cuts, such as income tax cuts, exclusions, or credits to be government spending; rather they allow people to keep more of their own money. However, the premium "tax credits" in "ObamaCare" are indeed government spending. They consist of advanceable refundable tax credits under which the Federal government will issue checks to pay for qualifying individuals to purchase health plans. Such payments clearly constitute government funding, and H.R. 3 would prevent such funding for health plans that include elective abortion. There is a difference between tax benefits which amount to government funding and tax benefits which take the form of government tax incentives. H.R. 3 would also prevent other tax benefits, such as the small business tax credits in "ObamaCare," from specifically creating a tax incentive to purchase health plans that include elective abortion. Last, H.R. 303 removes abortion as a deductible medical expense. In doing so, H.R. 3 Section 303 applies the principles of the Hyde Amendment to the tax code. H.R. 3 does not impact the employer tax deduction nor the employee exclusion.

Letter from Cardinal Danile N. DiNardo, Archbishop of Galveston/Houston, Chairman, Committee on Pro-Life Activities, United States Conferece of Catholic Bishop

Secretariat of Pro-Life Activities
3211 Fourth Street NE • Washington DC 20017-1194
202-541-3070 • FAX 202-541-3054 • EMAIL FROLIFE@USCCB.ORG • WEB WWW.USCCB.ORG/PROLIFE

January 21, 2011

Dear Member of Congress:

The bipartisan "No Taxpayer Funding for Abortion Act" (H.R. 3) was introduced yesterday by Reps. Chris Smith (R-NJ) and Dan Lipinski (D-IL) and already has 161 additional sponsors. I am writing to urge you to support and co-sponsor this important legislation if you have not yet done so.

Here I also wish to reaffirm the Catholic bishops' strong support for two other new bills addressing related issues, H.R. 358 and H.R 361. I have written separate letters about these; in this letter I note briefly how they relate to H.R. 3.

H.R. 3 will write into permanent law a policy on which there has been strong popular and congressional agreement for over 35 years: The federal government should not use taxpayers' money to support and promote elective abortion. Even public officials who take a "pro-choice" stand on abortion, and courts that have insisted on the validity of a constitutional "right" to abortion, have agreed that the government can validly use its funding power to encourage childbirth over abortion.

So secure is this agreement, in fact, that some in the past have simply *assumed* that it is already fully implemented at all levels of the federal government. For example, some wrongly argued during the recent debate on health care reform that there was no need for restrictions on abortion funding in the new health legislation, because this matter had already been settled by the Hyde amendment. However, the Hyde amendment is only a rider to the annual Labor/HHS appropriations bill; and while it has been maintained essentially intact by Congress over the last 35 years, it only governs funds appropriated under that particular act.

While Congress's *policy* has been remarkably consistent for decades, implementation of that policy in *practice* has been piecemeal, confusing and sometimes sadly inadequate. Federal funds are prevented now from funding abortion by riders to various annual appropriations bills, as well as by provisions incorporated into specific authorizing legislation for the Department of Defense, Children's Health Insurance Program, foreign assistance, and other programs. On various occasions a gap or loophole has been discovered that does not seem to be addressed by this patchwork of provisions – as when unelected officials in past years were construing the Indian Health Service or the Medicare trust fund to allow funding of elective abortions, and Congress had to act to correct this grave situation.

The absence of a government-wide law against federal funding of abortion led most recently to the passage of major health care reform legislation that contains at least *four* different policies on federal funding of abortion. One program under the Act, on health plans in state

exchanges, complies with the first sentence of Hyde (against direct and traceable funding of abortion procedures themselves) but violates Hyde's second sentence (against funding health plans that cover abortions). Another, on state high-risk insurance pools, appropriates its own new funds outside the bounds of the Hyde amendment, and allows those funds to be used for abortions or not, depending on a decision by the Secretary of Health and Human Services. Yet another provision, on community health centers, omits any reference to Hyde, and allows its new funding to be governed by underlying mandates in the authorizing legislation for these centers – mandates that in other health programs have been interpreted by federal courts to *require* federal funding of abortion when not corrected by Hyde language. A fourth provision, on school-based clinics, explicitly excludes abortion funding. All except the last of these disparate policies are incompatible with the Hyde amendment; each of them is incompatible with all the others.

If a bill like H.R. 3 had been enacted first, the debate on legislation like this would not have become a debate on abortion funding, and the final product would not have been so badly compromised by provisions that place unborn human lives at grave risk.

The Catholic bishops also support the Protect Life Act (H.R. 358) to address these and other abortion-related problems in the health care reform law itself. The benefit of H.R. 3 is that it would prevent problems and confusions on abortion funding in future legislation. Federal health bills could be debated in terms of their ability to promote the goal of universal health care, instead of being mired in debates about one lethal procedure that most Americans know is not truly "health care" at all. Annual appropriations bills could be discussed in terms of how their funding priorities best serve the common good, instead of being endangered because those favoring abortion want to use them to reverse or weaken longstanding federal policy on abortion funding.

H.R. 3 would also codify the Hyde/Weldon amendment that has been part of the annual Labor/HHS appropriations bills since 2004. Hyde/Weldon has ensured that federal agencies, and state and local governments receiving federal funds, do not discriminate against health care providers because they do not perform or provide abortions. It is long overdue for this policy, as well, to be given a more secure legislative status, and so the Catholic bishops support the Abortion Non-Discrimination Act (H.R. 361) as a free-standing bill that addresses this need. No hospital, doctor or nurse should be forced to stop providing much-needed legitimate health care because they cannot in conscience participate in destroying a developing human life.

In short, I urge you to co-sponsor H.R. 3, the No Taxpayer Funding for Abortion Act, and help ensure its enactment.

Sincerely,

Cardinal Daniel DiNardo

Cardinal Daniel N. DiNardo
Archbishop of Galveston/Houston
Chairman, Committee on Pro-Life Activities
United States Conference of Catholic Bishops

Letter from Sr. Carol Keehan, DC, President and CEO,
Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

February 9, 2011

Joseph R. Pitts
Chairman, House Energy and Commerce Subcommittee on Health
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Catholic Health Association of the United States (CHA) would like to express our continued support for the intent of your legislation, H.R. 358, the Protect Life Act, to further ensure protection of the unborn and of providers' conscience rights.

We have had the opportunity to review your revised version of H.R. 358 and would like to share our concern regarding one specific modification to your legislation. Section 1303(f) regarding emergency services laws, including Emergency Medical Treatment and Active Labor Act (EMTALA), now includes a reference to a new provision regarding provider nondiscrimination (Section 1303(g)). Your provider nondiscrimination language is similar to the conscience protections of the Weldon Amendment. **CHA member hospitals have been providing compassionate, quality care under both EMTALA and the "Weldon Amendment," without conflict since the enactment of these provisions. Accordingly, CHA does not believe that there is a need for the provider nondiscrimination section to apply to EMTALA.**

As the national leadership organization of more than 2,000 Catholic health care systems, hospitals, long-term care facilities, sponsors, and related organizations, the Catholic health ministry provides care throughout the nation to patients of all ages, races and religious beliefs. Catholic hospitals provide a higher percentage of public health and specialty services than other health care providers including state and local government, other not-for-profit, or investor-owned (for-profit) hospitals. These services include neonatal ICU, obstetrics, breast cancer screening and mammograms, children's wellness, child and adolescent psychiatric services, community outreach, dental services, crisis prevention, palliative care, pain management programs, nutrition programs, hospice, HIV/AIDS services, geriatric services, alcohol and drug abuse treatment, and trauma care. Many of these services are critical to our communities and we continue to provide them even though many of these services are not self-sustaining and must be subsidized by other hospital revenue.

Building upon our country's tradition of pluralism and the freedom to exercise our beliefs, CHA has long supported language within appropriations legislation to prohibit federal funding of abortions (Hyde amendment) and language to protect hospitals and other institutional and individual health care providers should they decline to provide, pay for, or refer for abortions (Weldon Amendment).

1875 Eye Street NW, Ste. 1000 Washington, DC 20006 *phone* 202.296.3993 *fax* 202.296.3997 **www.chausa.org**

A Passionate Voice for Compassionate Care

Again, while we continue to believe the current provisions of the Affordable Care Act (ACA) prevent federal funding of abortion, we support your efforts to further ensure permanent protection of the unborn and of provider's conscience rights and look forward to working with you.

Sincerely,

Sr. Carol Keehan, DC
President and CEO

cc: House Energy and Commerce Health Sub-Committee Members

1875 Eye Street NW, Ste. 1000 Washington, DC 20006 *phone* 202.296.3993 *fax* 202.296.3997 **www.chausa.org**

Prepared Statement of the American Civil Liberties Union (ACLU)

THE AMERICAN CIVIL LIBERTIES UNION

WRITTEN STATEMENT FOR A HEARING ON

H.R. 3, the No Taxpayer Funding for Abortion Act

TO THE

Subcommittee on the Constitution, Civil Rights and Civil Liberties
The Committee on the Judiciary, U.S. House of Representatives

February 2011

Laura W. Murphy, Director
ACLU Washington Legislative Office

Vania Leveille, Senior Legislative Counsel
ACLU Washington Legislative Office

On behalf of the American Civil Liberties Union (ACLU), a nonpartisan public interest organization dedicated to protecting the principles of freedom and equality set forth in the Constitution and in our nation's civil rights laws, and its hundreds of thousands of members, activists, and 53 affiliates nationwide, we would like to thank Chairman Franks, Ranking Member Nadler, and members of the Judiciary Committee's Subcommittee on the Constitution, Civil Rights and Civil Liberties for the opportunity to submit a statement for a hearing on H.R. 3, the No Public Funding for Abortion Act.[1]

H.R. 3 is an expansive and deeply troubling measure and we note some, not all, of our concerns below. The ACLU opposes H.R.3 because it further entrenches discriminatory laws that deny abortion care to women who rely on the government for their health care. The bill also extends these unjust prohibitions into the private sector in an unprecedented attempt to greatly undermine, if not eliminate, the insurance market for abortion. Abortion is basic health care for women and it is a right protected by the United States Constitution. Congressional interference in women's private decision-making, as embodied in this bill, is wrong, harmful and discriminatory.

1. H.R. 3 Denies Low Income Women Access to a Fundamental Constitutional Right

The legislation currently before the Subcommittee provides that "no funds authorized or appropriated by federal law, and none of the funds in any trust fund to which funds are authorized or appropriated by federal law, shall be expended for any abortion."[2] This language is intended to codify current abortion funding restrictions on appropriations bills and would do away with Congress' need to consider each year riders that harm women by singling out and excluding abortion from a host of programs that fulfill the government's obligation to provide health care to certain populations. In so doing, the bill would permanently deny millions of women, including Native Americans, federal employees, Peace Corps volunteers, poor women, and women in federal prisons, access to abortion care except in very limited circumstances.

The inequity caused by these restrictions is almost as old as the constitutional right to abortion itself and was opposed by the ACLU from the onset. Although Medicaid originally, and appropriately, covered medically necessary abortions, poor women's access came under attack in 1976 with the adoption of the Hyde Amendment and was blocked for nearly a year by an injunction obtained by the ACLU, Planned Parenthood, and the Center for Constitutional Rights, who challenged the law on behalf of a pregnant Medicaid recipient and health care providers in *McRae v Matthews*.[3] Although the Supreme Court would later uphold the Hyde restriction, the devastating and detrimental impact it has had on low-income women's exercise of a fundamental right cannot be denied. As a result of Hyde and its progeny, women who rely on the government for their healthcare do not have access to a healthcare service readily available to women of means and women with private insurance. A woman who does not have independent financial resources must scramble to raise the necessary funds, delay receiving

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[1] H.R. 3, 112th Cong. (2011).
[2] *Id.* at § 301.
[3] *See* 421 F.Supp. 533 (E.D.N.Y. Oct 22, 1976). The United States Supreme Court vacated the injunction in August 1977 after issuing two decisions that upheld state limitations on the use of public funds for abortion. Three years later, the Court would uphold the constitutionality of the Hyde Amendment. *See Harris v. McRae*, 448 U.S. 297 (1980). The ACLU has also initiated and supported legal battles in state courts to ensure abortion access for low-income women affected by these funding restrictions. *See* Brief of the Appellees, *State, Dept. of Health & Social Services v. Planned Parenthood of Alaska*, No. S-09109 (Alaska February 10, 2000).

abortion care (which can increase the medical risks and costs) and often is left with no choice but to carry to term in circumstances where she is physically, emotionally, mentally and financially unprepared to or incapable of caring for a child.

The Hyde Amendment and similar bans should be repealed – not made into permanent law as H.R. 3 asserts – because they are discriminatory and harm women's health. If a woman chooses to carry to term, Medicaid (and other federal insurance programs) offers her assistance for the necessary medical care. But if the same woman needs to end her pregnancy, Medicaid (and other federal insurance programs) will not provide coverage for her abortion, even if continuing the pregnancy will harm her health. The government should not discriminate in this way. It should not use its power of the purse to intrude on a poor woman's decision whether to carry to term or to terminate her pregnancy and selectively withhold benefits because she seeks to exercise her right of reproductive choice in a manner the government disfavors.

The words of Justice Brennan resonate and echo loudly today and apply equally to the bill currently before the Subcommittee when he noted that,

> "the Hyde Amendment is a transparent attempt by the Legislative Branch to impose the political majority's judgment of the morally acceptable and socially desirable preference on a sensitive and intimate decision that the Constitution entrusts to the individual. Worse yet, the Hyde Amendment does not foist that majoritarian viewpoint with equal measure upon everyone in our Nation, rich and poor alike; rather it imposes that viewpoint only upon that segment of our society which, because of its position of political powerlessness, is least able to defend its privacy rights from the encroachments of state-mandated morality."[4]

And let there be no doubt that H.R. 3's primary concern, like the Hyde Amendment before it, is ***not*** the use of taxpayer dollars but rather,

> "The legislation before us is the product of an effort to deny to the poor the constitutional right recognized in Roe v. Wade even though the cost may be serious and long-lasting health damage....The denial of Medicaid benefits to individuals who meet all of the statutory criteria for eligibility, solely because the treatment that is medically necessary involved the exercise of the fundamental right to choose abortion, is a form of discrimination repugnant to the equal protection of the laws guaranteed by the Constitution. [It] marks a retreat from Roe v. Wade and represents a cruel blow to the most powerless members of our society."[5]

H.R. 3 represents a new assault on women's access to care, but it is premised on the same shameful disregard for and coercive interference in poor women's lives. Congress should restore to women, not further deny, access to the full range of reproductive health care services, including coverage of abortion, in any health care program supported by the government.

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[4] *Harris*, 448 U.S at 331.
[5] *Id.* at 338

2. **H.R. 3 Reinstates the District of Columbia Abortion Ban, Disenfranchises and Marginalizes D.C. Residents and Denies Women of Color Access to Basic Health Care**

Beginning in 1980, Congress prohibited the use of federal funds appropriated for the District of Columbia to pay for abortion services except in cases where the woman's life is endangered or she is a victim of rape or incest. In 1988, Congress went one step further by also preventing the District of Columbia from using its own locally-raised, non-federal revenues to provide abortion care to its low-income residents. This violation of the District's autonomy was relieved for only two years, in 1993 and 1994, when Congress voted to lift the ban but reinstated a year later. The ban remained in effect until 2009 when Congress, with the Obama Administration's support, removed the restriction.

Repeal of the DC abortion ban in 2009 allowed District residents – a majority of whom are people of color – and their elected representatives to decide whether and how to meet the needs of poor women in their communities. The ACLU opposes H.R. 3 because it would take away that right.[6]

A. *The DC abortion ban violates the spirit of the Home Rule Act, intrudes upon the District's autonomy, and disenfranchises District residents.*

Article I, Section 8 of our Constitution gave Congress the authority to establish a federal district (Washington, D. C) and to exercise complete legislative control therein. However, in 1973, Senators and Representatives holding widely divergent political views, also recognized that the citizens of the District of Columbia had been denied the most basic privilege enjoyed by all other Americans – the right to elect those men and women who will control their local governments. They enacted the Home Rule Act to "grant to the inhabitants of the District of Columbia powers of local self government…and relieve Congress of the burden of legislating upon essentially local District matters."[7] The Home Rule Act was viewed by many as a key civil rights victory for the predominantly African American residents of the District.

With the enactment of home rule, Washington's citizens gained the right to elect their own mayor and council, which was empowered to legislate over areas of local concern. Thus Congress clearly recognized the importance of allowing the District's leadership and residents to exercise control over their municipal affairs. While the scope of the local legislative prerogative has never been precisely defined, the Supreme Court has held that our system of limited federalism reserves certain subject areas, including fire prevention, police protection, sanitation, public health, and parks and recreation for state and local decision-making. The provision of services to pregnant women – including abortion care – is clearly a matter of local public health policy intended to be left to the District of Columbia under home rule. Congress should respect the democratic process in the District and respect the choices its residents and leaders make.

As one member of Congress noted, "the government of the District of Columbia representing the wishes of its citizenry must…be able to choose how to spend its revenues collected through property and income taxes and other sources."[8]

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[6] H.R. 3, 112th Cong. § 340 (2011).
[7] Home Rule Act, Pub. L. 93-198, §102, 87 Stat. 777 (1973).
[8] *See* 132 Cong. Rec. H4872 (daily ed. July 24, 1986) statement by Rep. Theodore Weiss (NY).

The District abortion ban is antithetical to the spirit of the Home Rule Act. Measures such as the abortion ban serve only to disenfranchise and marginalize the District's leaders and residents. Through this provision, non-resident Members of Congress impose their own ideology, morality or religious belief upon the District's residents and utterly disregard the needs or wishes of the broader community or those directly impacted. Most egregiously, those who seek to negate the will of the District's residents or leaders are not accountable to the people of the District. That which they could not do in their own home districts, they do with impunity against the residents of the District. Measures such as the abortion ban erode and undermine such progress and serve only to accentuate the voicelessness of those residing in the District.

B. Restrictions on the District's expenditure of its own tax money are especially egregious.

Our forefathers fought the Revolutionary War to end the burden of taxation without representation. Yet the District's citizens have yet to fully reap the benefits of that victory. Indeed, the Home Rule Act represents their only claim to representative democracy. But even this limited right is diminished when Congress attempts to dictate how local funds may be spent.

This grievance is even more pronounced because a majority of Washington, D.C.'s budget comes from local tax dollars paid by residents. It appears that "the greatest portion of the District's appropriation consists of Congress appropriating the District's own local tax dollars as if they were federal funds."[9] The federal contribution consists mainly of entitlements that all states receive.

C. Local, non-federal revenues can be used to pay for abortion care in the states, but Congress tramples on the District's ability to assert that right.

In 1980, the Supreme Court held that the Hyde Amendment's restriction on federal Medicaid funding of abortions was constitutional despite its devastating impact on poor women. But at the same time the Court also ruled that state and local governments were still free to pay for abortion for poor women with their own funds. The Court stated that "a participating state is free, if it so chooses, to include in its Medicaid plan those medically necessary abortions for which federal reimbursement is unavailable."[10]

In recognizing the limited federal role in establishing local health policy, the Supreme Court placed the primary fiscal responsibility for funding abortions with the state legislatures and, in the special case of the District of Columbia, with the District government. In fact, numerous states currently use their own, non-federal funds, to provide medically necessary abortions. Congress does not order New York, California or Arizona not to spend local tax dollars on abortion and it should not do so with the District.

D. The fact that Congress appropriates an annual federal payment for the District does not permit it to specifically restrict the use of the District's funds.

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[9] *See* A New Paradigm for District-Federal Relations: Finding a Fair Balance Between Local and Federal Priorities in Governing the District of Columbia, 2001-2002 Policy Agenda, at 13-5; *see also*, D.C. Fiscal Policy Institute, *Meeting DC's Challenges, Maintaining Fiscal Discipline, Improving the DC-Federal Relationship* (February 2007).
[10] *Harris*, 448 U.S at 311.

The federal payment (a small percentage of the District's annual budget) is neither a gratuity, a subsidy, nor a grant. Rather, as Congress has acknowledged, the payment is a reimbursement for revenues lost and costs incurred by the District due to the federal presence.[11] It is clear that the payment – which is less than the federal aid received by many states – may not be used to justify restrictions on the use of District money. "Nowhere is it contemplated that the Federal payment should be used to set policies for the District government."[12]

3. H.R. 3 Expands the Federal Refusal Law and Removes Emergency Care Obligations

H.R. 3 expands and codifies the Federal Refusal Law (also known as the Weldon Amendment) and provides new remedies for those allegedly aggrieved, including a private right of action.[13] Since 2004, the Weldon Amendment in the Labor-HHS appropriations bill has provided broad immunities for hospitals, insurance companies, and other health care providers that refuse to provide, pay for, cover, or even refer for abortions. It offers immunities to health care institutions and professionals who deny women access to critical information and sets up roadblocks for states seeking to enforce their own laws.

Additionally, H.R. 3 provides that "nothing in this chapter or any other federal law shall be construed to require any State or local government to provide or pay for any abortion or any health benefits coverage that includes coverage of any abortion."[14] This provision is directed at removing the narrow, but incredibly important, obligations that states and hospitals have to ensure that women facing life-threatening circumstances are able to get medically necessary abortions. For example, under Emergency Medical Treatment and Active Labor Act (EMTALA), hospitals are obligated to provide appropriate stabilizing care, including an abortion when medically necessary, to a patient presenting with an emergency condition.[15] But, because section 308 of the bill states that no federal law may be construed to require a state or local government to provide *any* abortion, the Smith bill appears to create an exception to the EMTALA requirement for public hospitals if the emergency care the woman needs is an abortion, even if the woman's life is at risk.

H.R. 3 also appears calculated to allow states to deny low-income women coverage for abortions necessary to save their lives. Although federal law prohibits federal dollars from being used to provide Medicaid coverage of virtually all abortions, current law does mandate coverage in a narrow set of circumstances: where the abortion is necessary to save the woman's life and where the pregnancy was a result of rape or incest. The Smith bill appears to remove this requirement and permit states to deny coverage for a woman who needs an abortion to save her life or where the pregnancy is the result of rape or incest.

We oppose H.R. 3's adoption and expansion of refusal laws and we are uniquely positioned to do so. The ACLU has a long, proud history of vigorously defending religious liberty. In Congress and in the

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[11] Proponents of the DC abortion ban argue that its removal has allowed federal funding of abortion. This is, unfortunately, not the case. Removal of the DC abortion ban has not altered the current prohibition against federal funding of abortion services. The Hyde Amendment remains in force and forbids federal funding of abortion services for low income women on Medicaid. All states and the District of Columbia continue to be bound by the Hyde Amendment.
[12] *See* 125 Cong. Rec. H6032 (daily ed. July 11, 1979).
[13] H.R. 3, 112th Cong. § 211.
[14] *Id.* at § 308.
[15] 42 U.S.C. § 1395dd(a)-(d) (West 2011).

courts, we have supported legislation providing stronger protection for religious exercise - even against neutral, generally applicable laws. For nearly a decade, the ACLU fought to preserve or restore the highest level of constitutional protection for claims of religious exercise. We were founding members of the coalition that supported the Religious Freedom Restoration Act in 1993, and we were instrumental in urging Congress to enact the Religious Land Use and Institutionalized Persons Act of 2000. We have also represented persons challenging burdens on the exercise of their religious beliefs.[16]

We have been equally vigilant in our advocacy of reproductive freedom. The ACLU fought long and hard to persuade Congress to pass the Freedom of Access to Clinic Entrances Act to protect reproductive health clinics, patients, and professionals from deadly violence. We have participated in nearly every critical Supreme Court case protecting reproductive freedom, from *Roe v. Wade* to *Planned Parenthood v. Casey* to *Gonzales v. Carhart*. This history makes the ACLU well-positioned to comment on refusals to provide health care.

A. Framework for Analyzing Refusals

The framework the ACLU utilizes for analyzing religiously based refusals to provide health care balances protection for the public health in general, reproductive health in particular, patient autonomy, and gender equality with protection for individual religious belief and institutional religious worship. We reject the imposition of religious doctrines on those who do not share them, especially at the expense of the public health. At the same time, we support the accommodation of an individual's religious or conscientious objections, so long as patients' rights, including the right not to be discriminated against, are not compromised as a result. We also seek to insulate pervasively sectarian institutions from having to comply with laws that interfere with their religious practices.

The ACLU framework centers around two critical questions. First, we ask whether the refusal places burdens on people who do not share the beliefs that motivate the refusals. The more the burdens falls on such people, the less acceptable any claimed right to refuse. Second, we ask whether the objector is a sectarian institution engaged in religious practices, or is it instead an entity -- whether religiously affiliated or not -- operating in a public, secular setting. The more public and secular the setting, the less acceptable an institution's claimed right to refuse.

In the reproductive health context, it is often possible to accommodate individual -- as opposed to institutional -- refusals to provide certain health care services. But there must be adequate safeguards if an individual health care provider refuses to provide a service. Whatever their religious or moral scruples, health care professionals should give complete and accurate information, make appropriate referrals, effectuate informed health care decisions, and provide care in an emergency.

In the reproductive health context, the risk of imposition on those who do not share the objector's beliefs is especially great when an institution -- such as an employer, hospital, health plan, pharmacy, or other corporate entity -- refuses to provide a reproductive health service. The refusal of such institutions directly affects employees, patients, enrollees, and customers of diverse backgrounds and faiths. The

[16] For example, we have sued to protect the right of Jewish students to wear a Star of David pendant at school; we have sued to defend the right of conservative Christian activists to broadcast on public access television; and we have filed a brief in support of two women who were fired for refusing to work at a Greyhound racetrack on Christmas day.

law should not permit an institution's religious strictures to interfere with the public's access to reproductive health care. While entities operating in the public world ought to play by public rules, churches, temples, mosques, and other institutions whose purpose is to practice and teach religion ought generally to be able to refuse to provide services to which they have a religious objection.

Concrete examples may be clearer than general principles: every rape survivor ought to be offered emergency contraception to protect herself from getting pregnant as a result of the assault, no matter where she is treated. An administrative assistant working at a Catholic university should not have to pay out-of-pocket for birth control pills because her employer believes contraception is a sin. A church should not have to purchase contraceptive coverage for its ministers and other clerics. The factors we identify for evaluating refusal clauses should lead to these kinds of fair results.

With this in mind, the refusal provisions of H.R. 3 fail to pass muster. Like the Weldon Amendment, provisions in H.R. 3 would allow virtually any health care entity to refuse to provide, cover, pay for, or even refer patients for abortions even when such actions are otherwise legally mandated. It represents a flawed and one-dimensional approach that fails to balance competing rights. This broad federal refusal clause endangers women's lives and undermines women's ability to make their own health care decisions during pregnancy.

4. **H.R. 3 Imposes an Abortion Coverage Ban in the New Insurance Exchanges**

The Patient Protection and Affordable Care Act (ACA) creates new state-based market places called exchanges for individuals and small businesses to buy health insurance. Although the original bill ensured that no federal dollars could be used to pay for abortion except in cases of rape, incest and life endangerment, during debate on the bill an abortion coverage ban amendment was offered (i.e. Stupak Amendment) that would have barred anyone receiving a subsidy from buying a private insurance policy in the exchange that includes abortion.

The abortion coverage ban/Stupak Amendment was deeply troubling and alarming for a variety of reasons. Because the overwhelming majority of individuals in the exchange would have received some subsidy, it is clear that amendment would have meant that no policy sold in these exchanges would include abortion. It was clearly intended to create disincentives and impose obstacles to inclusion of abortion coverage in private plans, paid for predominantly with private dollars, in the exchanges. This would have jeopardized the abortion coverage that millions of women currently have and left women in a worse position than before health care reform. It would also have compromised fundamental privacy rights by forcing a woman to reveal her most private reproductive health concerns and decisions: if she wants abortion coverage she must ask her employers, insurers, or her spouse or partner for the plan covering abortion or for an abortion rider.

After a public outcry, Congress defeated the abortion coverage ban/Stupak Amendment. Instead, it enacted strict requirements that insurance companies must adhere to if they wish to offer (and consumers if they wish to buy) policies that include abortion. Under those requirements, insurance companies who want to offer policies that cover abortion must obtain two separate payments from the individual seeking insurance – some dollar amount for abortion coverage and some dollar amount for everything else – and they must deposit the funds in two seperate accounts. This procedure applies to everyone who purchases a plan with abortion coverage in the exchange.

H.R. 3 would resurrect the abortion coverage ban that the 111th Congress rejected and eliminate privately funded insurance coverage for abortion in the exchanges. It represents nothing less than a direct attack on a woman's ability to make personal, private medical decisions and puts politics before a woman's health.

5. **Conclusion**

Abortion is a legal, medical procedure protected by the United States Constitution. It is also basic health care for women. Yet H.R. 3 is an unalloyed and unapologetic attack on women's fundamental right and access to abortion. It first targets women -- many of whom are poor and women of color -- who rely on the government for their health care and seeks to permanently deny them coverage for a pregnancy-related health care benefit to which they are entitled. Then, under the guise of "safeguarding" taxpayer dollars, H.R. 3 advances an aggressive campaign empowering the federal government to destabilize the private insurance market for abortion coverage, intrude in a woman and her families' private medical decisions, and endanger women's lives by removing obligations to provide life-saving care in emergency situations.

The ACLU strongly opposes H.R. 3.

Prepared Statement of the Center for Reproductive Rights

Center for Reproductive Rights
Supplemental Testimony

Before the Subcommittee on the Constitution
Committee on the Judiciary
United States House of Representatives

February 14, 2011

The Center for Reproductive Rights uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to protect, respect, and fulfill. Reproductive freedom lies at the heart of the promise of human dignity, self-determination, and equality embodied in both the U.S. Constitution and the Universal Declaration of Human Rights.

We envision a world where every woman is free to decide whether and when to have children; where every woman has access to the best reproductive healthcare available; where every woman can exercise her choices without coercion or discrimination. More simply put, we envision a world in which every woman participates with full dignity as an equal member of society.

In this written testimony, we respond to arguments by anti-choice witnesses at the hearings before the Judiciary Committee's Subcommittee on the Constitution regarding H.R. 3 (the "No Taxpayer Funding for Abortion Act") and the Energy and Commerce Health Subcommittee regarding the bill that had been numbered H.R. 358 prior to revision (the "Protect Life Act").

First, we observe that access to abortion is a fundamental part of providing a full range of reproductive healthcare choices for women. One in three American women will have an abortion in her lifetime. Abortion is one of the most common procedures performed in American medicine. In 2005, for example, 1.21 million abortions were performed, and 22 percent of all pregnancies were terminated by an abortion.[1] Abortion is among the safest medical procedures, and is considered a low-risk procedure.[2]

Unsafe abortion occurs around the world and in the U.S. when legal or financial barriers prevent women from accessing services in an appropriate medical context. As both our work around the world[3] and a recent global Guttmacher Institute survey bear out,[4] erecting barriers to abortion access does not significantly reduce the number of abortions, or make them more "rare," as suggested by testimony.[5] Instead, barriers merely

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increase the suffering of women seeking services and increase the risk of maternal injury and death.[6]

Those who wish to reduce the incidence of abortion should look to the evidence: accurate sexual education and the widespread availability of contraception are most effective.[7] Yet the same members of Congress who are promoting this anti-choice legislation are at the same time presently leading the charge to eliminate funds for family planning. Similarly, the religious and anti-choice leaders who support the proposed bills represent institutions that will not provide or support access to effective contraceptive methods or information about human sexuality.

Despite its status as healthcare, attacks on abortion service providers remain distressingly commonplace. Even in the U.S., abortion providers are routinely subjected to harassment, intimidation and violence. Our 2009 study[8] found that anti-choice protestors personally threatened healthcare workers, both staff and doctors, pursuing them at home, seeking to publish their names and faces so that they could be more effectively targeted, and interrupt them in their work through constant surveillance and disturbance. Clinic staff and physicians experience picketing, stalking, smear campaigns, and harassing leafleting at their residences and other threats to themselves and their families. As the murder of Dr. Tiller in 2009 shows, providers are also targeted for assassination.

In light of these realities, we find it extremely disturbing that those testifying before Congress would actively seek to further marginalize this group of healthcare professionals by labeling provision of abortion services a "marginal" activity, as Ms. Alvare did in her testimony.[9] To the extent that it is the case that abortion providers are scant in many areas of the country, that is the result of sustained, ideologically and politically motivated campaigns by anti-choice state lawmakers and activists, who labor to increase the personal and financial costs of abortion provision. Those who intentionally join the effort to systematically marginalize providers should surely be barred from using the stigmatizing environment they have created as proof of anything concerning the practice of abortion.

Moreover, while the Supreme Court has recognized an interest in potential life, as Ms. Alvare's testimony asserts, she failed to put this recognition in an appropriate constitutional and legal context. The Court has repeatedly upheld access to abortion services as an integral aspect of women's privacy and autonomy, noting, for example, that the decision whether to bear a child is central to a woman's "dignity and autonomy," her "personhood" and "destiny," her "conception of ... her place in society.[10] Moreover, the Court has been clear that a woman's health must always take precedence.[11]

With these overall points made, we next address each of the major contentions concerning the legislation put forward by anti-choice witnesses.

1) It is inappropriate to treat tax credits as federal funding.

The notion that tax credits are a form of federal funding was fallacious during the fight over the terms of the Affordable Care Act (ACA), and remains so today. We explained last year in the heat of the debate that there was no logical limitation to the proposition that tax subsidies for insurance plans were "federal funding" for the healthcare services being covered in the plans, and that, in fact, the contention had the potential to invalidate abortion coverage in all employer-based healthcare plans:

> More fundamentally, Americans are currently allowed to pay for the premiums of their employer-provided health insurance with "pre-tax" income, thereby reducing their tax liability because their net taxable income is reduced by the amount of their health insurance premiums. And employers are allowed to provide health insurance as a tax-free benefit to employees. A majority of plans in the private insurance market today provide abortion services coverage. Thus the logic of denying abortion coverage to those who get a tax credit to help pay insurance premiums could be extended to everyone who gets a tax deduction to help pay their insurance premiums. That is the slippery slope that the House of Representatives has embarked upon.[12]

The highly politicized debate over healthcare reform and abortion coverage often lost sight of the facts, as the notion that the tax credits ever constituted "federal funding" was dubious at best. Even the purposes of the eventual compromise in the form of the highly burdensome so-called "Nelson Amendment" are suspect.

Its complicated requirements for insurers require segregation of two forms of entirely private dollars (dollars for coverage from policyholders) into two separate accounts. These strictures actually do nothing to affect the flow of federal dollars, as the ACA's federal tax credits are given to insurers directly and thus are always separate from the private funds of policyholders, whether these private funds were kept in one account or six. The ACA's rules are pointless: they literally impose expensive bookkeeping burdens on insurance companies and even, potentially, on policyholders for no discernible policy reason.

Nor, by any stretch of the imagination, does the ACA "subsidize" abortion services. As a reviewing court in a recent legal challenge to healthcare reform concluded: "[The Affordable Care Act] contains strict safeguards at multiple levels to prevent federal funds from being used to pay for abortion services beyond those in cases of rape or incest, or where the life of the woman would be endangered." Any claim to the contrary, the court said, is not "plausible."[13]

The proposed legislation either bans coverage altogether in the exchanges (H.R. 358) or does this and also levies a tax increase on businesses and plans that would offer abortion coverage (H.R. 3). In either case, the purpose is clear: to end all coverage for abortion services in the private insurance marketplace. In their reach, these radical and extreme bills far exceed any existing legislative requirements related to abortion coverage. Even the onerous Hyde Amendment, which restricts coverage of abortion

services for Medicaid recipients, permits states to provide coverage for abortion services using wholly state dollars.

Conceptually, the idea that tax credits or exemptions constitute federal funding should raise all manner of alarms for religious institutions. Though access to abortion is a fundamental constitutional right, H.R. 3 would invite invasive government oversight and regulation of individuals' private health insurance purchasing decisions on the theory that even a penny of tax subsidization transforms a private purchase into a government expenditure subject to any number of governmental regulations and dictates.[14]

This argument is both laughable and inaccurate. It would mean that any personal expense for which a tax deduction is available – be it a dental operation or the purchase of a home – is now a government expenditure. And it is inaccurate, because the Supreme Court has consistently held that while direct government funding is attributable to the government, private payments that are eligible for tax credits are attributable to private individuals, because the private, individual choice attenuates the government's involvement.

In particular, the Supreme Court has highlighted the public funding/private funding distinction in cases concerning the Establishment Clause – repeatedly holding that while direct government expenditures are considered government spending, indirect government expenditures that are mediated by private individuals are not. The analogy to H.R. 3 is obvious: like religious tax exemptions and deductions, the tax credits targeted by H.R. 3 are private, non-governmental expenditures:

- In *Mueller v. Allen*, for example, the Supreme Court rejected an Establishment Clause challenge to a tax-deduction program for private schools, despite the fact that 96% of the beneficiary parents sent their children to religious schools.[15] In rejecting the challenge, the Court explained that the "private choices of individual parents" vitiated the government's role, and that "no 'imprimatur of state approval' can be deemed to have been conferred."[16]

- Similarly, in *Witters v. Wash. Dep't of Servs. for the Blind*, the Supreme Court upheld vocational scholarships that paid for students to study at religious institutions to become pastors, holding that "[a]ny aid ... that ultimately flows to religious institutions does so only as a result of the genuinely independent and private choices of aid recipients."[17]

- And in *Zobrest v. Catalina Foothills Sch. Dist.*, the Supreme Court upheld a federal program permitting sign-language interpreters to interpret in religious schools.[18] In so doing, the Court noted that "[b]y according parents freedom to select a school of their choice, the statute ensures that a government-paid interpreter will be present in a sectarian school only as a result of the private decision of individual parents."[19]

In 2002, reflecting on decades of jurisprudence, the Supreme Court noted that "our decisions have drawn a consistent distinction between government programs that

provide aid directly [to recipients] and programs of true private choice, in which government aid reaches [recipients] only as a result of the genuine and independent choices of private individuals."[20] Based on that distinction, the Court upheld a voucher program in which the majority of students enrolled in religious schools.[21] Since 2002, circuit courts of appeals have similarly found that private choice renders private an otherwise impermissible government expenditure.[22]

Like the religious tax schemes and programs that the Supreme Court has upheld, the tax-credit-eligible purchase of insurance under the Patient Protection and Affordable Care Act is a private choice and not attributable to the government. Similarly, an individual's purchase of health insurance – which H.R. 3 seeks to regulate – is a private matter, whether or not the purchase is eligible for a tax subsidy.

Even more fundamentally, it is inappropriate to dramatically extend and codify the Hyde Amendment as a blanket restriction on coverage for abortion services. Although arguably a legislative habit, this in itself offers scant justification for the practice. As our study from last fall demonstrated, the Hyde Amendment today imposes tragic costs on very poor women, who have had to sell or pawn their possessions, forgo paying bills, get evicted for failure to pay rent, go hungry, and suffer the fear of not knowing whether they would be able to access the care they needed due to their lack of coverage for abortion.[23] Even its exceptions are illusory, as rape and incest victims who need the coverage are often denied its support in practice due to administrative ineptitude and delay.[24]

Moreover, it remains a remarkable oddity that abortion is singled out politically for such extraordinary solicitude concerning the taxpayer. Although many voters objected strenuously to the Iraq war, and many continue to object to the federal death penalty or the presence of federal detention centers in Guantanamo Bay, taxpayers in those situations did not and cannot claim a veto over the flow of federal dollars for those hotly disputed activities. Yet logically, such federal spending is no more or less "coercive"[25] than spending for any other controversial federal program. The courts have only very rarely recognized taxpayer standing as a valid basis for conscience-based objections given the range of government spending and the difficulty in administering only programs that lack controversy. Anti-choice advocates have not actually explained, outside of legislative habit, why the abortion issue is *sui generis* in a vast sea of government spending.

Indeed, the utter lack of boundaries around the claims of anti-choice opponents[26] amply demonstrates the inexhaustibility of their arguments. To the extent that a single federal dollar, spent on anyone, supports a healthcare system in which abortion care is available, it appears anti-choice forces would claim that dollar is a "subsidy" for abortion that violates taxpayers' selectively sensitive sensibilities. The only system that would satisfy such all-inclusive criteria is one totally lacking in abortion coverage or services in either the private healthcare market or federally supported healthcare. While this may be their goal, it would be contrary to the clear and demonstrated medical needs of American women and contrary to constitutional principle.

"Pro-choice" means nothing if the choice is for practical or financial reasons unavailable to women. Contrary to testimony,[27] bans on funding for abortion do nothing to advance freedom of choice, as they limit the exercise of choice in practice. Those who do not support abortion as a choice remain free not to have one, and of course are unaffected by the presence or absence of a funding ban. For this reason, the notion that a funding ban is a "middle ground" of any kind is absurd on its face.

2) Refusal provisions cannot trump patient protections for women.

Anti-choice witness Helen Alvare testified before the Energy and Commerce Committee Subcommittee on Health that "[c]onscience protection is not a zero-sum game between conscience-driven health care providers and the patients they serve, particularly the most vulnerable women."[28] Under questioning, she and National Right to Life Committee Federal Legislative Director Doug Johnson both claimed that there is no conflict between religiously affiliated hospitals' denial of appropriate medical care and the reproductive needs of women in an emergency.

Proponents of the new refusal provisions argue that refusals resulting in a denial of both needed care and accurate medical information impose no cost on women or their health. Setting aside the important principle that all women who seek care in hospitals are entitled to a full range of constitutional and legal options that protect their health and fertility, and to evidence and science-based medical care, that assertion is flatly wrong. Promulgated by the United States Conference of Catholic Bishops, the *Ethical and Religious Directives for Catholic Health Care Services*, a set of religious dictates that guide medical practice at Catholic hospitals, on their face contravene medical standards of care.

For a number of serious health conditions, including miscarriage management, ectopic pregnancy, and preeclampsia and eclampsia, the medical standard of care can – and sometimes should – include termination of the pregnancy.[29] Catholic and religiously affiliated hospitals are on record as refusing to provide the full range of treatment options consistent with an evidence-based standard of medical care – including the ethical and legal requirement to allow informed consent by providing patients with accurate information about the full range of treatment options.

Ten to twenty percent of all diagnosed pregnancies end in miscarriage, sometimes referred to as spontaneous abortion.[30] The standard of care for a miscarriage when a woman's condition is unstable is immediate uterine evacuation.[31] As described above, Catholic hospitals refuse to provide the standard of care for patients miscarrying. The Directives are also at odds with the treatment for preeclampsia and eclampsia, which "can affect the kidney, liver, and brain of the pregnant woman," and if left untreated, "lead to long-term health problems and even death of the fetus and/or the pregnant woman."[32] The only treatment is termination of the pregnancy.[33]

The Directives prohibit birth control, emergency contraception, infertility treatment, sterilization, and abortion.[34] Directive 45 states that "Abortion (that is, the

directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo. Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation."[35] Directive 47 permits "[o]perations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child."[36]

> "In direct contradiction of medical guidelines, the Religious Directives apply the [doctrine of "double effect"] to severe preeclampsia, eclampsia or HELLP syndrome. According to Fr. Thomas O'Donnell, a leading Catholic theologian on health care issues, pregnancy termination in eclampsia when there is no hope that the fetus can survive outside the uterus "must be viewed as a direct abortion and in violation of the uniquely divine prerogative of absolute dominion over human life." He comes to this conclusion despite his acknowledgment that the disease is very serious and can cause damage to many organs of the body and maternal death."[37]

Several jarring reports of Catholic hospitals'[38] repeated disregard for women's lives were described in a 2008 article in the American Journal of Public Health. One woman who was 14 weeks pregnant suffered ruptured membranes and was in the middle of a miscarriage. She could not obtain appropriate treatment at the Catholic hospital and was forced to travel 90 miles to another hospital – notwithstanding the fact that there was no chance that the fetus could survive.

In another instance, a woman was already septic (an infection of the organs that is often fatal),[39] and a doctor at another facility who was contacted regarding the transfer recommended a uterine aspiration. The Catholic hospital staff refused, despite the fact that the woman was hemorrhaging. Rather than treat the woman, the Catholic hospital staff proposed giving her a transfusion and "just wait[ing] till the fetus die[d]" before helping the woman. A doctor at the receiving hospital reportedly filed a violation of the Emergency Medical Transfer and Active Labor Act (EMTALA), a key patient protection law, regarding the Catholic hospital in that case.

Yet another woman, who was pregnant at 19 weeks, was described by a doctor as "dying before our eyes." She had a 106 degree fever and the whites of her eyes were filled with blood, but still the Catholic hospital refused to treat her until the fetus finally died. The woman barely survived after spending 10 days in the intensive care unit.[40]

In each of these instances, the woman faced a life-threatening emergency and was in the process of miscarrying. The end of the pregnancy was inevitable; the only question was how much danger and suffering the woman would be put through in the process. In some of these reported cases, it is clear from the story that the treating physician *wanted*

to provide medically indicated care for their patient in need and was prevented from doing so by the Catholic-owned institution.

Indeed, refusal claims by institutions, rather than individual physicians, trespass on the sacred trust between a patient and her doctor by imposing a set of rules that has no basis in law, medicine or health. In these instances, the consciences of providers are violated by their practice setting, and the well-being of patients is unnecessarily put at risk. In an unprecedented erosion of federal patient protections, the proposed refusal provisions in H.R. 358 would allow institutions to put their broad religious views before the well-being of patients.

Tragically, officials at these institutions, and the witnesses before the Subcommittees seem not to notice that the death of a pregnant woman almost always also means the death of the fetus and so the Hobson's choice they present is false. In such situations, rather than choosing between the life of a pregnant woman or a fetus, the reality is that the fetus will not live, and the woman need not die.

Proponents of refusal maintain that their own religious views should be imposed on unknowing patients. Indeed, they assert that they should be allowed to deny care to low-income and vulnerable patients, who have the fewest resources or options. Ms. Alvare notes, "[i]f not for [conscience-driven] institutions and providers, a great deal more of the work of caring for the sick, the poor and the marginalized would fall to the government, or simply go undone."[41] In fact, Catholic hospitals appear to provide less care to Medicaid patients and less charity care than hospitals under other forms of sponsorship.[42]

More fundamentally, refusals to provide care, by definition, always close off options for medical treatment that should be considered by patients. Under Alvare's theory, the poor and marginalized will be dependent on institutions who do not offer medically appropriate care. These patients would also be denied information about the full range of care options and information about how to obtain a particular course of treatment, despite the fact that medical standards of care and professional guidelines dictate that patients must have complete and accurate information about all of the available and medically indicated treatment options.[43]

Anti-choice witnesses also claimed that Catholic institutions provide superior care to patients.[44] These assertions are based on a study that does not track obstetric outcomes,[45] and thus bears little relevance to a majority of the issues in which appropriate standards of care conflict with the Directives.

It is deeply troubling that proponents of refusal provisions in H.R. 3 and H.R. 358 seek such an absolute exemption from treating women in need. Richard Doerflinger, Associate Director of the Secretariat of Pro-Life Activities at the United States Conference of Catholic Bishops, testified before the Judiciary Committee Subcommittee on the Constitution that the legislation would "allow health care providers to decline involvement in abortion *in all circumstances*."[46]

In other words, the law would disregard generally applicable anti-patient dumping laws, supplanting them with religious directives that allow hospitals to deny reproductive healthcare to women. In addition to EMTALA, laws that would be trumped by the proposed refusal provision include the Medicare Conditions of Participation, which require that hospitals "must meet the emergency needs of patients in accordance with acceptable standards of practice."[47]

Proponents of refusal provisions suggest that, absent such refusal clauses, Catholic institutions would be forced to close their doors.[48] Currently, all hospitals – including Catholic hospitals – are subject to EMTALA's patient protections. In fact, the Catholic Health Association, the leadership organization for over "2,000 Catholic health care systems, hospitals, long-term care facilities, sponsors, and related organizations," has stated that it "does not believe there is a need" for the refusal provision to apply to EMTALA.[49] Proponents of the heightened refusal provision are looking for a new exemption, and a way to legalize the appalling and illegal denial of emergency care.

Proponents also disingenuously argue that H.R. 358's provision allowing refusals to trump emergency services laws will not alter EMTALA's protections for pregnant women. Their claims are belied by the plain text of H.R. 358, which, for the first time, would make state and federal emergency services laws "subject to" the new, expanded, refusal rule.

They speciously contend that EMTALA currently allows hospitals to refuse to administer needed medical services to pregnant women experiencing an emergency medical condition. That is simply not the case.

Under EMTALA, hospitals must provide immediate stabilizing treatment to patients with an emergency medical condition, and cannot transfer an unstable patient – a patient who "within reasonable medical certainty" is likely to experience a "material deterioration."[50] EMTALA does not allow hospitals to delay care until a woman is at death's door. An emergency medical condition is a "medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (A) placing the patient's health in serious jeopardy, (B) serious impairment to bodily functions, or (C) serious dysfunction of any bodily organ or part."[51]

Proponents of refusal argue that inclusion of the term "unborn child" in EMTALA obviates any duty to provide appropriate medical care to women in emergency situations. There is no basis for that assertion. EMTALA prohibits patient dumping in two distinct situations – medical emergencies, and when women are in active labor. EMTALA prohibits a hospital from dumping a patient in labor whose fetus is in distress as part of her labor. Nothing in the text or interpretation of EMTALA sanctions refusing to administer immediate and complete care to a woman with an emergency medical condition, including when the standard of care indicates pregnancy termination.

Congress should emphatically reject these dangerous legislative proposals.

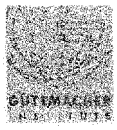
Endnotes

[1] Jones, Zolna, Henshaw and Finer. Abortion in the United States: incidence and access to services 2005, Perspectives on Sexual and Reproductive Health, 2008:40: 6-16.
[2] *See, e.g.*, Guttmacher Institute, *Facts on Induced Abortion in the United States* (Jan. 2011); Henshaw SK, Unintended Pregnancy and Abortion: A Public Health Perspective, in: Paul M et al., eds., *A Clinician's Guide to Medical and Surgical Abortion*, New York: Churchill Livingstone, 1999, pp. 11–22.
[3] Center for Reproductive Rights, *In Harms Way: The Impact of Kenya's Restrictive Abortion Laws* (2010), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/InHarmsWay_2010.pdf (hereinafter *In Harms Way*); Center for Reproductive Rights, *Forsaken Lives: The Harmful Impact of the Philippine Criminal Abortion Ban* (2010), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/phil_report_Spreads.pdf (hereinafter *Forsaken Lives*).
[4] Susheela Singh, Deirdre Wulf, Rubina Hussain, Akinrinola Bankole and Gilda Sedgh "Abortion Worldwide: A Decade of Uneven Progress," Guttmacher Institute, at 25 et seq Oct. 13, 2009 (Noting that abortion occurs at roughly equal rates in regions where it is broadly legal and in regions where it is highly restricted. The key difference is safety—illegal, clandestine abortions cause significant harm to women, especially in developing countries.).
[5] Testimony of Richard Doerflinger on Behalf of the U.S. Conference of Catholic Bishops, Testimony Before the U.S. House of Representatives – Committee on the Judiciary – Subcommittee on the Constitution, at 9, Feb. 8, 2011, *available at* http://judiciary.house.gov/hearings/pdf/Doerflinger110208.pdf ("Abortion coverage, and therefore abortion, may become more rare, a result favored by all but the most committed advocates for abortion.") (hereinafter "Doerflinger Testimony").
[6] *See, e.g., In Harms Way*; *Forsaken Lives*.
[7] Susheela Singh, Deirdre Wulf, Rubina Hussain, Akinrinola Bankole and Gilda Sedgh "Abortion Worldwide: A Decade of Uneven Progress," Guttmacher Institute, at 37 et seq, Oct. 13, 2009 (noting the importance of access to family planning counseling and contraception in reducing rates of unintended pregnancies and abortion).
[8] Center for Reproductive Rights, *Defending Human Rights: Abortion Providers Facing Threats, Restrictions, and Harassment* (2009), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/DefendingHumanRights.pdf.
[9] Testimony of Professor Helen Alvare, Testimony Before the U.S. House of Representatives – Committee on Energy and Commerce – Subcommittee on Health, at 5, Feb. 9, 2011, *available at* http://republicans.energycommerce.house.gov/Media/file/Hearings/Health/020911_Health_ProLife/Alvare.pdf (hereinafter "Alvare Testimony").
[10] *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 851 (1992).
[11] *Id.* at 846.
[12] Nancy Northup, *Hijacking Healthcare Reform*, The Guardian, Dec. 1, 2009 *at* http://www.guardian.co.uk/commentisfree/cifamerica/2009/dec/01/abortion-healthcare-reform-stupak.
[13] *Liberty University v. Geithner*, No. 6:10-cv-00015-nkm, 2010 WL 4860299, at *24 (W.D. Va. Nov. 30, 2010).
[14] H.R. 3 also represents an exponential increase in government intrusion over the Hyde Amendment. While the Hyde Amendment restricts *government funding* and *government health coverage*, H.R. 3 would restrict *privately purchased* health insurance. This distinction appears to be lost on H.R. 3's supporters, who have blithely claimed that "[t]he reduction of taxation is a form of government subsidy." Testimony of Cathy Cleaver Ruse (Family Research Council), Testimony before the U.S. House of Representatives – Committee on the Judiciary – Subcommittee on the Constitution, Feb. 8, 2011, *available at* http://judiciary.house.gov/hearings/pdf/Ruse100208.pdf. The Supreme Court has long distinguished direct government funding – where the expenditure is directly attributable to the government – from indirect expenditures including tax credits – where the expenditure is attributable to the action of private individuals
[15] *Mueller v. Allen*, 463 U.S. 388 (1983). *Cf. Walz v. Tax Comm'n of City of New York*, 397 U.S. 664 (1970) (upholding a property tax credit for religious institutions' properties used exclusively for religious purposes).
[16] *Id.* at 399.
[17] 474 U.S. 481, 487 (1986)

[18] 509 U.S. 1 (1993).
[19] *Id.* at 10 (emphasis added).
[20] *Zelman v. Simmons-Harris*, 536 U.S. 639, 649 (2002) (citations omitted) (emphasis added).
[21] *Id.*
[22] *See, e.g.*, *Steele v. Indus. Dev. Bd. of Metro. Gov't Nashville*, 301 F.3d 401, 416 (6th Cir. 2002) (upholding the issuance of tax-exempt bonds to support private religious university because "The nature of the aid conferred by the tax free revenue bonds is not direct aid"); *see also Am. Jewish Cong. v. Corp. for Nat'l and Comm. Serv.*, 399 F.3d 351 (D.C. Cir. 2005) (AmeriCorps payments to participants teaching in religious schools is permissible because participants' decision on where to teach represents a "true private choice").
[23] Center for Reproductive Rights, *Whose Choice? How the Hyde Amendment Harms Poor Women* 28-29 (2010), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Hyde_Report_FINAL_nospreads.pdf
[24] *See, e.g.*, *id.* at 35.
[25] See Doerflinger Testimony at 8 ("…using the coercive power of government to enlist the unwilling aid of taxpayers … who disagree with them").
[26] *See, e.g.*, Testimony of Douglas Johnson, Federal Legislative Director, National Right to Life Committee, Testimony Before the U.S. House of Representatives – Committee on Energy and Commerce – Subcommittee on Health, at 13, Feb. 9, 2011, *available at* http://republicans.energycommerce.house.gov/Media/file/Hearings/Health/020911_Health_ProLife/Johnson.pdf (hereinafter "Johnson Testimony") (arguing that even if a state bans coverage on its exchange, "the taxpayers in such a state will still be paying to subsidize abortion-covering insurance plans in other states, and the other abortion-expanding components of the law").
[27] *See* Doerflinger Testimony at 2 ("Even public officials who take a 'pro-choice' stand on abortion have supported bans on public funding as a 'middle ground' on this contentious issue – sometimes observing that it is not 'pro-choice' to force others to fund a procedure to which they have fundamental objections."); *id* at 8 ("What this legislation does is place abortion coverage more in the arena of *individual choice* for women . . . .").
[28] Alvare Testimony at 2.
[29] *See* Craig P. Griebel, M.D. et al., Management of Spontaneous Abortion, 72 Am. Fam. Physician 1243, 1246 (Oct. 2005) (standard of care for miscarriage is immediate uterine evacuation); National Health Law Program, *Health Care Refusals: Undermining Quality Care for Women*, 48 & n. 189 (2010) (hereinafter *Health Care Refusals*) *available at* http://www.healthlaw.org/images/stories/Health_Care_Refusals_Undermining_Quality_Care_for_Women.pdf.
[30] Royal College of Obstetricians and Gynaecologists, The Management of Early Pregnancy Loss, Guideline 25, Oct. 2006, at 1.
[31] Craig P. Griebel, M.D. et al., Management of Spontaneous Abortion, 72 Am. Fam. Physician 1243, 1246 (Oct. 2005).
[32] *Health Care Refusals*, 48 & n. 189.
[33] *Id.*
[34] *See* United States Conference of Catholic Bishops. Ethical and Religious Directives for Catholic Health Care Services. Washington, DC: United States Conference of Catholic Bishops (available at www.usccb.org/bishops/directives.shtml) (hereinafter "Ethical and Religious Directives"); Lori R. Freedman, et al., *Where There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 Am. J. of Pub. Health 1775 (2008).
[35] Ethical and Religious Directives.
[36] *Id.*
[37] *Health Care Refusals* at 52.
[38] Catholic hospitals are not the only religious institutions that deny women the medical standard of care. *See* Ramesh Raghavan, A Question of Faith, 297 JAMA 1412 (2007) (describing a Baptist hospital that refused to treat his wife's miscarriage because she had not yet developed a life-threatening infection).
[39] *Health Care Refusals* at 47.
[40] Lori R. Freedman, et al., *Where There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 Am. J. of Pub. Health 1774 (2008).

[41] Alvare Testimony at 7; *see also* Doerflinger Testimony at 7.
[42] Lois Uttley and Ronnie Pawelko, "No Strings Attached: Public Funding of Relgiously-Sponsored Hospitals in the United States," 5 (2002).
[43] *Health Care Refusals* at 47.
[44] *See* Doerflinger Testimony at 7; Alvare Testimony at 7.
[45] David Foster, *Research Brief: Differences in Health Systems Quality Performance by Ownership* (Thompson Reuters, August 9, 2010) *at* http://100tophospitals.com/assets/100TOPSystemOwnership.pdf (cited in Doerflinger at 7 n.14.)
[46] Doerflinger Testimony at 10 (emphasis added). *See also* Letter from Catholic Medical Association to Chairman Pitts (Feb. 10, 2011) (stating that refusal must apply in "all circumstances," including with respect to "emergency abortions").
[47] Centers for Medicare & Medicaid Services, 42 C.F.R. § 482.55, Condition of participation, Emergency services.
[48] *See, e.g.*, Doerflinger Testimony at 5, Alvare Testimony at 7.
[49] Letter from Sister Carol Keehan, President and CEO, Catholic Health Association to Chairman Pitts (Feb. 9, 2011).
[50] 42 U.S.C. § 1395dd(e)(3)(B).
[51] 42 U.S.C. § 1395dd(c)(1).

Material submitted by Cory L. Richards, Executive Vice President, and ice President for Public Policy, the Guttmacher Institute



February 10, 2011

The Honorable Trent Franks, Chairman
Judiciary Subcommittee on the Constitution
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Thank you for the opportunity to submit this statement on behalf of the Guttmacher Institute in opposition to H.R. 3, the No Taxpayer Funding for Abortion Act, on which a hearing was held before the Subcommittee on the Constitution on February 8, 2011.

Through its work as an independent, not-for-profit organization focusing on reproductive health research, policy analysis and public education in the United States and internationally, the Guttmacher Institute has developed and analyzed a great deal of information on public- and private-sector abortion insurance coverage, the implications for the health and well-being of women and their families of insurance coverage or the lack thereof, and the relationship between insurance coverage and abortion incidence. Many of the Institute's research findings, along with key research findings of other experts in the field, are addressed in two articles directly relevant to H.R. 3 from the *Guttmacher Policy Review* that are summarized below and attached for inclusion in the record.

A primary purpose of H.R. 3 is to write into permanent law an annually imposed policy, commonly referred to as the Hyde amendment, that sharply limits abortion coverage (currently to cases of life endangerment, rape and incest) under Medicaid, the joint federal-state health insurance program for the nation's lowest-income citizens. H.R. 3 would also make permanent the Hyde amendment's so-called progeny, a series of policies that similarly restrict abortion coverage or services for other groups of women dependent on the government for their health insurance or health care, ranging from women in federal prisons to women in the U.S. armed forces.

As discussed in "The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States" (Winter 2007), a number of studies conducted over the last three decades have assessed the impact of the Hyde amendment's near-ban on Medicaid insurance coverage of abortion. A review of these studies published by the Institute in 2009 concluded that some three in four poor women seeking an abortion manage to obtain one notwithstanding the lack of coverage. This may be a testament to their determination not to bear a child they feel unprepared to care for, but their doing so also may come at a considerable price to themselves and their families. Various studies indicate that many Medicaid enrollees denied abortion coverage are forced to divert money meant for rent, utility bills, or food or clothing for themselves and their children as they scrape together the funds to pay for the procedure. This is especially problematic because both the cost and the risk of an abortion increase as a pregnancy continues. In 2009, the average charge for an abortion was $451 at 10 weeks' gestation, but it jumped to $1,500 at 20 weeks. And the risk of death from abortion, although exceedingly small at any point, increases exponentially with gestational age. Thus, a poor woman seeking an abortion in the absence of Medicaid coverage is

often caught in a vicious cycle: the longer it takes for her to obtain the procedure, the harder it is for her to afford it, even as the risk to her health is increased. And, of course, one in four Medicaid enrollees who would have an abortion if Medicaid coverage were available is unable to do so and carries her unwanted pregnancy to term.

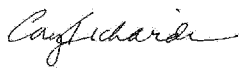
I would like to address a point on which Guttmacher research is frequently invoked and misrepresented. It simply does not follow that because one in four Medicaid enrollees who would have an abortion if it were covered under Medicaid is unable to do so in the absence of such coverage, restoration of federal Medicaid coverage would result in a significant increase in the incidence of abortion nationwide. As discussed in "Insurance Coverage and Abortion Incidence: Information and Misinformation" (Fall 2010), this is because only a small proportion of women are enrolled in Medicaid in any state, and because 17 states, including several of the nation's most populous, are among those that use their own money to pay for abortion services for poor women. Accordingly, lifting the Medicaid restrictions would translate into an estimated 5% rise in the total number of abortions in the group of states in which funding is currently restricted—and a 2.5% increase in the total number of abortions performed nationwide.

In conclusion, the Hyde amendment endangers poor women's reproductive health and violates their reproductive and human rights. Even the five-member majority opinion in the 1980 Supreme Court decision upholding Congress' ability to impose the Hyde amendment took pains to stress that the Court was not passing judgment on the merits of the funding restriction by deciding "whether the balance of competing interests reflected in the Hyde Amendment is wise social policy." On the contrary, said the Court, "if that were our mission, not every Justice who has subscribed to the judgment of the Court today could have done so." Indeed, the Hyde amendment is *not* wise social policy. Instead of enshrining the Hyde amendment in permanent federal law, Congress should be acting to repeal it—as it should be acting to repeal its progeny, the range of restrictive policies that similarly deny abortion coverage or services to various groups of women who are dependent on the federal government for their health insurance or health care.

Finally, it should go without saying that Congress should not be extending the harms of the Hyde amendment and its progeny further by seeking, as H.R. 3 does under the disingenuous "no taxpayer funding" label, to eliminate abortion coverage in what heretofore has always been considered the private insurance market by redefining "taxpayer funding" to encompass the standard tax treatment currently afforded to individual or employer-based health insurance plans should those plans include abortion coverage. Abortion is a legal, constitutionally protected and medically appropriate health care service that fully merits health insurance coverage, both in private-sector plans and in plans for those dependent on the federal government.

Thank you for the opportunity to provide these comments.

Sincerely,



Cory L. Richards
Executive Vice President
and Vice President for Public Policy

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The Heart of the Matter: Public Funding Of Abortion for Poor Women in the United States

By Heather D. Boonstra

This year marks the 34th anniversary of *Roe v. Wade*, the landmark U.S. Supreme Court decision that provided constitutional protection for abortion. In its 7-2 ruling, the Supreme Court recognized a woman's constitutional right to decide, in consultation with her physician, whether to terminate a pregnancy. This year also marks the 30th anniversary of the implementation of the Hyde Amendment, which bans federal funding for abortion in all but the most extreme circumstances. Named after longtime Rep. Henry Hyde (R-IL), who retired in 2006, the measure primarily affects Medicaid, the joint federal-state program that finances the provision of health services to eligible Americans deemed too poor to afford care on their own. More than seven million women of reproductive age—12% of all U.S. women in that age-group—are enrolled in the Medicaid program.

Medicaid enrollees are the poorest of poor Americans. For a woman to qualify, she must have an income below the very low eligibility ceiling set by her state. State income eligibility ceilings range as low as 18% of the federal poverty level in Arkansas and average 65% of poverty. That average translates to an annual income of $11,160, or roughly $930 per month for a family of three. Nearly four in 10 poor women of reproductive age are covered under Medicaid (related article, page 24). Most of these women are either pregnant or already a parent, as childless adults are typically ineligible at any income. As the average cost of an abortion at 10 weeks' gestation is $370, a poor woman with children who decides to have an abortion is likely to have very little left to survive on that month.

Poor women have been pawns in the congressional debate over abortion since the procedure became legal nationwide. For opponents of abortion, public funding has been a proxy for overturning *Roe*. As Hyde told his colleagues during a congressional debate over Medicaid funding in 1977, "I certainly would like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle-class woman, or a poor woman. Unfortunately, the only vehicle available is the...Medicaid bill." For prochoice leaders, on the other hand, public funding was a matter of fundamental fairness and equal protection under the law. "If we now restrict or ban Medicaid funding for abortions, the government will accomplish for poor women indirectly what the 1973 [Supreme Court] opinion expressly forbade it to do directly...a right without access is no right at all," said then-Sen. Edward Brooke (R-MA), speaking in opposition to the Hyde Amendment during one of the early congressional debates.

Three Decades of Restrictions

It may be hard to believe today, but public funding of abortion was hotly debated and threatened to shut the government down more than once in the 1970s. Annual debates were intense and protracted, with dozens of votes and innumerable hours spent arguing over the respective merits or demerits of the words "serious" versus "severe," "permanent" versus "long-lasting," "forced rape" versus "rape." The first version of the Hyde Amendment passed under election-year pressure in 1976, only to be reopened the following year. In December 1977, after a months-long, paralyzing debate in Congress—during which the Senate sought to liberalize the Hyde

Amendment to cover all "medically necessary" abortions, while the House tried to prohibit public funding for abortion in any circumstance—a compromise was reached that permitted the federal government to pay its share of the cost of abortions for women enrolled in Medicaid only in cases where their lives were threatened, where two doctors certified that continuation of the pregnancy would result in "severe and long-lasting" physical health damage, or where rape or incest had been reported. Most observers at the time thought this compromise would stick, at least for the near future, but in 1979, the limited physical health exception was dropped, followed by the rape and incest exceptions in 1981.

In June 1980, the Supreme Court upheld the constitutionality of congressional restrictions on abortion funding in *Harris v. McRae*. The court ruled that the Hyde Amendment did not violate the due process and equal protection clauses of the Constitution, declaring that "a woman's freedom of choice [does not carry] with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices." The federal government could choose to encourage childbirth over abortion by paying for the former and not the latter—even if to do so might not be "wise social policy." According to the Court, because the government did not cause women to be poor, it is not obligated to level the playing field for poor women: "Although government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation, and indigency falls within the latter category."

Following the Supreme Court ruling, and with Presidents Reagan and Bush in power during the 1980s, the Hyde Amendment essentially became a political nonissue. It was not until President Clinton took office in 1993 that poor women were on the agenda again. Prochoice forces in Congress fought hard to expand coverage to once again include cases of rape and incest, which they saw at the time as the first incremental step toward the long-term goal of an expanded Medicaid policy. That goal was dashed for the foreseeable future, however, when the Republicans, complete with a determined antiabortion leadership under Newt Gingrich (R-GA), gained control of the House in 1994.

The current version of the Hyde Amendment, established in 1997, allows federal funding for abortion in cases of rape and incest, as well as life endangerment, but tightens the life exception to permit payment only when the woman's life is threatened by "physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself." (At the state level, 17 states currently have a policy to use their own funds to pay for all or most medically necessary abortions sought by Medicaid recipients; see table.) In

CHOICE REVIEW

Although some states use their own funds to pay for medically necessary abortions for poor women enrolled in Medicaid, most states follow the restrictive federal standard.

Funds Abortions in Cases of Life Endangerment, Rape or Incest	Funds All or Most Medically Necessary Abortions
Alabama	Alaska
Arkansas	California
Colorado	Connecticut
Delaware	Hawaii
District of Columbia	Illinois
Florida	Maryland
Georgia	Massachusetts
Idaho	Minnesota
Indiana	Montana
Iowa	New Jersey
Kansas	New Mexico
Kentucky	New York
Louisiana	Oregon
Maine	Vermont
Michigan	Washington
Mississippi	West Virginia
Missouri	
Nebraska	
Nevada	
New Hampshire	
North Carolina	
North Dakota	
Ohio	
Oklahoma	
Pennsylvania	
Rhode Island	
South Carolina	
South Dakota	
Tennessee	
Texas	
Utah	
Virginia	
Wisconsin	
Wyoming	
33 + DC	17

Many state policies which "medically necessary" interpret the exception to the Hyde Amendment to include cases in which the woman's life is threatened by "severe and long-lasting" physical health damage, or where pregnancy is the result of rape or incest.

addition, over the years, Congress has enacted legislation essentially banning abortion funding for other large groups of Americans dependent on the federal government for their health care or health insurance, ranging from federal employees and military personnel to women in federal prisons and low-income residents of the District of Columbia (see box).

The Impact

Researchers have studied the impact of funding restrictions on women's reproductive decisions and have found that despite the relatively high cost of the procedure, most poor women in need of an abortion manage to obtain one—a testament to women's determination not to bear a child they feel unprepared to care for. But their doing so often comes at a cost, as many poor women have to postpone their abortion. For those who are affected, the delay is substantial: Poor women take up to three weeks longer than other women to obtain an abortion. Little wonder that, according to a 2004 Guttmacher study published in *Contraception*, 67% of poor women having an abortion say they would have preferred to have had the abortion earlier.

Research indicates that women who are economi-

Additional Federal Restrictions on Abortion Funding

Over the past two decades, Congress has enacted bans similar to the Hyde Amendment (repeatedly as part of the annual appropriations process or within permanent law) that together affect millions of women who depend on the federal government for their health care.

Military Personnel and Their Dependents

• TRICARE (formerly the Civilian Health and Medical Program of the Uniformed Services) is the military health care system serving 6.9 million active duty military personnel, retired personnel and members of their families. Data on the number of female enrollees are unavailable, but TRICARE is open to 212,000 women of reproductive age currently serving in uniform and 1.6 million female veterans, more than 60% of whom are younger than 65.

• Since 1979, the Department of Defense has prohibited abortion funding for military personnel, retirees and their dependents through TRICARE except when a woman's life is in danger. In 1985, the ban was made permanent. In 1997, Congress went even further by prohibiting the performance of abortions in military hospitals overseas even if paid for privately, except in cases of rape, incest or where the woman's life would be at risk.

• For the half million men and women in uniform who are stationed overseas, the imposition of abortion restrictions is doubly unfair. The denial of abortion services is not only costly, but for many, military health facilities are the only source of safe, high-quality health care, particularly where abortion is illegal. Because they cannot obtain an abortion in a military hospital even if they paid for it themselves, the only options for many are to make expensive arrangements to obtain a medically safe abortion in another country or risk unsafe conditions in-country.

Federal Employees and Their Dependents

• The Federal Employees Health Benefits Program (FEHBP) is the largest employer-sponsored health insurance program in the nation, currently covering nine million federal employees and dependents. Over one million women are currently employed as part of the federal workforce, the vast majority of whom make less than $40,000 per year.

• In 1983, Congress imposed a ban on FEHBP funds from being used to pay for insurance plans that cover abortion, except where a woman's life is in jeopardy. After a brief two-year hiatus, a slightly less restrictive policy was reimposed in 1996. Currently, FEHBP funds cannot be used to pay for insurance coverage of abortion, except in cases of life endangerment, rape or incest.

American Indians and Alaskan Natives

• The Indian Health Service (IHS) comprises more than 142 clinics and health care facilities that provide medical care to 1.9 million American Indians and Alaskan Natives, 918,000 of whom are women. The median age of Native Americans within the

cally disadvantaged are delayed at two key stages. Poor women typically take more time than better-off women to confirm a suspected pregnancy, which could be because of the cost of a home pregnancy test or the difficulty in getting a test from a clinic or doctor. In addition, they take several more days between making the decision to have an abortion and actually obtaining one. When asked why they were delayed at this stage, poor women are about twice as likely as more affluent women (after controlling for other personal characteristics) to report having difficulties in arranging an abortion, usually because of the time needed to come up with the money.

Moreover, other research shows that poor women who are able to raise the money needed for an abortion often do so at great sacrifice to themselves and their families. Studies indicate that many such women are forced to divert money meant for rent, utility bills, food or clothing for themselves and their children.

One reason why delays in obtaining an abortion are important is because the cost and the risk of a procedure increases with gestational age. In 2001, the average charge for an abortion in 2001 was $370 at 10 weeks' gestation, but jumped to $650 at 14 weeks and $1,042 at 20 weeks. Thus,

United States is 29, a full seven years younger than for American citizens overall. Native Americans are less likely than other Americans to have health insurance and are twice as likely to have incomes below the poverty line. IHS-supported health care is the only source of care for most American Indians.

• Before 1996, the IHS only covered abortions in cases of life endangerment; since that time, its abortion policy has been brought into alignment with the Hyde Amendment to include exemptions for rape or incest as well.

Poor Women in the District of Colombia

• Some 27,000 women in the District of Colombia depend on Medicaid for their health care. To qualify for Medicaid, women who are working parents must have an income below 207% of the federal poverty level (roughly $35,540 for a family of three in 2007).

• Because Congress has ultimate authority over all District government spending and operations, Congress has been able to bar the District from using locally raised revenues for abortion, except in cases involving life, rape or incest, a policy which has been in place since 1989.

Women in Federal Prisons

• No group of women is more restricted in their health care choices than those in correctional facilities. There are more than 12,000 women serving time in federal prisons—a population that is increasing at the rate of 4.6% per year. Approximately 80% of women in U.S. correctional facilities are aged 18–44.

• Since 1987, the Department of Justice has been prohibited from paying for abortions for women in federal prisons, except in cases of life endangerment or rape. A female inmate who can afford to pay for an abortion may obtain one outside the prison using private funds; under these circumstances, she must be provided an escort at no cost. However, a "conscience" provision allowing workers in federal prisons to refuse to serve as an escort was added in 1993.

Peace Corps Volunteers

• The vast majority of the nation's nearly 8,000 Peace Corps volunteers serve in developing countries where safe and reliable health care is a rare luxury. Close to 5,000 are women, mostly unmarried and young (average age, 28 years). Peace Corps volunteers receive only modest monthly stipends meant to cover the cost of living and little more.

• Peace Corps volunteers are denied a federally subsidized abortion even when their lives are at risk. Since 1979, Congress has prohibited funding of abortions for any reasons. For many female Peace Corps volunteers experiencing an unintended pregnancy, a medically safe abortion may be many thousands of miles and dollars away.

—Casey Alrich and Heather D. Boonstra

the longer it takes for poor women to obtain an abortion, the harder it is for them to afford it. In addition, the risk of complications increases exponentially at higher gestations, so many poor women become trapped in a vicious cycle in which their difficulties are exacerbated and their health risks increased.

Notably, a poor woman's access to a timely abortion depends on the policy in her state. According to the 2004 Guttmacher study, which looked at women obtaining abortion in 11 states, poor women living in states that use their own funds to pay for all or most medically necessary abortions obtain the procedure nearly a week earlier than women in the same states whose incomes are 100–149% of the poverty level, which are typically too high for Medicaid. By contrast, in states that restrict the use of funds for abortion, poor and near-poor women have their abortion at about the same gestation.

Perhaps the most tragic result of the funding restrictions, however, is that a significant number of women who would have had an abortion had it been paid for by Medicaid instead end up continuing their pregnancy. A number of studies have examined how many women are forced to forgo their right to abortion and bear children they did not intend. Studies published over the course of two decades looking at a number of states concluded that 18–35% of women who would have had an abortion continued their pregnancies after Medicaid funding was cut off. According to Stanley Henshaw, a Guttmacher Institute senior fellow and one of the nation's preeminent abortion researchers, the best such study, which was published in the *Journal of Health Economics* in 1999, examined abortion and birthrates in North Carolina, where the legislature created a special fund to pay for abortions for poor women. In several instances between 1978 and 1993, the fund was exhausted before the end of the fiscal year, so financial support was unavailable to women whose pregnancies occurred after that point. The researchers concluded that about one-third of women who would have had an abortion if support were available carried their pregnancies to term when the abortion fund was unavailable.

The Future

Most prochoice advocates would probably agree that today, just as in the late 1970s when annual battles raged in Congress for months at a time, the issue of Medicaid funding for poor women goes to the heart of who has access to abortion in this country and under what circumstances. Led by Speaker Nancy Pelosi (D-CA), the House leadership is now firmly supportive of abortion rights and access, even for poor women, and there is in all likelihood a prochoice majority, however slim, in the Senate. Yet the issue of public funding is not on the table, and it is not likely to be in the near-term future. Democratic majorities in the House and Senate are fragile, and party leaders, who have made it clear that they intend to govern "from the center," are unlikely to volunteer to take up such an inherently controversial issue anytime soon. Even many national prochoice leaders would argue that, with a president hostile to abortion rights and states like South Dakota passing abortion bans aimed at forcing an increasingly conservative Supreme Court to reconsider its fundamental abortion rulings, this is not the optimal time to force a reopening of the funding question.

Long stymied at the federal level, supporters of abortion funding have turned with some optimism to the states to jumpstart the movement. An impatient network of prochoice activists, spearheaded by the National Network of Abortion Funds, has teamed up to launch a public education campaign. The campaign, *Hyde—30 Years Is Enough!*, has been endorsed by the major national organizations and is thought to have a real chance of paying off in at least one state this year. Legislators in Maine are poised to debate whether that state should become the 18th in the nation to use its own funds to subsidize abortions for its Medicaid enrollees. It is to be hoped that Maine's campaign will be successful, and that it will be the first step in an accelerating, albeit undeniably uphill, campaign on behalf of the nation's poor women and a critical component of their overall reproductive health and rights. www.guttmacher.org

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Insurance Coverage and Abortion Incidence: Information and Misinformation

By Rachel Benson Gold

With a grim inevitability, the issue of restrictions on insurance coverage for abortion moved to center stage as the congressional health care reform debate came to a head in the fall of 2009. What was less predictable, perhaps, was that abortion opponents would misuse Guttmacher Institute research to bolster their assertion that anything short of a flat ban on coverage of the procedure would somehow greatly increase the number of abortions taking place in the United States. According to Richard Land of the Southern Baptist Convention, enactment of the Senate version of the measure—notwithstanding its stringent abortion coverage restrictions—would "lead, as some experts project, to a 30 percent increase in abortions in America. This legislation, if passed, will be the largest expansion of abortion since the *Roe v. Wade* decision in 1973."

The Senate bill was, in fact, enacted into law in March 2010 with its abortion restrictions intact (related article, page 2). Since then, however, a vastly overstated link between insurance coverage and abortion incidence—and the misuse of Guttmacher data to support it—has repeatedly been alleged at the state level, including as a prominent feature of model legislation drafted for state legislators by the antiabortion advocacy organization Americans United for Life. The Federal Abortion-Mandate Opt-Out Act, which would block coverage of abortion in the health insurance exchanges to be set up by states, asserts that the Guttmacher Institute "confirms that, based on Medicaid studies, more women have abortions when it is covered by private or public insurance programs."

The referenced Guttmacher "Medicaid studies" do indeed conclude that denial of abortion insurance coverage in the form of Medicaid funding impedes a sizable minority of America's poorest women from obtaining the procedure—and that restoration of coverage would result in an increase in abortion incidence among this population. However, the claim that restoration of federal Medicaid coverage would result in a significant increase in the incidence of abortion nationwide is not supported by the research, and extrapolating from Guttmacher's Medicaid findings to assert that coverage in the private insurance market is strongly linked to abortion incidence is entirely illegitimate.

This is by no means to say that the question of abortion insurance coverage is not important. Even if coverage may not determine whether most women actually obtain a procedure, it may have a major impact on the circumstances under which they do so and on the perception of abortion as a legitimate health care service. And on these matters, partisans on opposite sides of the abortion debate have sharply different views of what the situation ought to be.

Publicly Funded Abortions

Restrictions in place for more than three decades—measures often collectively referred to as the Hyde amendment for their original sponsor, former Rep. Henry Hyde (R-IL)—have sharply limited the use of federal Medicaid funds for abortion services for low-income women, currently to cases of life endangerment, rape and incest. Under the Hyde amendment, states may use their own funds to pay for abortions for

their Medicaid enrollees, and 17 states and the District of Columbia do so.

Claims of a strong link between abortion coverage and abortion incidence—both among the population of Medicaid enrollees and among the population at large—purport to be based on studies in five states (Georgia, Illinois, North Carolina, Ohio and Texas) in which neither federal nor state funds for abortion were available. These studies generally looked at what happened when Medicaid funding restrictions were first implemented some three decades ago and found that approximately one in four women who would have had a Medicaid-funded procedure if funds had been available were unable to do so.

By maintaining the Hyde amendment, health care reform represents the largest expansion of abortion funding restrictions since Hyde was first implemented.

Guttmacher Institute researchers—looking not at the past but contemporaneously at differences between states that are now using state dollars to fund abortions for low-income women and states where funding is restricted—nonetheless found a strikingly similar result. In an unpublished analysis presented at a scientific conference of demographers and statisticians in 2007, Guttmacher researchers compared the abortion rate (number of abortions per 1,000 women 15–44) among female Medicaid enrollees in funding states with that among Medicaid enrollees in nonfunding states. From the differences between the abortion rates for Medicaid enrollees in these two groups of states, the researchers concluded that restoring funding would result in a 28% increase among Medicaid enrollees in states where funding is currently restricted.

But making the leap from a finding that restrictions on public funding make abortion unattainable for about one in four women poor enough to be on Medicaid to the assertion that repealing the Hyde amendment would significantly increase the total abortion rate in those states, let alone in the United States as a whole, is entirely unsupportable. This is because only a small proportion of women are poor enough to be enrolled in Medicaid and therefore affected by the restrictions. In fact, according to the Guttmacher analysis, lifting the funding restrictions would translate into only a 5% rise in the total number of abortions in the group of states in which funding is currently restricted. (Nationwide, only 15% of women of reproductive age are covered by Medicaid; related article, page 17.)

And because several of the nation's most populous states, such as California and New York, are among those that use their own money to pay for abortion services for poor women, the national impact of repealing the Hyde amendment would be even smaller: According to the comparison of abortion rates among Medicaid enrollees in funding and in nonfunding states, the number of abortions among Medicaid-eligible women nationwide would be expected to rise by approximately 33,000 if the Hyde amendment were to be repealed—only a 2.5% increase in the total number of abortions performed nationwide.

In sum, two sets of research yield evidence that could be used to get a sense of the potential impact of repealing the Hyde amendment. The oldest studies, conducted at a time when Medicaid eligibility was much more restrictive than it is today (averaging 45% of poverty in those states, compared with a national average of 85% today), found that about one in four women who were denied funding for an abortion might be likely to have one if funding were restored. More recent work using an entirely different approach yielded a similar result. Contrary to the allegations of leading antiabortion activists, however, both lead to the inescapable conclusion that although the impact on Medicaid enrollees in states that have implemented the funding restrictions may be substantial, the impact of repealing the Hyde amendment on the overall level of abortion in the United States would be minimal.

But, of course, health care reform does not repeal the Hyde amendment. In fact, it essentially has the opposite impact. By maintaining the Hyde amendment, health care reform represents the largest expansion of abortion funding restrictions since Hyde was first implemented. This is both because the health care reform law includes a dramatic expansion of the overall Medicaid program to include all individuals with incomes under 133% of the federal poverty level ($24,352 for a family of three) and because the effect of that expansion will be felt disproportionately in states that do not subsidize abortion with their own funds.

According to a 2010 study conducted for the Kaiser Commission on Medicaid and the Uninsured by researchers from the Urban Institute, the Medicaid expansion provision will bring Medicaid coverage to an additional 15.9 million Americans by 2019. More than two-thirds of these new Medicaid enrollees will live in states where Medicaid funding for abortion is currently restricted. Moreover, the impact of the expansion will be more pronounced in states in which Medicaid coverage is currently less generous and in which more residents are uninsured. As a result, the group of states in which public funds are not available for low-income women needing an abortion will see a disproportionate impact from the Medicaid expansions in health care reform: The proportion of adults who are uninsured is expected to fall by 49% in the non-funding states, compared with 41% in the states where public funds are available.

Private Insurance Coverage

Claims by antiabortion leaders about the impact of Medicaid coverage on the nationwide abortion incidence constitute a serious misuse of Guttmacher data, but any use of those data to make allegations about the impact of coverage in the private market is completely unfounded. The Guttmacher Institute has not studied the impact of private insurance coverage of abortion. In fact, any discussion of the impact of the federal health care reform law on levels of abortion among those with private coverage is speculative at this point.

What is known is that under the legislation, some 16 million individuals who would otherwise be uninsured are projected to have private coverage by 2019, according to the Congressional Budget Office. The legislation signed into law in March will make it extremely difficult for insurers to include abortion coverage in the plans they will be marketing on the health insurance exchanges through which these individuals will be purchasing insurance. Indeed, the statute's coverage restrictions are so stringent that leading insurance experts have suggested that most insurers will simply decline to sell policies covering abortion on the exchanges—and eventually in the broader private market as well. Yet, even if some newly insured women do receive coverage for abortion, there is little reason to think that it would open new doors for those women to obtain abortions that they cannot afford today. These women, by definition, will have incomes higher than those on Medicaid, as the insurance exchanges will be designed for Americans with incomes above the 133% of poverty cutoff for Medicaid. And even when income eligibility ceilings for Medicaid were much lower than they are today, and far lower than they will be in 2019, three in four Medicaid enrollees were still able to obtain an abortion in the absence of coverage.

Meanwhile, a study published in the March 2010 issue of the *New England Journal of Medicine* did look at changes in the incidence of abortion in a state that adopted a universal insurance coverage policy but without any of the kinds of abortion coverage restrictions included in the federal legislation. This analysis, by Patrick Whelan of Harvard Medical School and Massachusetts General Hospital, examined the impact of insurance coverage in Massachusetts, a state whose experiment in health care reform is often cited as the model for the federal legislation. Massachusetts enacted its own universal health care plan in 2006. Since the beginning of 2007, the state has provided subsidized coverage to individuals with an income up to 300% of the federal poverty line who are either self-employed or unemployed, as well as to small businesses. In stark contrast to the federal law, abortion is covered for individuals with subsidized coverage, known as Commonwealth Care, as well as for Medicaid enrollees.

Yet, since the enactment of health care reform, the number of abortions in the state fell from 24,245 in 2006 to 23,883 in 2008, a decline of 1.5%, even as the insured population grew by 5.9% over the same period. (The number of abortions to teens fell by 7.4% over the same time period.) According to Whelan, these decreases came during a period of rising birthrates and population growth, which meant that the abortion rate in the state declined from 3.8 per 1,000 Massachusetts residents in 2006 to 3.6 per 1,000 in 2008.

The number of abortions in Massachusetts has reached its lowest level since the 1970s, even though more residents than ever were covered by health insurance and virtually all insurance plans covered abortion. As a result, Whelan noted, "The recent experience in Massachusetts suggests that universal health care coverage has been associated with a decrease in the number of abortions performed, despite public and private funding of abortion that is substantially more liberal than the provisions of the federal legislation."

Underlying Causes and Real Solutions

History, common sense and available data all suggest that insurance coverage for abortion is not a significant driver of the incidence of abortion, any more than insurance coverage of pregnancy-related care drives the number of babies born each year. Even the legalization of abortion nationwide that came with *Roe v. Wade* in 1973 did not somehow "create" abortion. Indeed, although the U.S. abortion rate rose rapidly in the years immediately following the Supreme Court decision before leveling off in the early 1980s, this was to a considerable extent because of legal abortions replacing abortions that previously had been performed illegally and had gone uncounted.

This reality is entirely consistent with the experience in other countries with generous abortion coverage under their national health systems. In the Netherlands and Germany, for example, where almost all abortions are free to citizens, abortion rates are less than half that in the United States. And in Canada, which has no national restrictions on abortion as well as a comprehensive national health system, the abortion rate is considerably below ours.

A wealth of evidence from around the world confirms that underlying levels of unintended pregnancy are the best predictor of abortion rates. Countries with low rates of unintended pregnancy have low rates of abortion, and vice versa. But what insurance coverage can affect to a much more significant degree are the conditions under which the procedures take place. Research on poor women affected by the funding restrictions under Medicaid shows both the financial obstacles women living at or near the poverty line must surmount and the personal indignities they must endure to obtain an abortion in the absence of Medicaid coverage. Moreover, poor women having an abortion do so more than a week later than do more affluent women, likely reflecting their increased difficulty in securing funds.

Better-off women with private insurance may not have to make the same financial sacrifices that poor women do to obtain an abortion, but they face many of the same indignities. From bogus "informed consent" procedures and waiting periods to unnecessary and costly ultrasound mandates, women seeking an abortion and the professionals providing the service are subjected to a host of restrictions and requirements not imposed on any other legal medical procedure in the United States. In that light, the campaign to end insurance coverage is yet another component of a long-standing and concerted effort by abortion rights opponents to paint abortion and ensure its societal treatment as something other than a legitimate medical procedure. And that is why, however limited the relationship between abortion coverage and actual abortion incidence may be, the eventual success or failure of that campaign will be consequential. www.guttmacher.org

Prepared Statement of Douglas Laube, MD, MEd, Board Chair,
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Testimony of Douglas Laube, MD, MEd
Board Chair, Physicians for Reproductive Choice and Health
Submitted to the House Judiciary Committee
Subcommittee on the Constitution
February 8, 2010

Physicians for Reproductive Choice and Health (PRCH) is a doctor-led national advocacy organization. Since 1992, PRCH has used evidence-based medicine to promote sound reproductive health policies. PRCH's network of physicians includes practitioners in obstetrics and gynecology, pediatricians, fertility doctors, family physicians, cardiologists, neurologists, radiologists, and others. We believe in reproductive choice for everyone.

PRCH welcomes the opportunity to submit testimony on H.R. 3, misleadingly named the "No Taxpayer Funding for Abortion Act." Other organizations will certainly discuss in detail the possible impact of this bill on the private insurance market for abortion and consequences for the tax code. As an obstetrician/gynecologist who represents a large network of physicians, I will discuss the women and families whose lives will be affected by this dangerous legislation.

Every day my colleagues and I treat women who are able to use their insurance to obtain needed medical care. Sadly, we also see women struggling to make the best decision for themselves and their families without the financial resources to pay for an abortion. H.R. 3 would not only decimate private insurance coverage for abortion, but also contains very limited exceptions that make no provision for a woman's health. This bill ignores the

very real situations women face and, if enacted, would have a devastating impact on their ability to access safe and legal abortion care.

In my practice in Wisconsin, I had a patient, Beth.* Beth was pregnant with her first child and looking forward to becoming a mother. Three months into her pregnancy, she developed dangerously high blood pressure. Without an abortion, she could have had a stroke or kidney damage. She made the very hard decision to end her pregnancy. Beth's medical condition is just one of many that can complicate pregnancy. But H.R. 3 would leave women like Beth without insurance coverage for abortions necessary to protect their health.

My colleague and fellow PRCH board member Dr. Nancy Stanwood from Rochester, New York, has seen the impact of policies such as this. She had a patient, Carol, who was excited to give birth to her first child. Her husband was a Marine, serving in Afghanistan. Their health insurance was provided through the military. Sadly, in Carol's second trimester, she learned that her baby had anencephaly; it would be born without a brain.

After much painful deliberation, she and her husband chose abortion. They were shocked to learn that their health insurance would not cover the abortion and would only cover situations where Carol's life was in danger. Her husband was outraged, telling Dr. Stanwood, "I'm over there defending my country, and they won't even take care of my family?" Under this bill, insurance coverage could be barred for heartbreaking situations like Carol's.

Dr. Kristina Tocce in Denver treated a patient with a complicated pregnancy. An ultrasound showed that her patient Consuela's fetus was not developing kidneys. Most infants with this problem do not live more than a few hours. Also, Consuela's placenta was covering the opening to her cervix; this condition, if left untreated, can result in life-threatening bleeding during delivery and requires a cesarean section. Conseula and her husband decided to terminate

* All patient names have been changed to protect confidentiality.

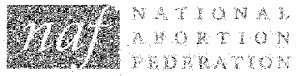
the pregnancy, but her insurance was through Medicaid. Because Consuela's medical condition did not yet endanger her life, she did not qualify for abortion coverage under Medicaid's life exception. Out of pocket, her abortion would have cost more than $4,000, an impossible sum. Consuela continued to carry the pregnancy and suffered tremendous emotional turmoil. Six weeks later, her fetus died in utero. The legislation under consideration would put women all over the country into situations like Consuela's.

In Seattle, Dr. Deborah Oyer had a patient, Allison, a 34-year old mother of three with an unintended pregnancy. She was still deciding whether to continue her pregnancy when she discovered her youngest child had leukemia. She and her husband quickly realized that they could not have another child at that time. Allison needed to take leave from work and stay at the hospital with their daughter for the many treatments to come. Her husband needed to stay at home, two hours away from the hospital, to work and care for their two other children. Fortunately, Washington Medicaid covered her abortion. But Allison and her family would have faced great hardship if they had had to pay out of pocket. Access to affordable insurance that covers abortion is essential for women and their families.

H.R. 3 also has an expansive refusal clause that allows individuals and entities to refuse to provide abortion care, potentially even in emergency situations. Dr. Sara Imershein in Washington, DC, cared for a pregnant mother of two, Brenda, who had vaginal bleeding and bulging membranes—a sign in this case of an inevitable miscarriage. Brenda needed an abortion to stop the bleeding and avoid having a blood transfusion. The religious hospital where she was being treated opted to transfer Brenda across state lines to another facility, where she did need to have a blood transfusion. Treatment at the original facility would have been safer and less expensive. Such refusal to provide immediate medical care harms women.

For these real women and their families, abortion was a difficult decision made after consultation with their physicians and consideration of the medical issues involved. Abortion was a critical medical procedure that protected their physical health as well as the health and well-being of their families. While the egregious trivialization of rape has reportedly been removed from the bill, H.R. 3 still threatens millions of American women by making insurance coverage for abortion impossible to obtain. No consideration is afforded to protect women's health. Real women like Beth, Consuela, Allison, and Brenda will suffer as a result. It is critical to the lives and health of American women that this bill be defeated. On behalf of PRCH, I thank you for the opportunity to submit this testimony.

Letter from Cassing Hammond, MD, Director, Section of Family Planning & Contraception, Associate Professor of Obstetrics and Gyncology, Northwestern Feinberg School of Medicine, and Chair, National Abortion Federation Board of Director



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February 14, 2011

Dear Members of the House Judiciary Subcommittee on the Constitution:

I am writing regarding recent Congressional testimony for HR3, the "No Taxpayer Funds for Abortion Act" and HR 358, the "Protect Life Act". As an obstetrician-gynecologist with more than 20 years of experience providing both obstetric and complex abortion care, I wish to set the record straight.

I direct Northwestern University's Center for Family Planning & Contraception as well its academic Section of Family Planning. The medical center where I work performs nearly 13,000 deliveries annually. Most patients are healthy women having healthy babies, but I am frequently asked to provide abortions for women confronting severely troubled pregnancies or their own life-endangering health issues. Physicians who provide health care to women cannot choose to ignore the more tragic consequences of human pregnancy—and neither should Congress. The following portraits of the women I see illustrate just a few of the circumstances where abortion saves women's lives:

- One of my own obstetric patients carrying a desired pregnancy recently experienced rupture of the amniotic sac at 20 weeks gestation. The patient had a complete placenta previa, a condition where the afterbirth covers the opening to the uterus. Although the patient hoped the pregnancy might continue, she began contracting and suddenly hemorrhaged, losing nearly a liter of blood into her bed in a single gush. Had we not quickly intervened to terminate the pregnancy, she would have bled to death, just as women do in countries with limited access to obstetric services.

- My service frequently receives referrals from Northwestern's Division of Maternal Fetal Medicine and other high risk pregnancy services throughout the Chicago area. One of the more frequent reasons for referral is preterm rupture of membranes with chorioamnionitis, an intrauterine infection which can develop at any time during pregnancy. Since antibiotics will not sufficiently penetrate the endometrial cavity containing the baby, the treatment for this condition is to evacuate the uterus. If the infection occurs at term, we deliver the baby. If the condition occurs before 24 weeks, we must abort the pregnancy lest the patient become septic and die. Over my years of practice, I have had many patients who would have died without access to abortion in this situation.

- My service often receives consults regarding patients with serious medical issues complicating pregnancy. We recently had a 44-year-old patient whose pregnancy had been complicated by a variety of non-specific symptoms. A CT scan obtained at 23 weeks gestation revealed that the patient had lung cancer that had metastasized to her brain, liver, and other organs. Her family confronted the difficult choice of terminating a

president and ceo Vicki A. Saporta
board chair: Valerie Fennimore, MD board members: [illegible]

desired pregnancy or continuing the pregnancy knowing that the physiologic burden of pregnancy and cancer might worsen her already poor prognosis. The family chose to proceed with pregnancy termination.

- My service often receives referrals regarding unusual obstetric conditions because we work at a tertiary care center. One complex condition referred to my service involved a patient who had a twin gestation in which one of the embryos was a molar pregnancy. Molar pregnancy is an abnormal pregnancy in which the embryo fails to develop—or develops partially—and the placenta develops into grape like tissue clusters. The abnormal placenta of molar gestation expands the uterine cavity and often causes severe hemorrhage. Patients are also more likely to develop a number of other medical problems during their pregnancy including intractable nausea and vomiting and early onset hypertensive disorders. Longer term, molar gestation places the patient at higher risk of developing choriocarcinoma, a cancer in which placenta-like material spreads throughout the body. Most molar gestations involve no embryo, but this patient had one normal twin and one molar gestation. Although she was only 22 weeks gestation, her uterus already approximated the size of a term pregnancy containing enough grape like clusters of placenta to fill a milk crate. We admitted the patient to the intensive care unit, obtained 10 units of blood in case severe bleeding occurred, and successfully terminated the pregnancy. By intervening when we did, we preserved the patient's life, her health, and her ability to have children in the future.

- My service sometimes sees patients who have received organ transplants or are awaiting transplants. I remember one woman in her early twenties who had end stage alcoholic cirrhosis of the liver. She had stopped using alcohol and successfully balanced school, work, and frequent hospitalizations to deal with her severe liver disease and related disorders. While awaiting a transplant, she conceived. She decided to terminate the pregnancy rather than accept the risks to her life and health posed by continued gestation. We have cared for other patients who chose to terminate while awaiting transplant or after undergoing transplant of heart, liver, and other organs. Although some of these patients might manage to continue pregnancies to term, each patient's circumstance is highly variable with unpredictable risk to life and health.

- A colleague on my team recently took care of another patient with leukemia. We have had many during my 15 years at Northwestern. Several years ago, we had three patients with leukemia requiring pregnancy terminations at approximately the same time. Because leukemia causes abnormal blood cells, patients with leukemia confront increased risk of both bleeding and infection. Pregnancy compounds these risks, particularly if they need to receive ongoing chemotherapy during the pregnancy.

- My service frequently sees patients with early pre-eclampsia, often referred to by the term "toxemia". Pre-eclampsia usually complicates later gestation, but occasionally complicates pregnancy as early as 18 to 20 weeks, well before the fetus is viable. The only treatment for severe pre-eclampsia is delivery. Otherwise, the condition will worsen, exposing the

> mother to kidney failure, liver failure, stroke and death. One Christmas morning I had to leave my own family so that I could provide a pregnancy termination for a remarkably sick, pre-eclamptic teenager.

Patients like those described above rarely knew that pregnancy could jeopardize their lives and health. Some opposed "abortion", even while they themselves were undergoing an abortion. Like most tertiary obstetric centers, we receive referrals of such patients from within our own system and throughout our metropolitan area. Some of the referrals come from providers or sectarian institutions that ostensibly oppose abortion, but rely upon us as the "safety valve" to assure that patients get care they need and deserve. We usually manage to intervene before a risk to health becomes a risk of life, but we do so because the law currently embraces patient and provider autonomy. What will obstetricians do when the law criminalizes interventions needed to save the lives of our daughters, wives, and mothers? Should health insurance only cover the cost of obstetrics when everything goes well—or should it also cover the cost of a standard obstetric procedure when the patient's life and health is most at risk?

I hope our elected representatives will allow those of us who experience these circumstances on a regular basis to set the record straight—and prevent the passage of legislation that would harm women, families, and those who care for them.

Cassing Hammond, MD
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Associate Professor of Obstetrics and Gynecology
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Chair, National Abortion Federation Board of Directors

Prepared Statement of the National Abortion Federation

Testimony of the National Abortion Federation on HR 3: An Unprecedented Attack on Women's Access to Abortion Care

On February 8, 2011, the House Judiciary Subcommittee on the Constitution heard testimony on HR 3, the "No Taxpayer Funding for Abortion Act," sponsored by Representative Chris Smith. Despite its name, HR 3 goes far beyond codifying the current ban on federal funding for abortion care. HR 3 would make it all but impossible for women to get insurance coverage for abortion care in the new state health exchanges, even if they pay with their own money. This extreme bill would also let public hospitals refuse to provide emergency abortion care even when necessary to save a woman's life.

The Emergency Medical Treatment and Active Labor Act (EMTALA) creates a legal safety net guaranteeing that anyone in need of emergency health care, including those people unable to pay for health care, cannot be denied such care at public hospitals. HR 3 would strip EMTALA of its power to ensure that women who are in emergency situations receive life-saving abortion care at public hospitals, with disastrous consequences for poor women in emergency situations.

Proponents of the bill assert that abortion care is never necessary to save a woman's life; however, that is simply not true. In fact, just last year, such a case garnered national media attention when a Catholic nun and longtime administrator of St. Joseph's Hospital and Medical Center in Phoenix was excommunicated for allowing a woman to terminate her pregnancy in order to save her life.

The pregnant woman was critically ill with pulmonary hypertension, which limits the ability of the heart and lungs to function. According to a statement from St. Joseph's Hospital Vice President Suzanne Pfister, "In this tragic case, the treatment necessary to save the mother's life required the termination of an 11-week pregnancy."

On the National Abortion Federation's toll-free Hotline, we have heard from many other women who needed to obtain abortion care in order to save their lives—women who had cancer and needed to immediately begin live-saving treatment. Such treatment would harm the fetus and is incompatible with carrying the pregnancy to term. Dr. Cassing Hammond, Director of the Section of Family Planning and Contraception at Northwestern Feinberg School of Medicine, provided written testimony to the Subcommittee on the Constitution chronicling the life-saving abortions he is regularly called upon to provide.

Additionally, HR 3 would permanently ban all federal funding for abortion care, thereby endangering the health of women who rely on the federal government for their health care. Even though abortion has been legal in this country for more than 35 years, restrictions on public funding make it unavailable to many women. These include low-income women eligible for

Medicaid, federal employees insured by the Federal Employees Health Benefits program, women in the military, and Native American women who rely on the Indian Health Service for health care. This is an unjust restriction. Women should have access to abortion care regardless of the fact that they depend on the federal government for their health care.

HR 3 also interferes with the District of Columbia's ability to determine for itself how to use locally raised funds. The bill prohibits the use of local revenue for abortion care as part of the Medicaid services provided by the District.

Current law prohibits using federal funds for abortion care unless the pregnancy is a result of rape or incest or in certain circumstances that endanger the life of the pregnant woman. In addition to the prohibitions on abortion care already detailed above, Representative Smith's bill is so extreme that the original language attempted to narrow the definition of rape and incest. After weeks of public outcry, Representative Smith promised to remove this offensive language from HR 3. He has yet to do so.

The narrowing of the rape and incest provisions are an indication of the extreme nature of HR 3. This bill would adversely affect the lives and health of women. Abortion care is basic health care for women and should not be treated differently from other health care services.

HR 3 could have devastating consequences for the more than one million women who choose abortion each year—women like Dana Weinstein and Mary Vargas who stood with Democratic Members of the House of Representatives to oppose both HR 3 and HR 358, the "Protect Life Act." Dana and Mary explained how these two bills would have impacted their ability to make the decisions that were best for their families.

Dana found out during a very wanted pregnancy that her baby was missing a main part of its brain, and that the surface of the brain was malformed and severely underdeveloped, a condition called polymicrogyria. Her baby would likely not survive birth. Dana and her husband did not want to bring a child into the world that would only be here in a vegetative state, if at all.

Dana was unable to obtain the abortion care she needed in her home state of Maryland, so she had to travel across the country to Colorado to one of a small number of specialized providers and pay $17, 500 out-of-pocket for her care. She then had to enlist the help of legal counsel and spent more than a year appealing before her insurance company finally agreed to cover the total cost of her abortion care. However, it was a significant financial burden for her family to shoulder, especially at such a devastatingly emotional time.

After undergoing years of fertility treatments, Mary was pregnant with a son, already named David, when she found out at 22 weeks of pregnancy that due to the atrophy of his lungs and kidneys—a condition known as Potter's Syndrome—there was virtually no chance of his survival beyond a few hours, if indeed he survived until birth. Her husband was a federal employee so their insurance would not cover her abortion care.

Mary and her husband were faced with the choice of terminating the pregnancy if they could afford the out-of-pocket expenses, or waiting and allowing their son to suffer without comfort—to feel his bones being crushed and broken in the absence of amniotic fluid, until he died in utero, or at delivery, suffocating to death in the absence of developed lungs. As Mary describes, they chose to terminate the pregnancy "because choosing mercy was the only thing we could do for our unborn son."

HR 3 is an unprecedented attempt to restrict women's access to abortion care. This bill would prevent millions of American women from obtaining insurance coverage for abortion care even if they pay with their own funds. It is imperative that we defeat this extreme attack on women, and ensure that women like Dana and Mary can access the abortion care they need.

Statement of Dana Weinstein

Good afternoon. My name is Dana Weinstein. In July 2009, I was happily pregnant and excitingly, anxiously expecting the arrival of our second child. For nearly 8 months, I had been loving my baby in utero and explaining to our then 2.5 year old son that he was going to become a big brother. Never, EVER did I imagine I would need to have an abortion...and certainly not one so late in my pregnancy.

At my 28 week sonogram the ventricles in our baby's brain measured a little elevated and my perinatologist arranged for further testing. Two weeks later, I had an MRI performed to see what was going on inside my baby's head. It was then that we learned the shocking, horrific, and devastating news. Our baby was missing a main piece of its brain…the part that connects the right and left hemispheres literally wasn't there. It never developed. This is known as agenesis of the corpus callosum. Even worse, the surface of the brain was malformed and severely underdeveloped, a condition called polymicrogyria. Additionally, where brain mass and tissue should have grown and been plentiful, only large pockets of empty space and gaping holes existed. Despite all the prenatal care and testing I had throughout the pregnancy, this was not detected until I was seven and a half months along. And no amount of surgery, medicine or physical therapy could reverse, improve, or fix this horrendous diagnosis.

We learned that because of the severe brain anomalies, our baby would have had on-going seizures 70% of the time. And that was best case scenario. Our daughter would lack the physical coordination to suck, swallow, feed, walk, talk or know her environment—if she survived birth at all. The sonogram already showed the baby was not swallowing. And in hindsight, I believe her constant, non-stop movements—movements that I so lovingly joked about throughout the pregnancy as being payback for having a calm, easy-going first child—were the result of spasms caused by the brain abnormalities.

If we had carried our baby to term, we would have needed a resuscitation order in place prior to giving birth as she was incapable of living without significant medical assistance.

We did not want our daughter to exist solely because of machines. We did not want to bring a child into this world that would only be here in a vegetated state, if at all. For our baby, for our son, and for our family, my husband and I made the heartbreaking decision to terminate the pregnancy. We did what I believe was the most loving, humane act a parent could do—put an end to our baby's suffering.

Because I was late in my pregnancy, I had to travel to Colorado to one of a handful of facilities in the U.S. that provides later abortion care. It was awful to go through the hell of ending my very much wanted and loved pregnancy and to have to do it across the country, so far from my home and loved ones.

My upfront medical expenses were $17,500, which does not include an additional $3,000 in travel costs to obtain care. Since I had to go to an out of network provider, the maximum my insurance would cover was just $1,200. With the help of legal counsel and more than a year of appealing, my insurance company finally agreed to cover the total cost of my abortion care. The financial stress caused my family unnecessary anxiety during an already heartbreaking, devastating, and frightening time.

To be forced to carry a pregnancy to term because of a lack of financial resources or insurance coverage is beyond cruel, especially in situations like mine. The week I had to endure between learning the devastating diagnosis and when I could begin the termination process was agonizing. Each constant movement of my baby—movement that for months had brought me such joy and reassurance—was like a dagger to my heart. Looking down at my full pregnant belly knowing how sick my daughter was, and knowing that she would not live was horrendous. To force women to endure this for weeks or even months and give birth because of a lack of medical coverage is outrageous.

I am appalled that Congress is taking up this issue again. I can't help but ask…what about circumstances like mine? How can families facing such a terrible prognosis be omitted from abortion coverage? We exist and as painful as it is to talk about, we need to be heard and we need to be considered.

To say I am angered by those who are trying to prevent abortion coverage in the health care system is an understatement. I applaud our leaders and members of the Judiciary Committee here today who are taking the brave step in fighting against those trying to prevent women like me from being allowed to have the option to terminate my pregnancy and to have insurance coverage.

I am speaking today for all the women who are too fearful or made to feel ashamed, to put a face on abortion. I'm speaking today on behalf of my daughter, who I know is in a much better place. And, I'm speaking today for all of the women, who like me just a year and a half ago, never imagined they would need the help of an abortion.

Thank you.

Statement of Mary Vargas

Good morning. My name is Mary Vargas. I am a lawyer and a mother, and like most Americans I would lay down my life for my children. Like many women I never thought I would choose to end a pregnancy, but that was before David. As I make plans to visit the grave of my son on the anniversary of his death next week, I know that the choice a woman makes is not always what she would have anticipated before an abstract tragic reality became her own story.

As a lawyer, I represent people who are seeking dignity and equality. I represent both individuals with disabilities who experience discrimination and women who are denied insurance coverage for abortion care—because both in the end are about dignity and fundamental human rights. Because of my experiences, both personal and professional, I believe in a woman's right to choose.

When I was 22 weeks pregnant with my very much wanted second son whom we had already named David, he was diagnosed with a fatal form of Potters' Syndrome. His kidneys had stopped working and atrophied. As a result, his lungs could not develop. We prayed that we could hold him, regardless of disability, but our options were unspeakable.

We could terminate the pregnancy, if we could find doctors and nurses willing to provide care, and if we could pay for it out of pocket, since my husband's insurance was restricted from covering abortion care. Or we could wait. We could allow our son to suffer without comfort, to feel his bones being crushed and broken in the absence of amniotic fluid, until he died in utero, or at delivery, suffocating to death in the absence of developed lungs. Two specialists confirmed that he had no chance at life.

We struggled with the moral questions, the ethical questions, the religious questions, the practical questions, and how to explain to our living child that his brother would not be coming home. We questioned the meaning and value of mercy.

We "chose" to end the pregnancy – not for us, but because choosing mercy was the only thing we could do for our unborn son. I would have liked to have held him. Yet, I know our decision was the right one for our child. I know because of this experience that many times the choice to terminate a pregnancy is made *because* a woman value's life: because she or her unborn child, or both is dying, or because they are suffering towards no purpose.

It wasn't a choice I would wish on my worst enemy, but I'm grateful the choice was mine. As a lawyer, I carry in my heart the words of a client who described what it felt like to lose her child. Late in her pregnancy, despite the best prenatal care, she faced a devastating medical diagnosis that her baby was missing a main part of its brain and would likely not survive or only survive in a vegetative state. She considered her unborn child's suffering, and made the difficult decision to end her pregnancy. She described feeling as if she would literally go insane with grief at the loss. In this devastating time, she discovered that her ability to make the choice to terminate her

pregnancy—a choice which she and her husband and her faith leader believed moral and right—was restricted by her state government and her insurance carrier.

Not only did she have to go through the hell of ending her very much wanted and loved pregnancy, but she had to do it across the country far from her home and loved ones because care was not available in her state. And she had to obtain legal counsel, and spend more than a year appealing to her insurance company before they would finally agree to cover the more than $17,000 she had to pay out of pocket for the abortion care she needed.

In the end, what I know to be true both as a professional and as a mother, is that the decision to terminate a pregnancy is a decision that can never be understood at a distance. It is because of these real life experiences with abortion, that I am appalled by the legislative efforts that deny the complexity of abortion, and the freedoms at stake. Neither the Smith Bill nor the Pitts Bill is a simple codification of existing restrictions on abortion (of which there are, already, many). This legislation is a deliberately crafted framework designed to remove abortion as an option for women, regardless of their circumstances. These bills would put women's lives and health at risk, and prevent women like me from exercising their own faith and morality. This cannot be who we are as Americans.

Thank you.

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The National Abortion Federation (NAF) is the professional association of abortion providers in North America. Our mission is to ensure safe, legal, and accessible abortion care, which promotes health and justice for women. Our members include clinics, doctors' offices, and hospitals, who together care for more than half the women who choose abortion each year in the United States, Canada, and Mexico City. For more information, visit our website at www.prochoice.org.

Prepared Statement of Silvia Henriquez, Executive Director, the National Latina Institute for Reproductive Health

H.R. 3 "No Taxpayer Funding for Abortion Act"
An Attack on Women of Color and Low-Income Women's Health

Testimony submitted by

Silvia Henriquez
Executive Director
National Latina Institute for Reproductive Health

U.S. House of Representatives
Committee on the Judiciary
Subcommittee on the Constitution

February 8, 2011

Members of the Judiciary Subcommittee on the Constitution: I am honored to submit this testimony on behalf of the National Latina Institute for Reproductive Health.

The National Latina Institute for Reproductive Health (NLIRH) strongly urges the committee to oppose H.R.3, the so-called "No Taxpayer Funding for Abortion Act." NLIRH works to ensure the fundamental human right to reproductive health for Latinas, their families and their communities. This bill will harm women, families and small businesses.

H.R.3 will codify harmful laws such as the Hyde Amendment, a discriminatory restriction that bars low-income women's access to abortion services, except in extreme circumstances. In addition to low-income women who are negatively impacted by the Hyde Amendment, other women that will be negatively impacted by these sorts of restrictions include women in the military, federal employees, residents of the District of Columbia, and American Indians and Alaska Natives. Abortion restrictions should not be codified and instead should be eliminated from federal law entirely. Hyde-like restrictions on abortion coverage impair the health of the tens of millions of women who rely on the government for their health care. Additionally, they disproportionately harm women of color, including Latinas who are disproportionately represented in these groups.

In addition to the codification provisions of H.R.3, the bill goes much further than current restrictions on public coverage of abortion services. The bill would undermine women's access to reproductive health care in the following ways:

- Usurp local decisions to cover women's health care equitably established under the health care reform law

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- Increase health disparities for women of color and low-income women
- Impose tax penalties on millions of families whose insurance covers women's heath care equitably. These penalties will negatively affect small businesses[1,2], low and moderate income families, self-employed people, displaced workers and individuals who spend a large proportion of their income on health expenses
- Essentially eliminate private health insurance coverage for abortion,, even though the coverage is paid for with private funds, as already mandated by federal law. Currently, 87% of private insurance plans cover abortion care; this bill will eliminate benefits for millions of women
- Make permanent those laws that obstruct women's health
- Potentially deny women abortion procedures in life-threatening situations

Abortion is a legal procedure that is part of a woman's reproductive health options. Women of color are actively at the forefront of the movement for reproductive justice and are coming out of the shadows demanding fair and equal reproductive rights. In a California survey, 65% of U.S.-born Latinos said that government should not interfere with our personal decisions about abortion.[3]

This bill would have a devastating impact on poor women, particularly Latinas and communities of color and is another callous attempt to restrict access to abortion at our expense. History tells us that making abortion too expensive as a means to reduce abortion rates is not only impractical, it is unjust.

- 25% of all women obtaining abortions are Latinas
- 42% of women obtaining abortions have incomes below 100% of the federal poverty line. Between 2008 and 2009, the poverty rate increased for Hispanics from 23.2% to 25.3%

Low-income women who are denied abortion coverage have to postpone paying for other basic needs like food, rent, heating and utilities to save money needed for an abortion. In addition, the time needed to save money means that low-income women tend to have abortions two to three weeks later than other women. In some cases, women that cannot pay for an abortion resort to self-inducing abortion or seeking unsafe, illegal abortions from untrained, unlicensed practitioners. Women of

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[1] Small businesses run by women will create one-third of all new jobs according to the Guardian Life Small Business Research Institute. Mark D. Wolf. Women-Owned Businesses: America's New Job Creation Engine. *Forbes*. Jan. 12, 2010. http://www.forbes.com/2010/01/12/small-business-job-market-forbes-woman-entrepreneurs-economic-growth.html. Accessed February 3, 2011.

[2] 28.2% of U.S. businesses are owned by women and 6.8% of U.S. businesses are owned by Latinos. U.S. Census Bureau, State & County QuickFacts, USA. Available at: http://quickfacts.census.gov/qfd/states/00000.html. Accessed February 3, 2011.

[3] Public Policy Institute of California. Available at: http://www.ppic.org/content/pubs/jtf/JTF_LatinosViewsJTF.pdf. Accessed February 7, 2011.

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color are disproportionately low-income and these conditions excessively impact these communities. Forcing women into the shadows of healthcare has never improved families or communities.

Although the authors of H.R.3 attempted to quiet the public's outcry against this bill by removing one word that narrowed the definition of rape, the removal of the word "forcible" does not correct the larger maladies inherent in the measure. The original cruel restrictions for victims of sexual violence demonstrate a complete disregard for women's safety and wellbeing that can be found in every section of this bill. In fact, at the same time that the word forcible was removed, a provision was added to a similar attack on women's health that would allow hospitals to deny abortion care to a woman even if her life is in danger. These attacks on women's health cannot be solved by merely adjusting the language under which they are brought or by replacing one word with an even more harmful provision.

NLIRH is extremely disappointed that attacking women's liberties is the largest priority of this important congressional session instead of focusing on the economy, jobs or measures that strengthen women, families and businesses. The American public has asked the federal government to focus on strengthening the economy and increasing employment. This measure does neither, and instead attacks women and populations that are suffering the most in the economic downturn.

NLIRH urges the committee to oppose H.R.3.

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Prepared Statement of Debra Ness, President, and Judith Lichtman, Senior Advisor, the National Partnership for Women & Families

"No Taxpayer Funding for Abortion Act" (HR 3)

Testimony submitted by

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Judith Lichtman, Senior Advisor

U.S. House of Representatives
Committee on the Judiciary
Subcommittee on the Constitution

February 8, 2011

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Members of the Judiciary Subcommittee on the Constitution: we are honored to submit this testimony on behalf of the National Partnership for Women & Families and the women and families we represent.

The National Partnership for Women & Families is a nonprofit, nonpartisan 501(c)(3) organization located in Washington, D.C. We have worked tirelessly for the last forty years to expand access to quality, affordable health care for all Americans that includes comprehensive reproductive health services; to eliminate discrimination in the workplace; and to enable women to meet the dual demands of work and family. The National Partnership vehemently opposes H.R. 3, the deceptively entitled the "No Taxpayer Funding for Abortion Act" and we urge Congress to reject this legislation.

Supporters of H.R. 3 claim that this bill simply seeks to permanently ban federal funding of abortion. But those claims are blatantly misleading. This radical proposal represents an extreme attack on abortion access that goes well beyond codifying the unjust and harmful restrictions on federal funding of abortion care that have long burdened low-income women who rely upon the federal government for their health care. H.R. 3 would also prevent women with private insurance from obtaining abortion care by increasing taxes on individuals and small businesses that want to keep the health plans they already have that include abortion coverage. This unprecedented restriction on private insurance coverage of abortion would even impact women who purchase health care with their own money and ultimately threatens the availability of abortion coverage in the entire private market.

The National Partnership urges Congress to reject H.R. 3 outright but also as one of many efforts to dismantle the historic Patient Protection and Affordable Care Act (ACA) passed by Congress and signed into law in 2010. The ACA represents an impressive effort to provide health insurance coverage to millions of previously uninsured Americans and to reign in some of the most egregious everyday practices of insurance companies. The failure of our current health care system to adequately address the health care needs of our nation has been particularly felt by women. Although women need and use health care services more than men, they face significant barriers in obtaining affordable care that adequately meets their needs. This landmark piece of legislation required numerous compromises by all stakeholders involved. While the National Partnership was not happy with every aspect of the bill, we recognized the potential for the ACA to provide sorely needed coverage and market reforms. We wholeheartedly supported passage of the reform law and are actively working on implementation efforts to ensure that ACA lives up to its potential. Repealing or undermining the ACA would harm women and families who can rely on more and better health care as a result of this bill.

Congress should reject H.R. 3 because it severely impedes the availability of abortion coverage in the private health insurance market and permanently denies low-income women, military women, DC residents and public employees access to insurance coverage of abortion care. The bill promotes an extreme definition of "federal funding" that would impact government spending in areas that extend well beyond abortion care.

Threatens the Availability of Abortion Coverage in Private Insurance Market

H.R. 3 diminishes the availability of abortion coverage in the private insurance market by eliminating tax benefits for many small and individual private health plans that include coverage of abortion care. This could ultimately eliminate the entire market for private health plans that include abortion coverage. Today, a majority of private health plans offer coverage that includes abortion care. Eliminating tax benefits for private plans that include abortion coverage means that individuals and small businesses that choose to keep these plans would face significant tax increases.

For example, self-employed individuals, individuals who spend a large portion of their incomes on health care or workers who lose their jobs due to outsourcing will be unable to take advantage of tax credits that make health care more affordable if they keep their health plan that includes abortion coverage. Small businesses that want to continue to offer comprehensive health coverage would not be able to take advantage of the Small Business Health Tax Credit, enacted as part of the Affordable Care Act, if their plans included abortion coverage. This tax credit for small businesses will be worth up to 50 percent of premium costs in 2014.

The tax impact on individuals even creates a disincentive for larger businesses and other large purchasers of insurance to provide health plans that include abortion coverage. Currently, individuals who spend more than seven and a half percent of their income on health care are able to deduct health care costs. However, if one of their employees were to be diagnosed with cancer or another costly disease that significantly increase their health costs, that employee would not be eligible for the tax deduction if the employee health plan offered abortion coverage (even if that employee were a single male or an elderly woman).

These tax penalties force consumers to face significantly higher taxes or drop plans that they already have that include abortion coverage. If consumers can no longer afford health plans that include abortion coverage, health insurers will eventually eliminate these plans from the private insurance marketplace.

Imposes Extraordinary Restrictions on Private Plans in Health Care Exchanges

H.R. 3 bans any federal expenditure to private health plans that include abortion coverage. This means that low and moderate income individuals and families eligible for premium assistance to purchase health plans through the state exchanges would be unable to select private plans that include abortion care. Because the majority of consumers purchasing plans in the new exchanges would be eligible for premium assistance, health plans would be forced to drop abortion coverage in plans sold through the exchanges – making insurance coverage of abortion unavailable even for consumers paying with private funds. The dual impact of imposing tax penalties for purchasing plans that include abortion coverage and banning abortion coverage in state health-insurance exchanges jeopardizes the existence of health insurance coverage of abortion care in the entire private health insurance market.

This marks an unprecedented restriction on the use of private funds and impedes the ability of women to choose new health plans that cover their health care needs. Congress extensively debated and rejected a similar proposal – embodied in an amendment authored by former Congressman Bart Stupak - during consideration of health care reform. The ACA ultimately included a provision that requires insurers choosing to offer plans that include abortion coverage, to adhere to stringent accounting procedures to segregate federal funds from private dollars used to cover abortion care. President Obama subsequently issued an Executive Order to ensure compliance with this provision. The National Partnership strongly opposes this provision in ACA but we make the point here to emphasize that there is widespread agreement that ACA already ensures that no federal funds can be used to pay for abortion coverage. To claim that further restrictions are needed is a disingenuous way to promote an extreme attack on access to abortion care.

Makes Existing Federal Restrictions on Abortion Coverage Permanent

H.R. 3 would codify existing restrictions on federal funding for abortion that prohibit abortion coverage in health insurance provided by the government, with few exceptions. These include women covered through Medicaid, women serving in the military and dependents of military personnel, women receiving veteran's benefits, women serving in the Peace Corps, women covered through the Indian Health Services, federal employees, and women in federal correctional facilities. The bill would also reinstate a ban on the District of Columbia, lifted in 2009, that prohibited DC from using its own funds to pay for abortion care.

The National Partnership remains adamantly opposed to abortion funding bans because they threaten women's health by making it harder to obtain abortion services. They are especially burdensome for low-income women who do not have the funds to pay for care that is not covered by their health insurance. In some instances, these restrictions eliminate access to abortion for women even if they use their own funds.

Conclusion

The National Partnership for Women & Families urges Congress to reject H.R. 3, the "No Taxpayer funding of Abortion Act." The bill goes well beyond codifying the unjust restrictions on access to abortion care that have long burdened low-income women. In seeking to impose sweeping restrictions on all forms of government spending that might possibly be linked to the provision of abortion care H.R. 3 goes too far. It takes away health coverage women already have and threatens to end all insurance coverage for abortion – regardless of whether federal funds are used.

Prepared Statement of Rabbi David Saperstein, Director and Counsel, Religious Action Center of Reform Judaism

Testimony of Rabbi David Saperstein
Director and Counsel
Religious Action Center of Reform Judaism
H.R. 3, the No Taxpayer Funding for Abortion Act
Tuesday 2/08/2011
2141 Rayburn House Office Building
Committee on the Judiciary—Subcommittee on the Constitution

On behalf of the Union for Reform Judaism, whose more than 900 congregations encompass over 1.5 million Reform Jews across North America, the Central Conference of American Rabbis, which includes more than 1,800 Reform rabbis, and the Women of Reform Judaism, which represents more than 65,000 Reform Jewish women, I submit this statement in strong opposition to the No Taxpayer Funding for Abortion Act (H.R. 3).

The Reform Jewish Movement has long supported a woman's right to make decisions about her reproductive health. Since the 1960s, the Union for Reform Judaism, the Central Conference of American Rabbis, and Women of Reform Judaism have urged an end to all restrictions on reproductive rights. In the era before *Roe v. Wade*, the Reform Movement cited a "moral imperative to modernize abortion legislation," lamenting that "illegal abortions yearly take a tragic and needless toll." When *Roe v. Wade* legalized abortion, the Reform Movement applauded the decision for its importance not only in protecting life, but also in safeguarding civil liberties. "The question of when life begins is a matter of religious belief and not medical or legal fact," the Union for Reform Judaism resolved in 1975. "While recognizing the right of religious groups whose beliefs differ from ours to follow the dictates of their faith in this matter, we vigorously oppose the attempts to legislate the particular beliefs of those groups into the law that governs us all. This is a clear violation of the First Amendment."

The Reform Movement views abortion as a deeply personal issue and, like most Americans, holds the core belief that women are moral decision-makers in their own right entitled to make fundamental medical and reproductive choices. A woman should make a decision about whether to have an abortion according to her own beliefs and in consultation with her clergy, her family, and her doctor; politicians and ideologues should not make the decision for her. We believe that religious matters are best left to religious communities and individual conscience, and decisions about health, including what constitutes a life-saving procedure, to patients in consultation with physicians.

We come to these beliefs inspired by the sanctity of life. In Judaism, women are commanded to care for the health and well-being of their bodies above all else. Banning potentially life-saving medical procedures and interfering with a doctor's medical decision-making run contrary to the Jewish commandment to protect life. Although an unborn fetus is precious and is to be protected as a potential human being, Judaism views the life and health of the mother as paramount, placing a higher value on existing life than on potential life.

The great physician and scholar Maimonides stated, "If a woman is in hard labor…her life takes precedence over [the fetus'] life." In the *Mishnah Ohaloth* 7:6, a woman is forbidden from sacrificing her own life for that of the fetus, and, if her life is threatened, she is allowed no other option but abortion. In addition, a number of scholars assert that if the mental health, sanity or self-esteem of the woman (e.g., in the case of rape or incest) is at risk due to the pregnancy itself, the woman is permitted to terminate the pregnancy ("Jewish Living: A Guide to Contemporary Reform Practice," page 240). It is due to the intrinsic Jewish belief in the sanctity of life that abortion is viewed under some circumstances as both a moral and correct decision.

Furthermore, the Torah makes clear from the beginning that all of humanity—men and women—was created *b'tselem Elohim*, in the Divine image of God (Genesis 1:26-27). With that Divine spark, women are perfectly capable of making moral decisions about their own bodies. We deeply believe that unnecessary restrictions on a woman's right to make those decisions violate the principle that God created everyone equally.

For these reasons, we are deeply concerned by and strongly oppose H.R. 3. This dangerous bill severely threatens the right to choice affirmed by the Supreme Court in *Roe v. Wade*. It would prevent women seeking needed reproductive health care from using their own, private money to pay for abortion services. It would reinforce the two tiers of health care recipients—the poor and the non-poor—by enshrining the "Hyde Amendment" into law, permanently barring any federal government money from being spent on abortions needed by women who rely on Medicaid, Medicare or the Indian Health Service except for in the cases of rape, incest or endangerment to the life of the mother. Most disturbing, the bill would limit the use of those funds to circumstances of "forcible rape," which is a term found nowhere in existing law and creates a false impression about the nature of sexual violence.

Yet the unacceptable and unconstitutional incursions into a woman's privacy do not end there: Women in the military would also continue to be barred from using their own, private money to pay for abortions on military facilities. In addition, businesses that pay for employee health plans that cover abortion would be denied tax credits, and medical deduction for payments to health plans that include abortions would be prohibited.

This bill, if passed, would likely lead many private health insurance plans to eliminate abortion coverage altogether, thus dramatically reducing women's access to safe and affordable abortion services. We cannot stand silent while the House of Representatives considers a bill that violates the U.S. Constitution, decades of U.S. Supreme Court precedent and many of our core Jewish values.

The No Taxpayer Funding for Abortion Act (H.R. 3) would result in greater government interference in what is typically a very private, and often religious, decision. As Reform Jews committed to the sanctity of a woman's life and personal dignity, and as Americans committed to core Constitutional principles, we must oppose H.R. 3 and urge your Subcommittee to do the same.

Prepared Statement of Nancy Keenan, President,
NARAL Pro-Choice American Foundation

"No Taxpayer Funding for Abortion Act" (H.R.3):
An Extreme Attack on Women's Access to Abortion Coverage

Testimony submitted by

Nancy Keenan
President

Also on Behalf of

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NARAL Pro-Choice North Carolina
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NARAL Pro-Choice Washington
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U.S. House of Representatives
Committee on the Judiciary
Subcommittee on the Constitution

February 8, 2011

Members of the Judiciary Subcommittee on the Constitution: I am honored to submit this testimony on behalf of NARAL Pro-Choice America, our state affiliates, and the pro-choice Americans we represent.

Today you are considering the "No Taxpayer Funding for Abortion Act" (H.R.3), introduced by Rep. Chris Smith (R-NJ), a bill that is misleading in its claim that it ends public funding for abortion care. This bill is not about public funding. Regardless of one's view on this issue, federal law is clear: federal funding of abortion is forbidden, except in very narrow circumstances. Instead, this bill is an attempt to reopen the debate on private insurance coverage of abortion and to dismantle entirely the Affordable Care Act.

Introduced as part of the effort to repeal and replace the health-care law, this bill exposes that anti-choice House leadership's view of "public funding" bears no resemblance to reality. The legislation's true objective is eliminating all coverage of abortion, even in private insurance plans. More sweeping in scope than its name implies, the Smith bill does far more than reinforce existing bans on public funding for abortion care; it launches a radical new anti-choice attack on abortion access.

Imposes Tax Penalties on the Purchase of Abortion Coverage

The Smith legislation interferes with coverage of abortion services within the private-insurance market and makes chaotic changes to tax policy. The legislation would force millions of families to pay taxes on their health-insurance benefits if their plan includes abortion. It does so by imposing tax penalties on many individuals and small businesses that choose private health plans that cover abortion care. (At present, 87 percent of private plans cover abortion services.[1]) In levying taxes on the purchase of plans that include abortion coverage, the Smith bill severely threatens the private market for comprehensive insurance coverage that includes abortion care.

Specifically, the law would:

- Force small businesses to choose whether to accept the Small Business Health Tax Credit enacted as part of the health-care law or to offer their employees comprehensive insurance plans that will cover all their potential health needs, including abortion care. Under the Smith bill, insurance plans that include abortion benefits are ineligible for the tax credit. Four million small businesses are estimated to be eligible for the credit if they provide health care to their workers.[2]

- Take away tax benefits from self-employed persons if their health-insurance plans include abortion coverage. Currently, self-employed persons are able to deduct the cost of their insurance policy from their income taxes. The Smith bill, however, makes all plans that

cover abortion non-deductible, and would deny this tax deduction to all self-employed persons whose plans include abortion coverage.[3]

- Impose tax penalties on many individuals who have high out-of-pocket health-care costs. Current law allows individuals to deduct all health-care expenses – including insurance premiums – that exceed 7.5 percent of their gross income. The Smith bill, however, would make insurance premiums for plans that include abortion coverage non-deductible, and force families who have abortion coverage to pay increased taxes.[4]

- Restrict the use of private dollars placed in tax-preferred Health Savings Accounts (HSAs). The Smith bill forbids individuals from using private funds saved in HSAs from being used to pay for abortion care, except in extremely limited circumstances.

The National Women's Law Center (NWLC) has quantified the impact that these tax penalties would have on hypothetical individuals and small businesses. According to the NWLC's analysis:

- A restaurant with 40 half-time employees whose wages totaled $500,000 and health-care costs totaling $240,000 per year would be eligible for a Small Business Health Tax Credit under current law. Under the Smith bill, however, that restaurant's taxes would be raised by $28,000 if its health insurance plan includes abortion coverage.[5]

- The Smith bill would cost a married self-employed individual who had a combined income of $98,000 and $7,000 in annual insurance premiums an additional $1,750 per year if that individual's insurance plan covered abortion services.[6]

- A woman who makes $25,000 is eligible to deduct from her taxable income any amount over $1,875 spent on health-care expenses, including on insurance premiums. If her insurance plan covered abortion, however, the Smith bill would take away her $1,731 deduction.[7]

Revives Core Provision of the Stupak-Pitts Amendment

In an effort to reopen the contentious issue of abortion coverage, the Smith legislation revives the core provision of the failed Stupak-Pitts amendment, and effectively would end abortion coverage for women in state insurance exchanges who use their own, private funds to pay for their insurance. The Smith bill makes it highly unlikely that insurance companies will opt to offer abortion coverage in state exchanges: it forbids any plan offering such coverage from accepting even one subsidized customer, forcing insurers to choose between offering their product without abortion coverage to the entire universe of consumers in a state exchange and offering a benefits package that does include abortion services to a small minority of unsubsidized customers. (Because a vast majority of participants in state insurance exchanges will be subsidized,[8] it seems clear which choice insurers are likely to make.) As a result, in

addition to women who will pay part, or even most, of their insurance premium with private funds, millions of unsubsidized individuals and small-businesses employees who obtain insurance through a state health-insurance exchange will be denied abortion coverage.

In addition to restricting who may purchase abortion coverage within state insurance exchanges, the Smith bill would impose crippling administrative burdens on plans that wish to cover abortion care. If the Smith bill becomes law, insurance companies that offer abortion coverage—as 87 percent of plans currently do[9]—would face high costs, technical complexities, and onerous administrative requirements.[10]

The bill's purported solution of "preserving" the option of abortion-coverage "rider" policies for women who purchase an exchange-based plan but seek abortion coverage is a false promise. Low-income women who receive insurance subsidies are unlikely to be able to afford a supplemental policy, and women who can afford to purchase riders are unlikely to do so, as unintended pregnancies are by definition unplanned. Moreover, existing data on rider policies suggest that they simply do not work. Information from the five states that ban abortion coverage entirely except by separate rider is not promising. Last year, *The Washington Post* discovered that insurance companies in those states reported a lack of availability and demand for such riders.[11] The implication of these data is that, under the Smith bill, abortion riders will likely not be available to customers.

The combination of imposing tax penalties for purchasing plans that include abortion coverage and banning abortion coverage in state health-insurance exchanges jeopardizes the entire existence of this important reproductive-health benefit. As the state exchanges grow, they will have a greater effect on the health-insurance industry as a whole, eventually becoming the standard for benefits packages.[12] The Smith bill, if enacted, could have an industry-wide effect, and, over time, cause the elimination of coverage of abortion services for most women – not just those who obtain coverage through a health-insurance exchange.

Recodifies Existing Bans on Abortion Coverage

This extreme proposal also would reinforce long-standing discriminatory bans on publicly funded abortion care by permanently denying low-income women, federal employees, women in the military, and residents of the District of Columbia access to abortion coverage.

Again, current law already bans public funding for abortion care; regardless of one's view of that policy, it is indisputably already the law of the land. The Smith bill writes the bans into permanent law, including the Hyde amendment, a discriminatory restriction that bars low-income women's access to abortion services, except in extreme circumstances. Currently, these various bans are renewed annually in appropriations bills and the annual Defense authorization legislation. The Smith bill would deny permanently coverage to the nearly 18 million

individuals insured by Medicaid,[13] the 6.7 million non-elderly and disabled individuals currently enrolled in Medicare,[14] and the 1.5 million American Indians and Alaska Natives who receive health insurance through the Indian Health Service (IHS).[15]

Additionally, the U.S. government offers health benefits plans to eight million federal employees, their dependents, and retirees, 44 percent of which are women.[16] The Smith bill permanently bans abortion coverage for these federal employees and their dependents, even though these workers pay a portion of their health insurance premiums with their own private dollars.

Similarly, the bill also recodifies the ban on abortion care for women in military hospitals overseas, a policy that a majority of members of the Senate Armed Services Committee voted to repeal in 2010, and permanently denies abortion coverage to the nine million individuals who receive health insurance through TRICARE, the military health plan.[17]

Likewise, the Smith bill would permanently deny abortion coverage to Peace Corps volunteers. Of the 7,671 U.S. citizens who are currently volunteers and trainees for the Peace Corps, 60 percent are women.[18] Finally, the Smith bill also reimposes the ban on Washington, D.C.'s ability to use its own local funds to cover abortion services for the 64,500 low-income women currently enrolled in its Medicaid program – an unfair restriction that Congress lifted in 2009.[19]

Overall, the more than 13.5 million adult women who receive health coverage through Medicaid and other government-sponsored programs described above permanently would lose access to abortion coverage, except in incredibly narrow circumstances.[20]

Discriminatory bans on abortion coverage create significant, often insurmountable, obstacles for women seeking abortion care. Low-income women often have difficulty raising the money to pay for abortion services and research indicates that economic barriers often cause them to obtain abortion care two to three weeks later in pregnancy than do wealthier women.[21] This is especially problematic because the cost of abortion care increases the longer the pregnancy continues. Later abortion care, which is already inaccessible to women in many states, ranges into the thousands of dollars, and can pose an insurmountable cost.[22] These burdens disproportionately affect women of color, who, because of the connection between racial discrimination and economic disadvantages, are more likely than white women to be poor, to lack health insurance, and to rely on government health-care programs or plans.[23] Reiterating the abortion-coverage bans in permanent law adds insult to already deeply injurious policies.

Finally, the Smith bill also recodifies the Helms amendment, a policy that denies some of the world's poorest women access to safe abortion care by prohibiting the use of U.S. funds to pay for abortion services in developing countries. Not only would the Smith bill jeopardize the availability of abortion coverage for American women, it would have detrimental international ramifications as well.

Redefining Rape and Incest

In an especially mean-spirited provision, the Smith bill narrows the already severely limited rape and incest exceptions that exist in federal law, denying, at minimum, abortion coverage to survivors of statutory rape and any incest survivor who is 18 years of age or older. Most federal laws that restrict access to abortion services allow exceptions for instances of life, rape, or incest. The language in the Smith bill, however, limits these exceptions to include only victims of "forcible rape" and "incest with a minor." This restriction would apply to all federal programs, affecting not only low-income women in Medicaid, but women in the military and all federal employees, as well. It also would apply to state health-insurance exchanges, and to the tax-benefits restrictions applied to the private insurance market. While the bill's sponsor has suggested that he may drop this offensive provision, its inclusion in the original version offers another indication of the bill's extreme nature.

Inadequate Exceptions

It should also be noted that the Smith bill excludes any kind of exception that would protect the health of the woman, or provide care in cases of fetal anomaly. While the absence of insurance coverage for abortion care hurts all women, it particularly harms those for whom pregnancy threatens their health. Many women welcome pregnancy at some point in their lives and can look forward to a safe childbirth; however, for some, pregnancy can be dangerous, and abortion restrictions, such as the Smith bill, that do not contain exceptions to protect women's health endanger these women. The Smith legislation would limit access even for women in the most desperate of circumstances, whose care is often the most expensive and the most urgent. For example:

- Vikki Stella, a diabetic, discovered months into her pregnancy that the fetus she was carrying suffered from several major anomalies and had no chance of survival. Because of Vikki's diabetes, her doctor determined that induced labor and Caesarian section were both riskier procedures for Vikki than an abortion. The procedure not only protected Vikki from immediate medical risks, but also ensured that she would be able to have children in the future. [24]

- Jennifer Peterson was 35 and pregnant when she discovered a lump in her breast. Tests showed she had invasive breast cancer. The cancer and its treatment, separate and apart from the pregnancy, were a threat to her health. Her pregnancy posed a significant added threat to her health during the onset and treatment of her cancer. About one in 3,000 pregnant women also has breast cancer during her pregnancy, and for these women, a health exception is absolutely necessary. [25]

- Gilda Restelli was well into her pregnancy when doctors discovered that her fetus had only fragments of a skull and almost no brain. She and her husband had been told by medical experts that their baby had almost no chance of survival after birth. Restelli quit

her job, not because she was physically incapacitated, but because she could no longer bear the hearty congratulations of strangers who were unaware of the tragic circumstances surrounding her pregnancy. The Restellis made the agonizing decision to end the pregnancy. [26]

- D.J., a federal employee, was 11 weeks into a wanted pregnancy when she learned that her fetus had anencephaly, meaning that the fetus would never develop a brain. Her doctor provided abortion care at a local hospital. Several months later, she received a bill for $9,000 – and was told her insurance would not cover the costs because, as a federal employee, she was not entitled to insurance coverage for abortion services unless the pregnancy endangered her life.

States Invited to Restrict Abortion Coverage In All Circumstances

The Smith bill also allows states to refuse coverage for abortion in all cases, even when a woman's life is in danger. Current federal law requires state Medicaid programs to cover abortion in cases where the pregnancy occurred because of rape or incest, or when the woman's life is in danger. When Congress expanded federal Medicaid funding for abortion care for rape and incest victims in 1993, more than one-third of the states initially refused to comply with the federal law. Eleven states were ordered into compliance by federal courts.[27] Every court that has considered the revised Hyde amendment has found that states that participate in the Medicaid program must cover abortion services in cases of rape or incest, regardless of state laws that are more restrictive. The Smith bill, however, would take away this already-minimal protection and allow states to refuse Medicaid coverage for abortion in all cases, even when a woman's life is in jeopardy.

Conclusion

The Smith bill represents an extreme new anti-choice agenda that drastically distorts the concept of "public funding." In trying to redefine this term falsely, the Smith legislation jeopardizes the ability of private citizens to use their own dollars to purchase abortion coverage in the new health system and levies harsh financial penalties on businesses and families who choose comprehensive insurance coverage. Reasonable lawmakers, even those who may not agree with the pro-choice perspective on the issue of public funding for abortion, should recognize this bill for what it is: a radical departure from the status quo.

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[1] Adam Sonfield et al., *U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Coverage Mandates*, 2002, Perspectives on Sexual Reproductive Health, 36(2):72-79 (2004).

[2] National Women's Law Center, *Oppose the Dangerous and Misleading "No Taxpayer Funding for Abortion Act"* (2010).

[3] National Women's Law Center, *Oppose the Dangerous and Misleading "No Taxpayer Funding for Abortion Act"* (2010).

[4] National Women's Law Center, *Oppose the Dangerous and Misleading "No Taxpayer Funding for Abortion Act"* (2010).

[5] National Women's Law Center, *Oppose the Dangerous and Misleading "No Taxpayer Funding for Abortion Act"* (2010).

[6] National Women's Law Center, *Oppose the Dangerous and Misleading "No Taxpayer Funding for Abortion Act"* (2010).

[7] National Women's Law Center, *Oppose the Dangerous and Misleading "No Taxpayer Funding for Abortion Act"* (2010).

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[9] Adam Sonfield et. al., *U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Coverage Mandates*, 2002, Perspectives on Sexual Reproductive Health, 36(2):72-79 (2004).

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Statement of National Council of Jewish Women on HR 3, No Taxpayer Funding for Abortion Act

Written Testimony submitted by
Nancy Ratzan, President, National Council of Jewish Women

US House of Representatives
Committee on the Judiciary
Subcommittee on the Constitution

February 8, 2011

The National Council of Jewish Women (NCJW) is a grassroots organization of volunteers and advocates who are inspired by Jewish values. Since 1893, NCJW members have turned progressive ideals into action, striving for social justice by improving the quality of life for women, children, and families, and by safeguarding individual rights and freedoms.

NCJW has a long history of strong support for the protection of every female's right to reproductive choices, including safe and legal abortion, access to contraception, and the elimination of obstacles that limit reproductive freedom. The ninety-thousand members, volunteers, and supporters of NCJW have long supported abortion care as an essential component in the spectrum of comprehensive, confidential, affordable reproductive health services that must be accessible to women, regardless of age or ability to pay. We believe that each woman must have the right to exercise her own moral judgment when making personal decisions, including those that affect her reproductive life. Ensuring that women, regardless of financial status or age, have access to comprehensive reproductive health services is essential not only to women's health but also to women's equality and economic opportunity.

We view HR 3, the "No Taxpayer Funding for Abortion Act," introduced by Representative Chris Smith (R NJ), as harmful to women and families on several fronts. This legislation would unjustly target their pocketbooks, imposing financial barriers on many American workers and discriminating against low-income women; cruelly endanger their health; and wrongly erode their right to privacy and religious liberty.

If enacted, the government would greatly restrict consumer options in the private insurance market and penalize the insurance companies and employers who offer

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abortion-inclusive health insurance coverage. While more than 85 percent[1] of private plans today offer such coverage, HR 3 would increase taxes on the individuals and families who now have abortion coverage and want to keep it, while barring others from buying this coverage with their own money. Penalizing consumers – male and female – with increased taxes as a means of restricting abortion coverage is an unjust and extreme move that would harm women, men, and their families.

HR 3 also puts women at risk. It would make permanent the Hyde Amendment, banning abortion for women receiving subsidized insurance – discriminating against low-income and other women who rely on federal health programs, such as Medicaid beneficiaries, US servicewomen, and federal employees. Moreover, this legislation would not provide exceptions for women whose health may be harmed by the continuation of a pregnancy and, as originally proposed, it would change long-standing definitions of rape and incest exceptions to deny care to some minors, women with disabilities, adult incest survivors, and others whose pregnancies are the result of rape. In so doing, this bill would callously and carelessly endanger women's health and well-being.

NCJW believes that the above reasons alone should be enough to oppose HR 3, but this legislation does take an additional step that makes it especially offensive to NCJW and all Americans who value individual rights and freedoms. The "No Taxpayer Funding for Abortion Act" would erode our nation's guarantee of religious liberty.

We recognize that abortion is a complex issue – replete with moral, bio-ethical, philosophical and theological implications. What is clear is that the issue engenders strong feelings on all sides. Different religions have differing views on when life begins; and even within religions, there can be varying opinions. We submit that this diversity of opinions is a question that our nation has answered by upholding the key, founding principle of religious freedom. A central part of the United States Supreme Court's 1973 decision in *Roe v. Wade* recognized that different moral and religious traditions have differing views of abortion.

Reproductive rights are integrally bound up with religious freedom. As a faith-based women's organization, we understand that those who would restrict women's access to abortion and other reproductive health care services are often motivated by their religious belief and seek to impose their religious views on others. Yet, having freedom of choice means that women are valued as moral decision-makers and are free to make decisions about their reproductive lives based on their own religious beliefs

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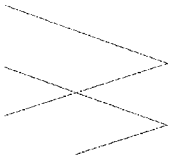

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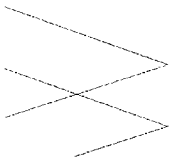
and conscience, in consultation with their physicians, families, and religious leaders – or whomever they choose to involve. For the legislature to mandate one religion's views on this very personal issue is to restrict religious liberty for all.

Judaism teaches that, during a pregnancy, the life of the mother takes precedence over the potential life of a fetus. In fact, the Jewish scholar, Rabbi Sofer, taught: "no woman is required to build the world by destroying herself."[2] We respect and recognize the right of religious groups whose beliefs differ from ours to follow the dictates of their faiths in this matter. But we ask no less for ourselves.

We oppose HR 3 because it blatantly disregards and undermines the basic right of our *freedom* to choose. And both *religious* freedom and *personal* freedom are the underpinnings of this right.

NCJW strongly and respectfully urges you to oppose HR 3. This legislation would take extreme measures that would not only impose discriminatory financial hardships on women and families and endanger women's health, but it would greatly impinge on religious freedom. As you deliberate the suitability and constitutionality of this legislation, we hope that you will take into account not only its detrimental impact on women's over-all health, equality, and economic opportunity, but also its impact on religious liberty.

[2] Resp. Hatam Sofer, E.H. No. 20



A PATH TO THE FUTURE.

A BELIEF IN ACTION.

Material submitted by the Center for Reproductive Rights

CENTER FOR REPRODUCTIVE RIGHTS

FACT SHEET

A Bait-and-Switch Attack on Reproductive Health: Radical New Anti-Choice Bill Would Deny Insurance Coverage to Millions of Women

On January 20, 2011, Rep. Chris Smith (R.-NJ) introduced extreme anti-choice legislation for consideration by Congress. While it is misleadingly called the "No Taxpayer Funding for Abortion Act" (H.R. 3), current law already imposes punishing restrictions on federal funding of abortion services, limiting it to documented rape and incest and to threats to the life of the pregnant woman.

The bill's sponsors assert that it would "merely codify" existing appropriations measures, but the bill is radically broad and is clearly intended to prevent all women from obtaining health insurance coverage for abortion services – even insurance paid for with private dollars or provided by employers in the private marketplace. **The bill would raise taxes on millions of American families and impose intrusive new government rules on private, personal medical decisions.**

It would remove important protections guaranteeing access to emergency services for women whose lives are in danger. Rape and incest survivors are also targeted by the law, which would exclude coverage for non-"forcible" rape victims and limit the incest exception to minors.

Even the bill's so called "codification" of restrictions annually voted on in Congress penalizes women who rely on government support to meet their basic medical needs. As the Center documented in a 2010 report, the Hyde Amendment and similar provisions cause delays in needed care that increase medical risks, and impose unconscionable hardships on poor women. **Yet abortion is an essential part of reproductive healthcare and one of the most common medical procedures sought by women; one in three women will have an abortion in her lifetime.**[1]

H.R. 3 Would Raise Taxes on Healthcare Coverage for Women and Families.

A majority of employer-based health plans now include abortion coverage.[2] H.R. 3 would create punishing new tax penalties designed to make coverage of abortion unavailable through private health insurance policies, stripping away coverage that millions of women currently have.

For example, the bill would:

- Ban tax credits for businesses that provide health plans that include abortion coverage, including the new Small Business Health Tax Credit, which was created to make health insurance affordable for small businesses and their employees.[3]
- Force self-employed individuals to pay new taxes on insurance plans if the plans include coverage for abortion.[4]
- Impose a ban on abortion coverage for women who purchase health insurance with premium assistance under the Affordable Care Act,[5] even though they would use their own private dollars to pay for part or most of the premiums.

Other Harmful and Discriminatory Restrictions in H.R. 3

For millions of women, federal programs are their only means of obtaining healthcare coverage. Current restrictions have imposed severe hardships on these women and others who get their insurance through federal employment:

- Poor women, who are subject to the severe limitations in the Hyde Amendment, which prevents women on Medicaid from accessing abortion coverage, are forced to go

without food or pawn household items as they struggle to raise the funds to pay for abortion services.[6] This struggle forces many women to delay obtaining services and have later abortions; others are forced to carry unwanted pregnancies to term.

- Servicewomen stationed overseas have been forced to turn to local medical facilities which may be inadequate or unsafe; some have even tried to self-abort.
- Restrictions on coverage for federal employees forced one woman to pay thousands of dollars after confronting incredibly difficult circumstances. After terminating a wanted pregnancy because she learned that the fetus had no brain and no chance of survival, she discovered that her federal insurance was barred from covering the procedure. In the midst of her grief, she was handed a $9,000 bill.[7]

Most of these restrictions have no home in permanent law. Instead, they are re-enacted each year in annual appropriations bills and have been changed many times. H.R. 3 would make these damaging restrictions permanent.

H.R. 3 would also deny home rule to the District of Columbia, forcing the District to remove abortion coverage from its own local Medicaid program. The District now uses its own funds to provide coverage for medically necessary abortions.

H.R. 3 Would Remove Protections for Women Facing Medical Emergencies by Permitting Patient "Dumping" by Hospitals

Currently, federal law ensures that a woman who needs emergency abortion care cannot be turned away by a hospital. Shockingly, H.R. 3 attempts to eliminate this reasonable and common-sense protection for patients at state and local government hospitals.

H.R. 3 would also deny protections to state and local government employees facing a life-threatening medical situations. Currently, employers that provide health insurance must ensure that policies cover abortion services in instances in which a woman's life is endangered. H.R. 3 would remove this fundamental protection for employees of state and local governments.

The Center for Reproductive Rights urges strong opposition to H.R. 3.

For more information, please contact:
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Endnotes

1 HEATHER D. BOONSTRA ET AL., ABORTION IN WOMEN'S LIVES 6 (2006), available at http://www.guttmacher.org/pubs/2006/05/04/AIWL.pdf.

2 Guttmacher Institute, *Memo on Private Insurance Coverage of Abortion*, Jan. 19, 2011, available at http://www.guttmacher.org/media/inthenews/2011/01/19/index.html.

3 I.R.C. § 45R.

4 Currently, to facilitate entrepreneurship, self-employed individuals can deduct the cost of healthcare premiums so as not to disadvantage them vis-à-vis those who have employer-based plans. I.R.C. § 162(l).

5 I.R.C. § 36B.

6 Center for Reproductive Rights, *Whose Choice? How the Hyde Amendment Harms Poor Women* (2010), available at http://reproductiverights.org/en/feature/whose-choice-how-the-hyde-amendment-harms-poor-women.

7 Statement of DJ Feldman on Harmful Impact of Abortion Coverage Restrictions, Nov. 16, 2009 at http://reproductiverights.org/en/feature/no-abortion-bar-statement-by-dj.

8 Emergency Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd.

CENTER FOR REPRODUCTIVE RIGHTS

FACT SHEET

Radical New Anti-Choice Bill Would Further Enshrine Anti-Choice Penalties for Poor Women

On January 20, 2011, Rep. Chris Smith (R-NJ) introduced extreme anti-choice legislation for consideration by Congress. While it is misleadingly called the "No Taxpayer Funding for Abortion Act" (H.R. 3), current law already imposes punishing restrictions on federal funding of abortion services.

H.R. 3 would make the Hyde Amendment – a ban on insurance coverage for abortion services for low-income women on Medicaid – even more intractable, because it would permanently codify a provision that must now be enacted by Congress as part of its annual appropriations measures. **The damage that would be done by H.R. 3 extends far beyond codification of the Hyde Amendment. The bill is clearly intended to prevent all women from obtaining health insurance coverage for abortion services – even insurance paid with private dollars or provided by employers in the private marketplace – and would raise taxes on millions of American families. But even simple codification of the Hyde Amendment would be tragic, because it has had a tremendously harmful effect on the lives of the most vulnerable women.**

The Facts on the Hyde Amendment

One in ten American women receives Medicaid, and women comprise more than two thirds of adult enrollees.[1] After Medicaid expansion goes into effect in 2014, millions more women will become part of the Medicaid program.[2]

The Hyde Amendment, named after a 1976 rider to the Appropriations Act sponsored by Representative Henry Hyde (R-IL), prevents the use of federal Medicaid funds for abortion except in cases of rape, incest, or endangerment of the life of the pregnant woman.

The few exceptions to the Hyde Amendment's strictures are exceedingly narrow. For example, the law denies abortion coverage to women who face serious health conditions. It also denies abortion coverage to survivors of domestic violence, despite the fact that abuse can often lead to unintended pregnancies and pregnancy often exacerbates abuse.

In practice, the bureaucratic hurdles for women to access the coverage provided by the exceptions to the Hyde Amendment also deny abortion coverage to survivors of rape and incest. While the law as written includes exceptions for cases of rape or incest, in reality, the long process required to seek Medicaid funding is often not desirable or even feasible. Women may be unable to go through the traumatizing experience of reporting and certification, and would have to continue their pregnancies for weeks while waiting for approval.

One abortion provider the Center recently interviewed reported the story of a minor who became pregnant after being raped by her mother's boyfriend. Local law enforcement was so moved by her situation that they took up a collection to help pay for an abortion.[3] In 2006, federal Medicaid funds went to cover a total of only 191 abortions under all three exceptions.[4]

Our Recent Findings on the Harm from the Hyde Amendment

A 2010 Report from the Center for Reproductive Rights documents this discriminatory policy's damaging effects. The Hyde Amendment forces women to continue unwanted pregnancies, causes them to delay receiving abortions, which increases medical risk, and imposes additional and significant financial strains on low-income and indigent women.[5]

The Center's researchers interviewed women about the many ways in which the Hyde Amendment's denial of coverage has harmed their lives. Below are some of their stories.

R.L. is a 26-year-old single mother, working and attending school full-time to become a registered nurse. Domestic abuse both led to her unintended pregnancy and created additional barriers to obtaining an abortion. R.L. thought her boyfriend seemed like the perfect man, as he was the son of two pastors, until they got engaged and he convinced her to quit her job and move to his extremely rural home. "Within 2 weeks, the abuse began . . . . I was cut off from everything I knew . . . . He didn't want me to work, so I was in a situation where I had to depend on him. . . . He would always threaten to kill me." R.L.'s boyfriend abused her physically and sexually both before and after he knew that she was pregnant. "I thought maybe I could think of something, get away, maybe keep the baby," she told us. "[B]ut it was so hard to get away from him." And once he discovered she was pregnant, the abuse became worse. "The forcing himself on me got worse, the not giving me food got worse, the taking it out on my kids got worse. . . . It took me two months to figure out how I was going to get an abortion."[6] The abuse left R.L. without a way to protect or provide for herself, and the Hyde Amendment left her without her only other means for medical care. When asked how the availability of Medicaid coverage would have affected her, she replied that it "would have changed a lot of things for me. I could have gotten away from [my abusive partner] a lot sooner. There was 10 weeks of me having to wait, panicking."[7]

C.M. is a 26-year-old single mother and disabled Iraq war veteran. Like many women, C.M. was working, going to school, taking care of her child, and trying to build a better life for her family, when an unintended pregnancy further complicated her life and burdened her already strained finances. "I worked nights until 4 or 5AM, then had a two-hour class from 9 to 11 [in the morning], then also classes on certain nights till 9 or 10. Then I'd have to pick up my son at 5 or so. . . . I'm also a disabled veteran . . . . I was diagnosed with post-traumatic stress disorder (PTSD, which I deal with constantly. I suffered a nervous breakdown in 2006 from PTSD, which is why I was working so hard to get my life back together . . . ."[8] Because of the Hyde Amendment, C.M. was forced to delay her abortion for over six weeks while she scraped together the necessary funds, forgoing bill and loan payments. As the weeks passed, the cost of the procedure continued to increase. By the time C.M. was able to obtain her abortion, the cost had risen to over $1,500, and she was forced to travel over 80 miles to undergo a more complicated, two-day procedure.

R.D. is a 27 year old single mother of two who works part-time and attends school full-time. Because the Hyde Amendment barred Medicaid from covering abortion services, it took R.D. weeks to raise the money she needed to obtain an abortion. Like C.M., because of that delay, she was forced to endure a two-day procedure. For R.D., one of the worst parts was the waiting, uncertain whether she would be able to pull together the money in time. "[T]he waiting was pretty awful. It was on my mind at all times. I lost 30 pounds not being able to eat, not being able to get it off my mind. What if I couldn't get the abortion, what was I going to do? At work and school, I just put on a happy face and did what I had to do. It's harder [to do the same] with [my] kids."[9]

These are just three of the millions of women subjected to compounded hardships because of the Hyde Amendment's denial of coverage for medical care. As our report documented, women have had to sell or pawn their possessions, forgo paying bills, get evicted for failure to pay rent, go hungry, and suffer the fear of not knowing whether they would be able to access the care they needed.[10]

Conclusion: H.R. 3 is Bad Policy for Women and Their Health

The Hyde Amendment undermines the goals of the very program that it restricts. Medicaid was created in order to ensure the provision of necessary healthcare to those too poor to otherwise afford it. In providing the Medicaid program, the government recognized that medical care is essential for all persons, yet at the same time is often out of reach of the poorest, whose health is often negatively affected by poverty and lack of access to healthcare. Abortion is the only medically necessary service that Medicaid cannot include.

Abortion is an essential part of reproductive healthcare and one of the most common

medical procedures sought by women. Yet the Hyde Amendment denies necessary abortion coverage to millions of women for the crime of being poor. Under H.R. 3, millions more women would confront these same obstacles.

The Center for Reproductive Rights urges strong opposition to H.R. 3.

For more information, please contact:
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Endnotes

1 Ctrs. for Medicare and Medicaid Servs., U.S. Dep't of Health and Hum. Serv., Medicaid Program – General Information, http://www.cms.hhs.gov/MedicaidGenInfo/ (last visited Jul. 22, 2010).

2 Kaiser Family Foundation, *Impact of Health Reform on Women's Access to Coverage and Care* (Dec. 2010), available at http://www.kff.org/womenshealth/upload/7987.pdf.

3 Center for Reproductive Rights, *Whose Choice? How the Hyde Amendment Harms Poor Women* 35 (2010), available at http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Hyde_Report_FINAL_nospreads.pdf.

4 Adam Sonfield, Casey Alrich & Rachel Benson Gold, Public Funding for Family Planning, Sterilization and Abortion Services, FY 1980-2006 (Occasional Report No. 38) 27 (2008), available at http://www.guttmacher.org/pubs/2008/03/28/or38.pdf.

5 Center for Reproductive Rights, *Whose Choice? How the Hyde Amendment Harms Poor Women* 11 (2010), available at http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Hyde_Report_FINAL_nospreads.pdf.

6 *Id.* at 25.

7 *Id.* at 24.

8 *Id.* at 27-28.

9 *Id.* at 28.

10 *Id.* at 28-29.

Material submitted by DC Vote

Congressional Interference Fact Sheet

Reproductive Rights: Congress is considering legislation, the **No Taxpayer Funding For Abortion Act (H.R. 3)**, which would for the first time **redefine DC as part of the federal government, overriding the autonomy afforded the District by the Home Rule Act** when it comes to abortion funding. While other localities could use their local funds to cover reproductive healthcare, the bill bars DC from doing the same under this bill.

Section 310 of the bill reads:

> (1) Any reference to funds appropriated by Federal law shall be treated as including any amounts within the budget of the District of Columbia that have been approved by Act of Congress pursuant to section 446 of the District of Columbia Home Rule Act (or any applicable successor Federal law).
>
> (2) The term `Federal Government' includes the government of the District of Columbia.

The battle over abortion funding in DC has raged for 30 years. From 1980 to 2009, Congress prevented the District of Columbia (and no other state) from using its own locally-raised tax dollars to fund reproductive healthcare for Medicaid-eligible women. In 2009 this restriction was lifted by Democrats in Congress. However, the new Republican majority in the 112th Congress has reintroduced the restriction in a bill specifying that DC's locally-raised funds should be considered federal funds and its government part of the federal government, effectively nullifying Home Rule in the District in this instance.

History of Congress interfering in DC's local health care decisions:

HIV/AIDS Prevention Programs: Washington, DC has the nation's highest incidence of HIV/AIDS, surpassing the threshold to officially be designated an "epidemic." From 1999 to 2008, Congress prohibited DC from using funds for syringe access programs, which has been proven in other metropolitan areas as the most effective way to prevent drug users from spreading HIV/AIDS. In 2009, the District found that at least 3% of District residents have the disease, a 22% increase since 2006.

Medical Marijuana: In 1998, two weeks before 69% of DC citizens approved ballot Proposition 59 to legalize medical marijuana, Representative Bob Barr (R-GA) added a rider to the Appropriations bill that forbade DC from using funds to count or certify the vote on the Proposition. In 2010, the rider was eliminated by Democrats, The DC Council has passed a law to enact the program and is developing distribution regulations. However, with other progressive local laws under attack, DC is bracing for congressional interference in this program as well.

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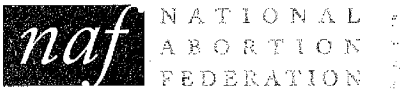
Press Release from the National Abortion Federation (NAF)



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FOR IMMEDIATE RELEASE
February 8, 2011

Smith Bill is Unprecedented Attack on Women's Access to Abortion Care

Statement of Vicki Saporta, President and CEO of the National Abortion Federation (NAF):

The Smith Bill is an unprecedented attempt to restrict women's access to abortion care. This bill would prevent millions of American women from obtaining private insurance coverage for abortion care even if they pay with their own funds. It would also permanently deny abortion coverage for vulnerable women who depend on the federal government for their health care, and prohibit access to abortion care even for women in life-threatening, emergency situations at public hospitals.

This bill could have devastating consequences for the more than one million women who choose abortion each year—women like Dana Weinstein who is standing with House Judiciary Democrats today to oppose this bill and explain how its provisions would have affected her ability to make the decisions that were best for her family. Dana chose to terminate her wanted pregnancy after she learned that her fetus was missing the main part of its brain and would likely not survive [full story below]. The Smith Bill would deny coverage for abortion care even in cases like Dana's.

It is unconscionable that anti-choice legislators are continuing their attempts to further restrict access to abortion care for women like Dana. Abortion care is basic health care for women and should not be treated differently from other health care services.

Representative Chris Smith's agenda is so extreme that this bill originally attempted to redefine rape and incest. Although he says he will give up these efforts after weeks of public outrage, the rest of the bill's provisions are also extreme and would adversely affect the lives and health of women. NAF calls on the House Judiciary Committee to defeat these extreme attacks on women and ensure that women can access the abortion care they need.

Statement of Dana Weinstein on Harmful Impact of Smith Bill

Good afternoon. My name is Dana Weinstein. In July 2009, I was happily pregnant and excitingly, anxiously expecting the arrival of our second child. For nearly 8 months, I had been loving my baby in utero and explaining to our then 2.5 year old son that he was going to become a big brother. Never, EVER did I imagine I would need to have an abortion...and certainly not one so late in my pregnancy.

At my 28 week sonogram the ventricles in our baby's brain measured a little elevated and my perinatologist arranged for further testing. Two weeks later, I had an MRI performed to see what was going on inside my baby's head. It was then that we learned the shocking, horrific, and devastating news. Our baby was missing a main piece of its brain...the part that connects the right and left hemispheres literally wasn't there. It never developed. This is known as

agenesis of the corpus callosum. Even worse, the surface of the brain was malformed and severely underdeveloped, a condition called polymicrogyria. Additionally, where brain mass and tissue should have grown and been plentiful, only large pockets of empty space and gaping holes existed. Despite all the prenatal care and testing I had throughout the pregnancy, this was not detected until I was seven and a half months along. And no amount of surgery, medicine or physical therapy could reverse, improve, or fix this horrendous diagnosis.

We learned that because of the severe brain anomalies, our baby would have had on-going seizures 70% of the time. And that was best case scenario. Our daughter would lack the physical coordination to suck, swallow, feed, walk, talk or know her environment—if she survived birth at all. The sonogram already showed the baby was not swallowing. And in hindsight, I believe her constant, non-stop movements—movements that I so lovingly joked about throughout the pregnancy as being payback for having a calm, easy-going first child—were the result of spasms caused by the brain abnormalities.

If we had carried our baby to term, we would have needed a resuscitation order in place prior to giving birth as she was incapable of living without significant medical assistance.

We did not want our daughter to exist solely because of machines. We did not want to bring a child into this world that would only be here in a vegetated state, if at all. For our baby, for our son, and for our family, my husband and I made the heartbreaking decision to terminate the pregnancy. We did what I believe was the most loving, humane act a parent could do—put an end to our baby's suffering.

Because I was late in my pregnancy, I had to travel to Colorado to one of a handful of facilities in the U.S. that provides later abortion care. It was awful to go through the hell of ending my very much wanted and loved pregnancy and to have to do it across the country, so far from my home and loved ones.

My upfront medical expenses were $17,500, which does not include an additional $3,000 in travel costs to obtain care. Since I had to go to an out of network provider, the maximum my insurance would cover was just $1,200. With the help of legal counsel and more than a year of appealing, my insurance company finally agreed to cover the total cost of my abortion care. The financial stress caused my family unnecessary anxiety during an already heartbreaking, devastating, and frightening time.

To be forced to carry a pregnancy to term because of a lack of financial resources or insurance coverage is beyond cruel, especially in situations like mine. The week I had to endure between learning the devastating diagnosis and when I could begin the termination process was agonizing. Each constant movement of my baby—movement that for months had brought me such joy and reassurance—was like a dagger to my heart. Looking down at my full pregnant belly knowing how sick my daughter was, and knowing that she would not live was horrendous. To force women to endure this for weeks or even months and give birth because of a lack of medical coverage is outrageous.

I am appalled that Congress is taking up this issue again. I can't help but ask...what about circumstances like mine? How can families facing such a terrible prognosis be omitted from abortion coverage? We exist and as painful as it is to talk about, we need to be heard and we need to be considered.

To say I am angered by those who are trying to prevent abortion coverage in the health care system is an understatement. I applaud our leaders and members of the Judiciary Committee here today who are taking the brave step in fighting against those trying to prevent women like me from being allowed to have the option to terminate my pregnancy and to have insurance coverage.

I am speaking today for all the women who are too fearful or made to feel ashamed, to put a face on abortion. I'm speaking today on behalf of my daughter, who I know is in a much better place. And, I'm speaking today for all of the women, who like me just a year and a half ago, never imagined they would need the help of an abortion.

Thank you for your time.

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The National Abortion Federation (NAF) is the professional association of abortion providers in North America. Our mission is to ensure safe, legal, and accessible abortion care, which promotes health and justice for women. Our members include clinics, doctors' offices, and hospitals, who together care for more than half the women who choose abortion each year in the United States, Canada, and Mexico City. For more information, visit our website at www.prochoice.org.

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