H.R. _____, A BILL TO AMEND THE PATIENT PROTECTION AND AFFORDABLE CARE ACT TO MODIFY SPECIAL RULES RELATING TO COVERAGE OF ABORTION SERVICES UNDER SUCH ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

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H.R. ———, A BILL TO AMEND THE PATIENT PROTECTION AND AFFORDABLE CARE ACT TO MODIFY SPECIAL RULES RELATING TO COVERAGE OF ABORTION SERVICES UNDER SUCH ACT

WEDNESDAY, FEBRUARY 9, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 1:06 p.m., in room 2322 of the Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Shimkus, Myrick, Murphy, Blackburn, Gingrey, Latta, McMorris Rodgers, Lance, Cassidy, Guthrie, Upton, Pallone, Dingell, Towns, Engel, Capps, Schakowsky, Gonzalez, Baldwin, Weiner, and Waxman (ex officio).

Also present: Representative DeGette.

Staff present: Gary Andres, Staff Director; Jim Barnette, General Counsel; Michael Beckerman, Deputy Staff Director; Alison Busbee, Legislative Clerk; Howard Cohen, Chief Health Counsel; Marty Dannenfelser, Senior Advisor, Health Policy & Coalitions; Julie Goon, Health Policy Advisor; Peter Kielty, Senior Legislative Analyst; Ryan Long, Chief Counsel, Health; Jeff Mortier, Professional Staff Member; Katie Novaria, Legislative Clerk; Heidi Stirrup; Lyn Walker, Coordinator, Admin/Human Resources; Karen Nelson, Deputy Democratic Staff Director for Health; Ruth Katz, Chief Public Health Counsel; Steve Cha, MD, Professional Staff; Phil Barnette, Democratic Staff Director; Karen Lightfoot, Communications Director; Alli Corr, Special Assistant for Health; and Mitch Smiley, Associate Clerk.

Mr. PITTS. The subcommittee will come to order. The chair will recognize himself for an opening statement.

OPENING STATEMENT OF HON. JOSEPH PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. First, I would like to thank my colleagues on both sides of the aisle for being here today for what promises to be a very interesting hearing. The new Republican Majority has stated its commitment to an open and fair legislative process, and that will be reflected in this subcommittee. I ask all of my colleagues

and our audience to treat each other and our witnesses with civility and respect. This hearing is an important part of the legislative process and we will conduct it accordingly. I would also like to acknowledge my friend, the Ranking Member, Mr. Pallone of New Jersey. Pennsylvania and New Jersey are as close together as the Phillies and the Yankees are far apart. This Phillies fan intends to work as closely as possible with Mr. Pallone, the Yankees notwithstanding.

I believe there are a great many things we can work on together for the good of this country, and I look forward to cooperating with you this year. When we disagree I hope we will always do so with dignity and respect, treating those who may disagree with dignity and respect. And I promise to do that on my part.

Pursuant to committee rules, I intend to make an opening statement of not more than 5 minutes and will then recognize the ranking member, Mr. Pallone, for an opening statement. The chairman of the Committee, Mr. Upton, will then have a chance to give an opening statement followed finally by the ranking member of the Committee, Mr. Waxman.

Today we will hear testimony from one panel of three witnesses, two invited by the majority, and one invited by the minority. All sides of the debate will be heard today and every member will have a chance to question each of the witnesses.

The testimony we will hear today regards the prohibition of taxpayer funding of abortion and abortion coverage. For decades there has been a clear prohibition against the use of federal dollars to pay for abortion. The Patient Protection and Affordable Care Act opened the door, for the first time in decades, to government financing of abortion. My colleagues will recall that the House acted affirmatively to fix this in a strongly bipartisan vote of 240 to 194 to 1. We are all aware that abortion itself can be a controversial subject. What is far less controversial is the question of whether the taxpayers should be financing it. The so-called Stupak-Pitts amendment last session affirmed the view of 60 to 70 percent of Americans that government taxpayer money should not be involved in abortion. Unfortunately, the Senate did not see fit to include the House prohibition in its version of the bill and it was the Senate Bill that became law.

We need to be clear about some things as we start. The government does not finance abortions and has not done so for decades thanks to the Hyde amendment. Moreover, the government has never told any medical professional or medical institution that it must perform abortions. This bill seeks to clarify these policies and give them permanence.

The President has on at least two occasions affirmed what we are doing her today. In his 2009 speech to a joint session of Congress, the President said, and I quote: "Under our plan no federal dollars will be used to fund abortions and federal conscience laws will remain in place." A year later in his Executive order, the President clearly endorsed the principle of no government funds going to abortion and again, clearly endorsed the principle of not forcing health care professions to act against the dictates of conscience. But an Executive order is not law. It can be rescinded at any time

by this or any future president. It can be overturned by a judge or simply ignored.

If we wish to respect the views of those who do not want their money used to finance abortion, if we wish to follow the wishes of 60 to 70 percent of Americans who believe the government should not pay for the procedure, then Congress should send this bill to President in short order. The President is clearly on record supporting the principles in the bill and when it gets to his desk, I hope he will sign it.

I think I have how much time—40 seconds. I will yield the remainder of my time to gentleman from Ohio, Mr. Latta.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The Chair will recognize himself for an opening statement.I'd like to thank my colleagues-on both sides of the aisle-for being here today for what promises to be a very interesting hearing.

The new Republican Majority has stated its commitment to an open and fair legislative process, and that will be reflected in this subcommittee. I ask all of my colleagues and our audience to treat each other and our witnesses with civility and respect. This hearing is an important part of the legislative process and we will conduct it accordingly.

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I believe there are a great many things we can work on together for the good of this country. I look forward to cooperating with you this year.

When we disagree, I hope we will always do so without being disagreeable. I promise to do my part.

Pursuant to committee rules, I intend to make an opening statement-of not more than five minutes-and will then recognize the Ranking Member, Mr. Pallone, for an opening statement. The Chairman of the Committee, Mr. Upton, will then have a chance to give an opening statement-followed, finally, by the Ranking Member of the Committee, Mr. Waxman.

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Unfortunately, the Senate did not see fit to include the House's prohibition in its version of the bill, and it was the Senate bill that became law.

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This bill seeks to clarify these policies and give them permanence.

The President has on at least two occasions affirmed what we are doing here today. In his 2009 speech to a joint session of Congress, the president said, and I quote: "under our plan, no federal dollars will be used to fund abortions, and federal conscience laws will remain in place."

A year later, in his Executive order, the president clearly endorsed the principle of no government funds going to abortion and-again-clearly endorsed the principle of not forcing healthcare professionals to act against the dictates of conscience.

But an executive order is not law. It can be rescinded at any time by this or any future president. It can be overturned by a judge, or simply ignored.

If we wish to respect the views of those who don't want their money used to finance abortion, if we wish to follow the wishes of the 60 to 70 percent of Americans who believe the government should not pay for the procedure-then Congress should send this bill to the President in short order.

The President is clearly on record supporting the principles in this bill. When it gets to his desk, I believe he will sign it.

The gentleman from New Jersey, the Ranking Member, Mr. Pallone, is now recognized for five minutes for an opening statement.

The Chairman of the full committee, Mr. Upton, is now recognized for an opening statement.

The Ranking Member, Mr. Waxman, is now recognized for an opening statement.

Mr. LATTA. I thank you, chairman, for yielding and for holding this very important hearing on the Protect Life Act. And as the chairman designated in his opening remark stating that the majority of Americans are opposed to the Federal Government funding abortion. And the question, of course, came up during the bill, the "Obamacare" legislation as to the use of federal taxpayer dollars to allow that coverage and also for the Stupak-Pitts amendment that was first supported, and then unfortunately we did not have, and then, of course, the Executive order.

So I would just like to say, Mr. Chairman, that we have to be vigilant in our defense of human life and work past the Protect Life Act so that the government funding is not used to pay for abortions through the Federal Government. The Anti-life policies cannot be tolerated and it is because it is absolutely morally wrong and opposed by again as I said the majority of tax payers. The passage of the Protect Life is the first step towards putting an end once and for all for all taxpayer funding of abortion as well as fixing a deeply flawed health care bill. And I look forward to the hearing and when the bill becomes law. I yield back.

Mr. PITTS. The gentleman's time has expired. The gentleman from New Jersey, the Ranking Member Mr. Pallone is now recognized for 5 minutes for an opening statement.

Mr. PALLONE. Thank you, Chairman Pitts. I look forward to working alongside you as well and the subcommittee and it is my hope that we can meet some common ground during this Congress. And I appreciate the comments you made in that regard. I just wanted to say briefly I remember the time when you—I told you I was going to the University of Pennsylvania farm in your district and I had a grand old time there with the pigs and the cows and all the other farm animals. And you still represent a good part of Lancaster County——

Mr. PITTS. All of Lancaster.

Mr. PALLONE [continuing]. Which is a wonderful, peaceful, quiet place—the Amish, and it is just a nice place, so let us work together. I definitely think we can.

Regardless of any one person's views, though, on the topic today, I want to stress the current law is clear. No government funding can be used for abortion under the Affordable Care Act except in cases of rape, incest, and to save the life of the woman. And today is not about public funding in my opinion. Today is an attempt by my colleagues on the other side of the aisle to reopen the contentious issue of abortion and dismantle the landmark healthcare law. The bill before us in my opinion is too extreme. It is a massive

overreach from what was delicately negotiated during health reform and it extensively restricts women's access to reproductive health services and life saving care. Its language does more than prevent federal funds from going to abortions. It is a step towards eliminating a choice that our Supreme Court has deemed legal and remains legal to this day. Religious and personal views should not put women's lives at risk.

Under current law, health care providers are obligated to provide emergency services, otherwise stabilize a patient, and make available the transfer to another facility should they take issue with performing abortion procedures. This bill eliminates these minimum moral obligations even to save a woman's life. The bill in my opinion is not pro-life. It is anti-woman. The same members of this committee who voted to repeal the Affordable Care Act last month charged that it will interfere with the doctor/patient relationship. And I can't think of a policy that is more intrusive of a doctor/patient relationship than the one before us today.

I strongly believe women need and are entitled to safe, affordable health care options and this bill only serves to create health and financial challenges that may be impossible to overcome. Now I—whatever time I have left, Mr. Chairman, I would like to yield a minute each to Ms. Capps, Ms. Baldwin, and Ms. Schakowsky in that order. We will see if we can accommodate all three in my time and so start with Ms. Capps.

Mrs. CAPPS. Thank you, Mr. Pallone. As you just stated, the notion that the Affordable Care Act allows for funding of elective abortion is false. So I must ask with national unemployment at 9 percent and the potential that we have right here in this subcommittee to create and strengthen a critical work—health care work force of the jobs there, why are we here debating this extreme legislation that would instead take reproductive rights away from women. Mr. Chairman, the debate today isn't about tax dollars or provider conscience. Instead it is about chipping away at the legal rights of women, including the right to receive life saving treatment or referrals from a hospital emergency room. Not even the Stupak Amendment we fought over last year tried to change this.

It is disappointing that this committee, one that is so important to job creation and the economy is wasting our time on this extreme legislation. And it is downright appalling that we are spending our first hours as a subcommittee in this Congress trying to restrict a woman's right. Now, instead—rights—instead of rehashing the culture wars we should be using our time in this subcommittee doing what the American people really want us to do, strengthen the economy and create jobs. And I yield to my colleague, Ms. Baldwin.

[The prepared statement of Mrs. Capps follows:]

PREPARED STATEMENT OF HON. LOIS CAPPS

Thank you, Mr. Chairman.I am troubled that we are here, rehashing the phony debate that the Affordable Care Act will become some sort of conduit for abortion payments.

This is false.

The non-partisan "fact-check.org" website makes it clear: the new law does not provide direct federal funding for abortion, except in cases of rape or incest, or to save the life of the pregnant woman.

In fact, the new health care reform law goes further.

It states specifically that federal funds are not to be used for coverage of any other kinds of abortions.

Add to this the existing Hyde Amendment, which has continuously been in law since the 1970s.

And the President's Executive Order specifically reaffirming that the provisions in the Hyde Amendment carry over to the new health care law.

So, I must ask, with national unemployment at 9 percent, and the potential that we have-right here in this committee-to create and strengthen healthcare workforce jobs, why are we here debating this extreme legislation that would take reproductive rights away from women, again?

Mr. Chairman, the debate today isn't about tax dollars, instead it is about chipping away at the legal rights of women, one extreme provisions at a time.

Perhaps Henry Hyde's own words describe the intent of those who support this extreme legislation best:

He proclaimed: "I would certainly like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle class woman, or a poor woman."

A careful read of the text shows that this bill does not just "codify Hyde."

Instead it goes far beyond:

Original text of the bill-language signed on to by 173 anti-choice members of Congress would have limited rape and incest provisions to levels never before seen-"no means no" would not have been enough.

After public outcry, this language has been changed, but another, extreme, life-threatening provision has been added.

Specifically, the bill includes language to exempt hospitals from EMTALA requirements to treat or provide referrals to women in need of life-saving emergency abortion care, even if they will die without it.

Not even the Stupak amendment we fought over last year tried to change this.

This bill's name is misleading-it does not protect life-instead it puts women and their families in danger.

It is not a so-called protection of tax dollars-it is a not-so-veiled attempt to roll back the rights of all women by infringing on the way they spend their own money and the decisions they make for themselves.

It is disappointing that this Committee, one that is so important to job creation and the economy is wasting our time here today.

And it is downright appalling that we are spending our first hours as a subcommittee on legislation that is all about restricting women's rights.

Instead of rehashing the culture wars, we should be using our time in this subcommittee to do what the American people really want-strengthen the economy and create jobs.

I yield back.

Ms. BALDWIN. Thank you. I share your concern that the very first hearing that we are having in this Congress isn't about creating jobs or bolstering our economy or helping families get health care coverage. Instead the majority has demonstrated that its top priority is attacking women's rights. This legislation takes away a woman's ability to make their own important life decisions about their reproductive health. And for—and this bill gives the government and insurance companies new power to make these decisions for them. And for that reason I think this legislation is extreme. This legislation is an unprecedented display of lack of respect for American women and for our safety. The bill would cut off millions of women from the private care that they have today. It would deny individual decision making by giving insurance companies more power and it would allow public hospitals to deny life saving care and dictate what women can do with their own health care dollars. With that I yield time to Jan Schakowsky.

Ms. SCHAKOWSKY. I would like to use that time to ask the chairman if I could offer for the record from the Catholic Health Association a letter which takes exception with some of the provisions—one of the provisions of the bill and also from the National Partner-

ship for Women and Families, and the National Health Law Program.

Mr. PITTS. Without objection it will be added to the record.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. All right, the gentleman's time is expired. Thanks. Thank you to those who made statements and now the chair would recognize the chairman of the Full Committee, Mr. Upton, for 5 minutes or such a time as he may consume.

Mr. UPTON. Thank you, Mr. Chairman. I intend to use 1 minute and then yield 2 minutes to Dr. Burgess, a minute to the vice chair Sue Myrick, and a minute to Cathy McMorris Rodgers. So in my minute I want to again thank you, Mr. Chairman. The discussion draft before us closely tracks the Stupak-Pitts amendment that the house adopted by a strong bipartisan majority in the last Congress. This includes the Hyde amendment language that has continuously been adopted by Congress since 1993. Unfortunately the massive health care plan that was ultimately enacted by Congress contains numerous loop holes that allow federal subsidies to be used to purchase plans that pay for abortions.

This bipartisan legislation today proposed by Chairman Pitts amends the health bill to clearly and statutorily prevent federal funding for abortion or abortion coverage through government exchanges, community health centers, or any other program funded or created by the new law. Additionally the bill protects the right of the conscience for health care professionals and assures that private insurance companies are not forced to cover abortion. I ask unanimous consent that my full statement be part of the record. I now yield to Dr. Burgess.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Thank you Mr. Chairman, the Discussion Draft before us closely tracks the Stupak-Pitts amendment that the House adopted by a strong bipartisan majority during the 111th Congress. This includes the Hyde amendment language that has continuously been adopted by Congress since 1993.

Unfortunately, the massive health care plan that was ultimately enacted by Congress contains numerous loopholes that allow federal subsidies to be used to purchase plans that pay for abortions. This legislation proposed by Chairman Pitts amends the health bill to clearly prevent federal funding for abortion or abortion coverage through government exchanges, community health centers, or any other program funded or created by the new law. Additionally, this bill protects the right of conscience for health care professionals and ensures that private insurance companies are not forced to cover abortion.

Those of us who support the Hyde amendment are encouraged by the fact that its enactment has contributed to a reduction in the number of abortions and saved the lives of thousands of unborn children. A clear majority of Americans share our view that taxpayers' dollars should not be used to pay for elective abortions. President Obama, among others, says that he wants to make abortion "rare". Let's find common ground on this legislation by acknowledging that abortion is not health care and conscientiously opposed taxpayers should not be forced to subsidize abortion.

Mr. PITTS. Without objection so ordered.

Mr. BURGESS. I thank the gentleman for yielding and just a couple of observations as we take up this legislation today. The Protect Life Act is not applying anything new. It is not applying restrictions. It merely extends the status quo, that taxpayer dollars will not be used to subsidize elective abortions, and that is it. Similar

language has been—is found in the Hyde amendment, that was passed in 1976, and has been reauthorized in each Congress throughout the appropriations process. H.R. 358 is only preserving language that Congress and doctors and patients have relied upon for decades. It does not change or alter the practice of medicine or the responsibility of physicians in any way. Past and present the Congress has said we will not pay for elective abortions. That does not change in this legislation.

Now, in my prior life I was a doctor. I am a doctor. I am an OB/GYN and I do value the sanctity of human life. I do believe that it is a miracle that it can even occur and for us to interfere in a harmful way is something that as an OB/GYN I think it wrong. But I understand that some people do feel differently. I think it is important to codify with this language that we are responsible for the judicious use of taxpayer dollars. Now as a doctor, I am sworn to aid those in need and I reject when people say this legislation would prevent doctors from providing care in times of need. Integrity and the relationship with patients upholding the oath that we all take as physicians are fundamentals. Arguments that people will be harmed, let alone left to die at the door, are just simply not true. There is a suspension of belief required to think that elective abortions versus medically necessary procedures are—can in fact be comingled. I see my time is at an end. I will yield to the——

Mr. UPTON. Vice Chairman.

Mr. BURGESS [continuing]. Vice Chairman.

Mr. UPTON. Sue Myrick.

Mrs. MYRICK. Thank you, Mr. Chairman. I am pleased to speak on behalf of this bill and I believe it represents a necessary improvement to the Patient Protection and Affordable Care Act that was signed into law last year. Americans broadly agree that taxpayer money should not subsidize elective abortions. This bill doesn't affect the legality of abortion services for American women. It is not a sea change from current policy. In fact, it merely carries forth what is already true for federal health programs such as the Federal Employee Health Benefit Program, Medicaid, SCHIP, and the Indian Health Service. To my knowledge there is no evidence that prohibition of coverage for elective abortions in these programs has negatively impacted women's health. I look forward to the testimony from our witnesses and I yield back.

Mr. UPTON. And the chair recognizes Cathy McMorris Rodgers.

Ms. MCMORRIS RODGERS. Thank you, Mr. Chairman. I, too, want to speak in support of the legislation. If we are committed to health care reform for everyone including women and children then health care protections for children should start at the moment their lives begin. We agree to allow children to stay on health care plans until age 26. We agree to provide our children's coverage for pre-existing conditions, and eliminate annual and lifetime caps, but what does it all mean if we are not going to protect them at the moment their lives begin? Two thirds of women polled during the health care debate representing all parties, races, marital statuses objected to the Federal Government paying for abortions. I would urge all of my colleagues to join in supporting the Protect Life Act and I yield back the balance of my time.

Mr. PITTS. The chair thanks the members for their statements. The ranking member of the Full Committee, Mr. Waxman is now recognized for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you very much, Mr. Chairman. I think we have to put this legislation in the context of this bill and other bills that are also moving in other committees on this very subject of abortion. Let there be no doubt about it. The objective is not to say the taxpayer's funds cannot be used for paying for a termination of a pregnancy. The objective of all this legislation is to say no woman will be able to buy insurance in this country that will cover a necessary medical procedure involving the termination of a pregnancy. Even though it is legal and it is a medical decision now will be taken over by the Congress to be made for the women involved.

The Affordable Care Act had a very sensitive, delicate balance and it was drafted in the Senate by Senator Nelson, whose pro-life record speaks for itself. That law prohibits the use of federal funds for abortion, keeps state and federal abortion related laws in place, it would not allow government tax credits to be used to pay for abortion services, but this bill goes beyond that. It would provide that there would in reality be no insurance policy for anybody buying in an exchange for health insurance to get a policy that would cover the termination of a pregnancy, even when it is medically necessary. This is an assault on women's reproductive health and their constitutional rights to choose when to bear children. Mr. Chairman, I would like to ask unanimous consent that I be able to yield 2 minutes of my time to Ms. DeGette, who is not a member of this subcommittee, but a member of the Full Committee.

Mr. PITTS. Without objection.

Ms. DEGETTE. Thank you very much, Mr. Chairman. There are some days in Congress I feel like I am in Alice in Wonderland where everything is upside down and today is certainly one of those days. The extreme legislation that we are considering today is not just simply saying that there shall be no public funds for abortion. That is already the law. That is the Hyde amendment. I disagree with the Hyde amendment, but in the annual HHS Appropriations Bill every year it says no federal funds shall be used for abortion. This was also protected in the health care legislation last year.

Let us be clear about what this extreme bill does. What this bill says is first of all it does codify Hyde, which is far beyond current law. But secondly, it says that anybody who purchases an insurance policy—an employer, or any American, male or female who purchases an insurance policy that covers all legal reproductive services now cannot have any kind of tax relief. So it is not about direct federal funding of abortion. We don't have that. We don't have that. What it is about is saying these indirect tax credits now will be interpreted as federal funding. That is the most vast restriction of a woman's right to choose that any of us will ever see in our lifetimes and what it would lead to if it became law is that no individual in this country or business in this country could pur-

chase an insurance policy that covered the full range of legal reproductive services unless they suffered essentially a tax increase.

Mr. WAXMAN. Thank you, Ms. DeGette.

Ms. DEGETTE. It is wrong. It is intrusive. And we just need to call it what it is. Thank you, Mr. Chairman.

Mr. WAXMAN. I yield the rest of my time to Ms. Schakowsky.

Ms. SCHAKOWSKY. Thank you, Mr. Waxman. Republicans ran on the promise of smaller government, but in fact it looks as if they want to reduce the size of government to make it just small enough so that it can fit in our bedrooms. This extreme legislation is an unconscionable intrusion into the important, and often wrenching, and often devastating life decisions of American women and their families. Not a single American woman's rights are safe under this extreme bill. Already the Hyde amendment unfortunately makes sure that poor women and federal employees and military women can't get the full benefits under the federal plans. But what this says is that women with their own money will be restricted from purchasing full reproductive services, including the right to terminate a pregnancy. It does raise taxes on businesses and individuals. One hundred sixty-three Republicans wanted to change the definition of rape. I think that is out of that bill now saying it can only be forcible. You have to prove that you were beat up I guess. And this can deny emergency care to save a woman's life. Let us do what the American people want. Let us create jobs. Let us get to the business of the economy and start limiting the rights of women in America.

Mr. PITTS. The chair thanks the members for their statements and we will now turn to our witnesses. Each of you has prepared statements that will be a part of the record, but I ask that you summarize your prepared statements in 5 minutes.

Our first witness is an Associate Professor of Law at George Mason University School of Law, Helen Alvaré. Professor Alvaré received her law degree at Cornell University in 1984 and a Master's Degree in Systematic Theology from the Catholic University of America in 1989. She has practiced law with the Philadelphia firm of Stradley Ronan Stevens & Young specializing in commercial litigation and free exercise of religion matters. She also worked for the National Conference of Catholic Bishops drafting amicus briefs on abortion and a variety of U.S. Supreme Court cases.

Next, we will hear from Professor Sara Rosenbaum, a Department of Health Policy Chair from George Washington University. Professor Rosenbaum received her Jurist Doctorate from Boston University Law School and has focused her career on health care access for low income, minority, and medically underserved populations. She also worked for the White House Domestic Policy Council during the Clinton Administration where she directed the drafting of the Health Security Act. While serving on numerous national organizational boards, she has also co-authored a help law textbook "Law and the American Health Care System".

Finally, we will hear from Douglas Johnson, Federal Legislative Director from the National Right to Life Committee, who will offer his testimony. Mr. Johnson has served as the Legislative Director of the NRLC since 1981. Over the past several years, Mr. Johnson has written extensively on the abortion related issues raised by

various bills to restructure the health care system including the Patient Protect and Affordable Care Act. He has also published extensively on other right to life issues, including partial birth abortion, fetal homicide, and human cloning, as well as on issues relating to restrictions on political free speech and critiques of how the news media covers some of these issues. So at this point I will recognize Ms. Alvaré.

STATEMENTS OF HELEN M. ALVARE, ASSOCIATE PROFESSOR OF LAW, GEORGE MASON UNIVERSITY SCHOOL OF LAW; SARA ROSENBAUM, J.D., HIRSH PROFESSOR AND CHAIR, DEPARTMENT OF HEALTH POLICY, SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES, THE GEORGE WASHINGTON UNIVERSITY; AND DOUGLAS JOHNSON, LEGISLATIVE DIRECTOR, NATIONAL RIGHT TO LIFE COMMITTEE

STATEMENT OF HELEN M. ALVARE

Ms. ALVARE. Thank you, Mr. Chairman. Good afternoon and thank you for this opportunity. My testimony today will address conscience protection in health care under the Protect Life Act. Initially I want to say that there is no need for us to view the matter of conscience protection as a zero-sum game between conscience-driven health care providers and the patients they serve particularly the most vulnerable. Opponents of conscience protection are portraying the situation this way but the opposite is true. It is by protecting conscience and elevating respect for life in health care that we are likely as a Nation to serve and reflect the values of most Americans particularly the vulnerable.

This can be understood from several angles. First, less privileged women are less likely to support abortion or abortion funding then their more privileged sisters or than men. They are also less likely to abort their nonmarital pregnancies than more privileged women. Second, abortion has not mainstreamed into American health care even 38 years after Roe. It remains, in the words of the New York Times "at the margins of medical practice". This, I believe, is why opponents of conscience want to force the government and conscience-driven providers to give them what the market has steadfastly refused—dispersed sources for abortions in hygienic medical settings.

Instead, today we have this: 87 percent of counties with no abortion provider, a small percentage of doctors willing to perform it according to the Guttmacher Institute because of stigma issues. Ninety-five percent of abortions delivered in clinics and not hospitals or doctor's offices. Just recently even an affiliate of Planned Parenthood, our largest abortion provider quit the national organization over its insistence they provide abortions. Finally, there are the regular reports of unhygienic or even horrific conditions at abortion clinics.

In recent weeks we can't have missed the reports about Planned Parenthood employees offering to cooperate with someone posing as a sex trafficking ring director of minor girls as young as 13. Planned Parenthood has acknowledged it needs nationwide retraining. Third, there's an emerging scientific and cultural willingness to conclude that abortion is killing and not health care for women.

Not only is this the word used by a majority of our Supreme Court, but abortion providers and supporters of abortion rights are using it regularly. More broadly, and I think this is new with respect to women's flourishing, there is emerging a critical mass of evidence from respected scholars and peer review journals that more easily available abortion is associated with women's what they are calling "immiseration", that is, making them miserable not their flourishing. Associate, that is, with creating a market for sex and mating that demands more uncommitted sexual encounters contrary to women's empirically demonstrated preferences thereby producing more sexually transmitted diseases, more nonmarital pregnancies, more single parenting, more abortions, more poverty.

Women of color, immigrants, and poor women are suffering the most from this. If opponents of conscience protection want to encourage high quality health care for women, they couldn't do better than ally themselves with supporters of conscience. These are the kinds of providers and institutions with a thick sense of vocation and a record particularly of assisting vulnerable women. These are not the providers we want to drive out of health care.

The Protect Life Act will assure that conscience-driven providers remain in this marketplace. It adds protections for them which reinstate the status quo but were not present in the Affordable Health Care Act. It adds protections regarding training for abortion and protects health care entities and providers against discrimination by governments and federally funded institutions—an important oversight. It explicitly protects existing state conscience protections from federal preemption. The Affordable Care Act also lacks sufficient enforcement mechanisms in connection with the limited conscience protections it did offer.

In conclusion, the freedom of religion and moral conscience is enshrined in the universal declaration of human rights. Our own President Obama has urged "secularists are wrong when they ask believers to leave religion at the door before entering the public square." Our founders understood that human beings require respect for conscience as a condition for living in freedom and integrity. Our founders knew and we know and we can ever measure it today, the relationship between the flourishing of religion and moral conscience and a good society. When it comes to abortion, conscience protection in some form has been the common ground between all sides of the debate even before Roe. Even when abortion was legal before Roe, conscience protections were attached to it. Our Supreme Court called them in Doe v. Bolton "appropriate". So it is contrary today to common sense those insisting that health care providers check their consciences at the door. This should be recognized for the marginal and dangerous opinion that it is. Thank you.

[The prepared statement of Ms. Alvaré follows:]

United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

Hearing on The Protect Life Act
February 9, 2011

Helen M. Alvaré, J. D.
Associate Professor of Law, George Mason University School of Law
Senior Fellow, Witherspoon Institute,
Task Force on Conscience Protection

SUMMARY

-Conscience protection is not a zero-sum game between conscience-driven health care providers and the patients they serve, particularly the most vulnerable women. The nation can and should both respect conscience-driven health care providers, and deliver to the most vulnerable Americans the health care their human dignity requires.

--First, there is no shortage of abortion providers in the United States, especially in the poorest communities, and among women of color.

-- Second, our nation's most vulnerable women—the poor, and women with less privileged educations -- are more likely to oppose abortion than are men, and than their more privileged sisters.

--Third, opponents of conscience protections are only attempting to force the government and conscience-driven private providers to give them what the market has steadfastly refused to do. If opponents of conscience believe this to be too few abortions, current law leaves them free to provide more abortion services.

--Fourth, there is a growing consensus among jurists, scientists and advocates on both sides of the abortion debate that abortion is killing. As such, it does not merit the title of "health care" or "standard of care."

--Fifth, there is evidence from a growing body of sociological, as well as law and economics literature, that more easily available abortion is associated with women's "immiseration," and not their flourishing.

-Proponents of conscience protection are among the most exemplary providers of care in our current health care marketplace.

-The Protect Life Act brings the Affordable Care Act into line with standards of conscience protection in health care long agreed upon at the federal level, and provides mechanisms for enforcement which are otherwise currently endangered.

-Freedom of religious and moral conscience is a universally recognized right and an intrinsic aspect of the history of the United States. This has been acknowledged by the majoirty since the beginning of legalized abortion in our nation. Opponents of conscience protection where abortion is concerned, occupy a very marginal position on this matter.

Good afternoon, and thank you for the opportunity to testify. I am a professor of family law and law and religion at the George Mason University School of Law and a Senior Fellow at the Witherspoon Institute. My testimony today addresses the importance of shielding from discrimination those health care providers and entities conscientiously objecting to abortion, under the Patient Protection and Affordable Care Act (hereafter "Affordable Care Act"). While I am not specifically addressing the question of federal funding of abortion, several of my arguments support the wisdom of those parts of the Protect Life Act which ensure that federal funds do not support abortion

As an initial matter, I want to suggest to the Committee that there is no need for us to view the matter of conscience protection as a zero-sum game between conscience-driven health care providers and the patients they serve, particularly the most vulnerable women. There is no question that as a nation, we can and should do both – respect conscience-driven health care providers, and deliver to the most vulnerable Americans the health care their human dignity requires. Protecting moral and religious conscience allows us to strike this balance; this can be understood from several angles.

First, clearly even if one believes that abortion is an integral part of women's health care -- which I do not – it is hard to claim a shortage of abortion providers when there occur over 1.2 million abortions annually in the United States, with a disproportionate number concentrated in our poorest communities, and among women of color.[1]

Second, our nation's most vulnerable women—the poor, and women with less privileged educations -- are more likely to oppose abortion than are men, and than their

[1] *See, e.g.* Characteristics of U.S. Abortion Patients, 2008, Guttmacher Institute (May 2010).

more privileged sisters. [2] They are also less likely to abort their nonmarital pregnancies than the latter group.[3]

Third, it appears that what opponents of conscience protections -- which they call "refusal clauses"[4] -- actually intend, is to force the government and conscience-driven private providers to give them what the market has steadfastly refused: widely dispersed sources for abortions provided in hygienic medical settings. What they have instead – even after 38 years of legal abortion in the United States -- is a market that looks like this: 87% of U.S. counties with no abortion provider[5]; steadily declining numbers of abortion clinics (which decline began long before clinic prayer vigils and protests began in earnest), largely due to the stigma associated with abortion among physicians and in the medical profession generally[6]; delivery of abortions, in the words of the *New York Times*, at the "margins of medical practice,"[7] *i.e.* abortions being performed in the vast majority of cases in free standing clinics (many run by one vocal interest group, Planned Parenthood) with relatively few (about 5%) abortions provided in hospitals or doctors

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[2] *See, e.g.* David M. Adamson, *et al.*, How Americans View World Population Issues: A Survey of Public Opinion (Rand Corporation, 2000), 55-56 (Table 5.7: Attitudes on Conditions Under Which Abortion Should be Available by Socioeconomic and Demographic Characteristics).

[3] *See* Kathryn Edin & Maria Kefalas, Promises I Can Keep: Why Poor Women Put Motherhood Before Marriage 45 (2009).

[4] Adam Sonfield, New Refusal Clauses Shatter Balance Between Provider 'Conscience," Patient Needs, 7 The Guttmacher Report on Public Policy (Aug. 2004).

[5] Guttmacher Institute, Trends in Abortion in the United Stated, 1973-2008 at http://www.guttmacher.org/presentations/trends.pdf.

[6] *See* Lori Freedman, *et al.*, Obstacles to the Integration of Abortion Into Obstetrics and Gynecology Practice, 42 Perspectives on Sexual and Reproductive Health 146 (September 2010) ("The majority were unable to provide abortions because of formal and informal policies imposed by their private group practices, employers and hospitals, as well as the strain that doing so might put on relationships with superiors and coworkers.... Several physicians mentioned the threat of violence as an obstacle...but few considered this the greatest deterrent). Guttmacher Institute, Trends in Abortion in the United Stated, 1973-2008, at http://www.guttmacher.org/presentations/trends.pdf;Project Daniel, Numbering the Days of 'Legal" Abortion, at http://www.operationrescue.org/archives/project-daniel-525-numbering-the-days-of-legal-abortion.

[7] Emily Bazelon, The New Abortion Providers, *New York Times Magazine*, July 14, 2010.

offices[8]; and a steady stream of reports of abortion providers violating the most basic standards of health care for vulnerable women,[9] or violating even women's human rights. Credible reports emerged just last week about employees of several Planned Parenthood clinics offering to cooperate with a man posing as the leader of a sex trafficking ring of minor girls.[10]

Still, extant abortion providers manage to perform over 1.2 million abortions annually, disproportionately among poor women and women of color. If opponents of conscience protection believe this to be too few abortions, current law leaves them free to provide more abortion services themselves, rather than force conscience-driven providers to do so by means of federal fiat. Although recent events indicate that even the nation's largest abortion provider is having difficulty convincing its own members to expand the supply of abortion. Just this past month, a Planned Parenthood affiliate resigned from the national organization after the latter insisted that each affiliate perform abortions. The head of the Texas affiliate reported to the Corpus Christi newspaper that "there are far greater needs in our area than abortion…We don't need to duplicate services." [11]

Fourth, when insisting that women's "health care" needs merit specialized attention – a claim I also affirm -- opponents of conscience protection ought to be willing to engage in a thoughtful conversation about the meaning of health care. In the case of abortion, we find ourselves today in the midst of an emerging scientific and cultural

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[8] National Abortion Federation, Abortion Facts: Access to Abortion, at http://www.prochoice.org/about_abortion/facts/access_abortion.html.

[9] *See* Karen Heller, Politics Clouded Safeguards against Practices Like Gosnell's, Philadelphia Inquirer, Jan. 26, 2011 (Gosnell was charged with killing 7 born alive children and one woman, a political refugee from Bhutan).

[10] *See* Caught on Tape: Planned Parenthood Aids Pimp's Underage Sex Ring, Feb. 1, 2011, at http://liveaction.org.

[11] Steven Ertelt, Planned Parenthood Chapter Quits, Forced by National to Do Abortions, Dec. 21, 2010, at http://www.lifenews.com/2010/12/21/state-5757.

awareness that abortion is not health care. A majority of our U.S. Supreme Court calls abortion "killing."[12] Many abortion providers and advocates of legal abortion do the same.[13] More broadly, there is emerging evidence from a growing body of sociological, as well as law and economics literature, that more easily available abortion is associated with women's "immiseration," and not their flourishing.[14] When Justice Sandra O'Connor wrote in the *Planned Parenthood v. Casey* opinion that women had "organized intimate relationships, and made choices that define their views of themselves and their places in society, in reliance on the availability of abortion in the event that contraception should fail,"[15] she was even more right than she likely knew. According to leading scholars, it certainly appears that more easily available abortion has led to

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[12] *Gonzales v. Carhart*, 550 U.S. 124, 129, 136 (2007).

[13] Sarah Terzo, ProLifeblogs.com, http://www.prolifeblogs.com/articles/archives/2009/12/is_abortion_kil.php, Dec. 4, 2009; See also the following statements: :"I agree that the way in which the arguments for legal abortion have been made include this inability to publicly deal with the fact that abortion takes a life."
Frances Kissling, President and CEO, Catholics for a Free Choice ("Speaking Frankly," *Ms.*, May/June 1997, page 67); "Sometimes a woman has to decide to kill her baby. That is what abortion is."Judith Arcana, Pro-Choice Author and Educator (Rosalind Cummings, "In Print: rights of the accused," *Chicago Weekly Reader*, Friday, February 17, 1995);I have angry feelings at myself for feeling good about grasping the calvaria (head), for feeling good about doing a technically good procedure which destroys a fetus, kills a baby." A New Mexico Abortionist (Diane M. Gianelli, "Abortion Providers Share Inner Conflicts," *American Medical News*, July 12, 1993, page 36); "[T]he pro-life slogan, 'Abortion stops a beating heart,' is incontrovertibly true." Naomi Wolf, Pro-Choice Author (Naomi Wolf, "Our Bodies, Our Souls," *TheNew Republic*, October 16, 1995, page 29); "One of the facts of abortion, he [Ron Fitzsimmons, executive director of the National Coalition of Abortion Providers] said, is that women enter abortion clinics to kill their fetuses. 'It is a form of killing,' he said. 'You're ending a life.'"An Abortion Rights Advocate Says He Lied About Procedure," by David Stout,*New York Times*, February 26, 1997, page A11; "Abortion kills the life of a baby after it has begun." Planned Parenthood ("Plan Your Children for Health and Happiness," pamphlet, 1963).

[14] *See e.g.* Jonathan Klick, Thomas Stratmann, Abortion Access and Risky Sex Among Teens: Parental Involvement Laws and Sexually Transmitted Diseases (2006) at http://www.vesonl.net/pdf/ParentalInvolvementActANDSTDReduction.pdf; Michael New Analyzing the Effect of State Legislation on the Incidence of Abortion Among Minors (Heritage Foundation, Center for Analysis Data Report #7-01); Timothy Reichert, Bitter Pill, First Things (May 2010), Tim Harford, The Logic of Life: The Rational Economics of an Irrational World (2009); George A. Akerlof, Janet L. Yellen and Michael L. Katz, An Analysis of Out-of-Wedlock Childbearing in the United States, 111 The Quarterly Journal of Economics 277 (1996); Roy F. Baumeister, Kathleen D. Vohs, Sexual Economics: Sex as Female Resource for Social Exchange in Heterosexual Interactions, 8 Personality and Social Psychology Review 339 (2004).

[15] *Planned Parenthood v. Casey,* 505 U.S. 833, 835 (1992).

expectations of more uncommitted sexual encounters – a situation which itself contradicts women's demonstrated preferences – and thereby to more sexually transmitted infections, more nonmarital pregnancies and births, and more abortions.[16] Women of color, poor women and recent immigrants, are suffering these consequences in disproportionate numbers.

If opponents of conscience protection want to encourage high quality, readily available health care for women, especially vulnerable women, they could not do better than to ally themselves with supporters of conscience protections. In the United States, this group is regularly comprised of the kinds of providers and institutions ready to assist the most vulnerable women, even with free or low cost care. These include, for example, Catholic hospitals which in 2009 alone, provided care for nearly 86 million patients at 561 hospitals.[17] These also include networks of individual doctors willing to provide free or low cost health care to women.[18] These providers have demonstrated their sense of vocation, and a sensitivity to the needs of the most vulnerable. If not for these 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. They are proof that protection of conscience and care for the vulnerable are not opposite values, but overlapping ones, or even one and the same. These are not the providers that the law should be driving out of the health care marketplace.

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[16] *See* Roy F. Baumeister, Kathleen D. Vohs, Sexual Economics: Sex as Female Resource for Social Exchange in Heterosexual Interactions, 8 Personality and Social Psychology Review 339 (2004). *See also*, note 14, *supra*, and all sources cited therein.

[17] U.S. Conference of Catholic Bishops, The Catholic Church in the United States at a Glance, at http://www.usccb.org/comm/catholic-church-statistics.shtml.

[18] *See, e.g.* Pregnancy Resource Center, A Passion to Serve, A Vision for Life, at http://www.apassiontoserve.org.

The Protect Life Act will help to assure that conscience-driven health care providers remain in this marketplace, able to continue to provide their vital services to all Americans, and particularly the most vulnerable. While the Affordable Care Act allowed such providers some protection, it did not go far enough. The final Senate bill, later passed by the House of Representatives, lacked some basic and important conscience protections. For example, while §1303 (b)(4) of the Affordable Care Act prohibits health are plans that qualify to participate in state health insurance exchanges from discriminating against any health care provider or facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions, it does not encompass refusals to train for abortion, nor does it protect providers or health care entities against discrimination by various government entities or institutions receiving federal funds. Also, the protection from discrimination by governmental actions, in §1553 of the Affordable Care Act is limited to procedures designated as assisted suicide, mercy killing and euthanasia. The Protect Life Act, on the other hand, adds that neither federal agencies nor programs, nor any state or local government receiving federal financial assistance, may discriminate against any institutional or individual health care entity or require any health plan created or regulated under the Affordable Care Act to discriminate against any institutional or individual health care entity on the basis of a refusal to train require or provide training for, perform, participate, provide coverage of or pay for or refer for abortions.

The Affordable Care Act also neglected explicitly to protect existing state conscience protections against preemption, even while it did protect against federal preemption of state abortion laws regulating abortion or abortion coverage. The Protect

Life Act explicitly provides that federal law does not preempt state conscience protection laws. This is crucial, given that these have been enacted today in 47 states and the District of Columbia.[19]

The Affordable Care Act also lacked sufficient enforcement mechanisms in connection with its limited conscience protections. Given the hurdles to claiming a private right of action in connection with federal conscience laws (*see, e.g. Cenzon-Decarlo v Mt. Sinai Hospital*, 626 F.3d 695 (2nd Cir., 2010)), and the current lack of detailed enforcement mechanisms associated with extant federal conscience protection laws (given the Obama administration's February 2009 proposal to rescind relevant regulations on this subject), it is important the that this comprehensive new health care law specify enforcement mechanisms. The Protect Life Act does this, by explicitly giving U.S. courts jurisdiction to prevent or redress violations. Furthermore it gives not only the Attorney General of the United States, but also "health care entit[ies]" the ability to commence an action. It also designates the Office for Civil Rights of the Department of Health and Human Services to receive and pursue investigation of such complaints.

In conclusion, the freedom of religious and moral conscience is enshrined in the United Nations' Universal Declaration of Human Rights.[20] Our current President, Barack Obama, has written that "[s]ecularists are wrong when they ask believers to leave their religion at the door before entering into the public square," and about how some of the greatest reform movements in U.S. history were spearheaded by religious and moral

[19] NARAL Pro-Choice America, Refusal Clauses, at http://www.naral.org/what-is-choice/abortion/abortion-refusal-clauses.html.
[20] Universal Declaration of Human Rights, Preamble, Article 1.

leaders.[21] We should be agreed as a nation on the proposition that human beings require respect for their religious and moral consciences as a condition for living in freedom and personal integrity. There should also likely be little disagreement about the role played by freedom of conscience in the very founding of our nation. From the beginning, too, Americans understood the positive role that people of faith and moral conviction played in the health and stability of their communities. George Washington in his *Farewell Address* (1796) opined that "Of all the dispositions and habits which lead to political prosperity, religions and morality are indispensable supports... A colume (sic) could not trace all their connections with private and public felicity." Early jurists concluded similarly. One Massachusetts Supreme Court opinion stated: "The object of a free government is the promotion and security of the happiness of the citizens. These effects cannot be produced, but by the knowledge and practice of our moral duties....Human law cannot oblige to the performance of the duties of imperfect obligation: as the duties of charity and hospitality, benevolence and good neighborhood...these are moral duties, flowing from the disposition of the heart, and not subject to the control of human legislation."[22]

Abortion supporters' insistence to the contrary -- that health care providers check their consciences at the door[23] --should be recognized for the marginal and dangerous opinions they are.

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[21] Barack Obama, Call to Renewal Keynote, Address, June 28, 2006, at http://barackobama.com/2006/06/28/call_to_renewal_keynote_address.php.

[22] *Barnes v. First Parish in Falmouth*, 6 Mass. 400 (1810).

[23] *See e.g.*, National Health Law Program, Health Care Refusals: Undermining Quality Care for Women (2010), pp. 21-22 ("[R]esearchers found that 63 percent of physicians thought it ethically permissible to tell patients about their personal objections to a particular health care service. Given the imbalance of power between physicians and patients, such disclosures violate the requirement to present medical facts that are unbiased and evidence based.")

Insofar as abortion is concerned, for as long as it has been legal, state and federal lawmakers have understood the need to provide accompanying conscience protection. Before *Roe. v. Wade*, in states with limited abortion licenses, conscience protections existed.[24] In *Roe's* companion case, *Doe v. Bolton*, the U.S. Supreme Court called Georgia's broad conscience protections for hospitals and providers "appropriate"; these included protections allowing hospitals for example, to refuse to provide abortions, or to set up ethics committees to evaluate requests for abortion, and allowing individual providers to refuse to cooperate with abortions. [25] Immediately post-*Roe*, the Church Amendment was enacted at the federal level to forbid health care entities receiving certain federal grants or contracts to discriminate in training and employment against health professionals or applicants for study because they are willing *or* unwilling to participate in abortion or sterilization. [26]

In sum, the Protect Life Act is a both a necessary and a wise amendment to the Affordable Care Act on so many grounds. It helps preserve within our nation's health care delivery system the valuable contributions made by conscience driven providers and institutions to the needs of the most vulnerable women and men. It indicates that abortion has not attained the status of a "standard" of health care, a message which might well help begin to reverse the negative role played by legalized abortion in the lives of American women, particularly the most vulnerable women. And it preserves in American law and culture the bedrock value of respect for religious and moral conscience.

Thank you again for this opportunity.

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[24] See Mark Rienzi, The Fourteenth Amendment Right of Conscience: *Roe*, *Casey* and the Right to Refuse, at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1662934. (working paper series).
[25] *Doe v. Bolton*, 410 U.S. 179, 197-98.
[26] 42 USC §300a-7.

Mr. PITTS. Thank you.

Please pardon the interruption to the witnesses, but a vote has been called on the floor. There are two votes, so the committee will stand in recess for votes and reconvene 15 minutes after the last vote to resume the hearing. Thank you. Committee's in recess.

[Recess.]

Mr. PITTS. The meeting will come to order. Thank you for your patience to the witnesses as the members were called to the floor for a vote. We have heard from Professor Alvaré. Next we will hear from Professor Sarah Rosenbaum. Welcome.

STATEMENT OF SARA ROSENBAUM

Ms. ROSENBAUM. Thank you very much Mr. Chairman and members of the Committee for providing me with the opportunity to speak before you today. The Hyde amendment and existing conscience protections both were expressly incorporated into the Affordable Care Act through section 1303 in order to ensure the preservation of conscience and to protect against public funding for abortions. The Protect Life Act would dramatically expand the reach of abortion prohibitions beyond the furthest limits of the Hyde amendment by incorporating its prohibitions direction into the Internal Revenue Code. The bill would achieve this result by amending the ACA to bar the use of premium tax credits, even though these credits must in many cases be repaid from personal income, if earnings increase for privately purchased health insurance products, if those products cover medically indicated abortions for which federal funding is barred, and even if the abortion coverage is paid for out of private income. This would be an enormous break from the existing provisions of law which allow tax credits to be used for products even if those products cover medically indicated abortions so long as that component of the product is purchased with private funding.

This change would produce three results. For the first time, the IRS would be required to assume major policy making and enforcement responsibility where federal abortion policy is concerned. Among its responsibilities the agency would be obligated to develop implementing policies that define critical terms. The IRS would have to define abortion in order to separate allowable claims such as claims related to spontaneous abortions and miscarriages from prohibited claims for induced abortions that fall outside allowable federal legal parameters. The IRS would have to define rape. It would have to define incest. It would have to define what is "a physical disorder, physical injury, or physical illness" that would as certified by a physician place the female in danger of death. The IRS would also need to establish a plan certification system to assure front end compliance as well as medical audit procedures for measuring corporate compliance.

Second, health plans could be expected to exit this optional coverage market entirely rather than expose themselves to IRS standards, audits, disallowances, and exposure for potential legal violation. The law would continue to permit but of course not require a plan to cover certain distinct types of abortions, but the consequences of crossing the line for a plan would be potentially so severe, i.e., loss of the right to sell qualified products in exchange,

that there is really no business reason to risk this kind of corporate exposure. This is particularly true given the weak market for this kind of a product that is a supplemental product in view of the modest income of so many people who will be buying their coverage through exchanges.

Women also conceivably could risk loss of coverage of abortion of important health care if they abortion supplements ironically. A health plan could deny claims that in the plan's view fall within what the plan would consider an abortion related exclusion as defined by the plan. Clearly such an exclusion would apply to treatment of the after affects of a medically indicated abortion whose aim is to restore a woman's health in childbearing. So, for example, if an abortion undertaken for physical health reasons resulted in sepsis, the plan would potentially exclude treatment of sepsis and aftercare for sepsis because it is related to the abortion.

Another example would be following up on treatment for stroke level blood pressure triggered by a pregnancy that is terminated for health endangerment reasons. The plan conceivably could deny ongoing treatment because the blood pressure was a condition brought on by a pregnancy that ended in an excluded abortion. While such a decision may be reversed on appeal, critical care could be lost.

Finally, the conscience clause provisions bear focus. They accomplish three goals. First, they explicitly strip legal protections from entities that are the subject of discrimination because of their willingness to provide lawful abortions. Second, the provisions create an expressed private right of action for both money damages and injunctive relief against State and Federal Governments for "actual" or "threatened" violations of the law without definition. Third, the nondiscrimination provision raises great uncertainty around EMTALA. While uniform enforcement of EMTALA screening, stabilization, and medical transfer requirements against federally obligated hospitals constitutes anything but discrimination, in my view if you are enforcing the law uniformly you are not discriminating. The fact is that the newly recodified provisions without clarifying language raise troubling questions for administrative and judicial enforcement. I have the utmost respect for religious healthcare institutions, but the literature including articles published in the peer review literature demonstrate instances in which crucial treatment involving pregnant women was withheld or delayed over what is termed conscience. EMTALA is a paramount protection unique in all of health law and in my view Congress should take no action that begins for any reason the long unraveling of its absolute safeguards.

[The prepared statement of Ms. Rosenbaum follows:]

United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

Hearing on the Protect Life Act

Sara Rosenbaum
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 9, 2011

Mr. Chairman and Distinguished Members of this Subcommittee:

Thank you for the opportunity to appear before you today to present remarks on the Protect Life Act (H.R. 538)

In revising the Patient Protection and Affordable Care Act, the proposed legislation would make far-reaching changes.

- Despite the fact that the ACA is absolutely clear that federal funds may not be used to pay for or provide abortions, the bill would reach beyond the furthest limits of Hyde Amendment and directly into the Internal Revenue Code. It would do so by amending the ACA to bar abortions in tax-favored products (including multi-state products). Specifically, the bill would bar the use of advance premium tax credits or cost-sharing reductions for health plans that cover abortions other than certain specified procedures, even if the additional medical cost protections are paid for privately. Furthermore, the law proposes a solution to restructuring private health insurance products that not only would eliminate access to coverage but could further compromise women's access to medically necessary health care.

- In response to claims that existing conscience laws are somehow lacking, the bill would amend the ACA to essentially reiterate current legal protections, a pretext for an additional amendment that would create an unprecedented federal private right to sue federal, state, and local governments for perceived violations. In adding a new private right of action barring discrimination by federal agencies and programs and federally assisted state and local governments, the bill would establish no similar privately enforceable protections for entities that are discriminated against because they provide legal abortions.

- The bill would preempt state anti-discrimination laws that protect entities that provide or pay for abortions, while saving from preemption only those state laws that protect conscience rights, restrict or prohibit abortion or abortion funding, or impose limitations on access to legal abortions.

- In creating new conscience rights under the ACA, the bill would fundamentally threaten women's right to emergency screening and stabilization treatment from Medicare-participating hospitals under the Emergency Medical Treatment and Labor Act (EMTALA)

The Bill's Revision to the ACA's Premium Tax Credit Policies Would Have Far-Reaching Effects on Health Insurance and Women's Access to Medically Necessary Health Care

The Protect Life Act would exclude the sale of health plan products that cover and pay for prohibited abortions, even if the additional coverage is paid for with private funds. Health plans, whose terms of coverage and payment reach excluded procedures, even if medically indicated, would not qualify for either refundable tax credits or cost-

sharing assistance. In other words, the amendments would upend the compromise reached prior to final passage.

Such an amendment would have a far-reaching impact. Although it would permit a supplemental coverage market if premiums are paid for with non-federal funds, the bill bars supplemental coverage whose administration is not entirely supported out of supplemental payments. This condition can be expected to lead to the complete exodus of abortion coverage from the affected market, help move the entire health insurance market away from coverage of barred procedures, and trigger dangerous spillover effects on women's access to health care. [1]

The ban contained in the Protect Life Act, when combined with the tax reforms contained in H.R. 3, No Taxpayer Funding for Abortion Act, will produce an industry-wide impact that will shift the standard of coverage for medically indicated abortions for all women. In view of how the health benefit services industry operates and how insurance product design responds to broad regulatory intervention aimed at reshaping product content, the coverage exclusions imposed can be expected to have an industry-wide impact, eliminating coverage of medically indicated abortions over time for all women, not only those whose coverage is derived through a health insurance exchange. As a result, this bill, particularly when combined with H.R. 3, can be expected to propel the industry away from current norms of coverage for medically indicated abortions. In combination with H.R. 3 and existing Hyde Amendment provisions applicable to Medicaid and other federal programs (including the federal employee health benefits program), the Protect Life Act will lead insurers to recalibrate product design away from any abortion coverage across the board, in order to accommodate the ban on products.

The supplemental insurance coverage provisions are unworkable and the bill carries enormous implications for women's access to medically necessary health care. The provisions of this bill will, by their very terms, defeat the development of a supplemental coverage market for medically indicated abortions. In any supplemental coverage arrangement, it is essential that the supplemental coverage be administered in conjunction with basic coverage. This intertwined administration approach is barred under this measure, because it prohibits comingling of funds for plan administration. The bar against commingling poses particular challenges in cases in which an underlying health condition necessitates the need for abortion, as well as in cases in which a medically indicated abortion leads to complications. Entirely separate networks, utilization management, and coverage determination procedures would be required. Furthermore, in situations in which the presence of an underlying condition (such as cancer) compels the need for an abortion, or where the abortion leads to further complications of a condition, the basic insurance plan can be expected to bar payment for such follow-on treatments on the grounds that they are related to a prohibited procedure.

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[1] 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.**

It is customary for plans to exclude such follow-on treatment where the precipitating event for the treatment is an excluded procedure. [2]

The Bill Would Preempt State Non-Discrimination Laws Aimed at Protecting Health Care Entities that Furnish Lawful Abortions

In preempting state nondiscrimination laws aimed at protecting plans and entities that pay for or provide abortions, the bill would usurp state powers to regulate their health care and health insurance markets by protecting health care entities engaged in lawful conduct. In a complete departure from principles of federalism in health care, the bill would preempt state laws that prohibit health plans from denying network membership to physicians who perform lawful abortions, or that prohibit plans from denying network status to hospitals that perform abortions in medically indicated cases, including those in which an emergency medical condition is present.

The Bill Would Create Enormous Liability Exposure in Federal and State Governments, While Recognizing Only Certain Types of Discriminatory Treatment

Despite the sweep of existing laws, including the Church Amendments, the Weldon Amendment, and the Coats Amendment,[3] proponents of this measure struggle to identify loopholes[4] and assert that codification within the ACA is essential. The bill

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[2] See, e.g. *Kenseth v Dean Health Plan,* 610 F. 3d 1652, (7th Cir. 2010), involving the authority of health plans to deny provision of otherwise covered procedures needed to address complications arising out of excluded treatments.

[3] The Church Amendments, part of U.S. law since the 1970s, make clear that the receipt of federal funds does not require an individual or institution to provide sterilization or abortion services and permit individuals to refuse to participate in such procedures if doing so would contravene religious or moral convictions. 42 U.S.C. §300a-7 (2008). The Coats Amendment, enacted in 1996, prohibits the federal government or any state or local government receiving federal financial assistance from "discriminating" against any physician, residency training program, or participant in a health professions training program on the ground that the person or entity refuses to receive or provide training in induced abortions, to perform such abortions, or provide referrals for such training or abortion. 42 U.S.C. §238n (2008) The Weldon Amendment, originally enacted in 2004 as part of the Labor-HHS appropriations bill and included in subsequent appropriations, provides that no funds made available in the bill can go to an agency or program or to a state or local government, "if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortion." Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, §508(d), 121 Stat. 1844, 2209 (2007).

[4] See, e.g., United States Conference of Catholic Bishops, Legal Analysis of the Provisions of the Patient Protection and Affordable Care Acct and Corresponding Executive Order Regarding Abortion Funding and Conscience Protection (undated). The memorandum identifies the points at which the ACA bars direct funding of abortions ((PPACA §4101 related to school health services, PPACA §1303(b) (2), barring the use of premium credits and cost sharing reductions to pay for abortions). The memo also concedes that the Conference itself is unclear as to whether existing laws, coupled with provisions of the Act are sufficient to assure that federal funds are not used to provide or pay for abortions. ("Given the length and complexity of the Act, we cannot exclude the possibility that the PPACA contains other particular exclusions of abortion funding in areas where that funding might otherwise be mandated. But this uncertainty only underscores the need to have a prohibition on such funding that covers the entire Act." Memorandum, note 3.) See, also, Helen Alvaré, How the New Health Care Law Endangers Conscience, *Public Discourse: Ethics, Law and the Common Good* (June 29, 2010), which in arguing for expansion of conscience clause protections

accordingly reiterates existing laws in the ACA itself, with a few relatively minor modifications.[5] But the real agenda here is visible in the bill's additional amendment to create an unprecedented, federal private right of action.[6] Furthermore, the bill would extend no similar private enforcement rights to entities that allege discrimination by the federal, state or local governments because they provide lawful abortions.

The extent to which the assertions that existing conscience laws are weak is merely a pretext for the creation of a federal right to sue the government becomes clear when modern jurisprudence doctrines governing private rights of action are considered. Under binding United States Supreme Court precedent, the right of private parties to sue to enforce federal laws cannot be implied.[7] Furthermore, at least one federal Court of Appeals has in recent years expressly applied this precedent to conscience clause claims and has expressly rejected the argument that a private right of action can be implied under federal civil rights doctrine. [8] Thus, proponents of conscience clause litigation need an express right of action to bring lawsuits, a right that cannot be granted in regulation and must be granted by Congress. Crafting such a right to sue makes sense only if there is an underlying right to which the right to sue is attached. Hence the strong assertions that somehow existing laws inadequately protect conscience, in order to bootstrap rights – and litigation rights – into the law.

Put simply, the claims that the ACA does not sufficiently protect conscience are inextricably intertwined with advocacy for the legislative establishment of (restated) conscience clause rights, along with a right to sue state, local, and federal governments. Moreover, the new provision is itself discriminatory. Only covered entities that refuse to engage in certain types of activities would possess such a right or be granted a federal right of action. Entities that experience discrimination because of their willingness to engage in lawful abortion practice and coverage would be given no such rights.

The new private right of action would empower the federal courts to reach both "actual" and "threatened" (both terms are undefined) violations of the new conscience

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also concedes the reach of numerous safeguards contained in the law, including §1303(b)(1) (barring the term essential health benefits from being interpreted to include abortion procedures), §1304(b)(4) (prohibiting qualified health plans from discriminating against any health care provider or facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions), §1553 (protecting conscientious objectors), the law's safeguards. Neither advocate of additional restrictions can identify instances in which the existing Presidential Executive Order related to community health centers and abortion funding has been ineffective. Nor do advocates argue that the July 2010 federal prohibition on the use of pre-existing condition plan funds to pay for abortions has been incomplete.

[5] In the case of Weldon, the bill would add "participate in," to the types of conscience-related conduct protected under the non-discrimination provision. In the case of Coats, the measure would slightly reword the existing law while expanding the meaning of "health care entity" protected under the law.

[6] Protect Life Act, §1303 as amended.

[7] *Alexander v Sandoval,* 532 U.S. 275 (2001). See, Sara Rosenbaum and Joel Teitelbaum, Civil Rights Enforcement in the Modern Healthcare System: Reinvigorating the Role of the Federal Government in the Aftermath of Alexander v Sandoval," *Yale Journal of Health Law and Policy* (Spring 2003).

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

clause right, and courts would be further empowered to issue "any form of legal or equitable relief," presumably including compensatory and punitive damages. A broadened range of health care entities would have the right to bring such suits, including an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.[9]

The Bill Could Have a Deleterious Effect on Women's Right to EMTALA Protections in the Case of Health and Life-Endangering Conditions

The Emergency Treatment and Labor Act (EMTALA)[10] represents perhaps the most important health care access law ever enacted in the U.S. Applicable to all Medicare-participating hospitals with emergency departments, the law establishes three basic obligations on the part of covered hospitals: to screen persons who come to the emergency department and on whose behalf a request for an examination is made, in order to identify the existence of an "emergency medical condition;" to stabilize emergency medical conditions in the case of persons who are patients of a hospital; and in the case of patients whose conditions cannot be stabilized, to undertake a medically appropriate transfer to a hospital with the capability to do so and that has agreed to accept the patient.[11] EMTALA defines the term "emergency medical condition" as

> **(A)** 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— **(i)** placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, **(ii)** serious impairment to bodily functions, or **(iii)** serious dysfunction of any bodily organ or part; or **(B)** with respect to a pregnant woman who is having contractions— **(i)** that there is inadequate time to effect a safe transfer to another hospital before delivery, or **(ii)** that transfer may pose a threat to the health or safety of the woman or the unborn child.[12]

EMTALA was drafted with preserving the health of pregnant women and their infants as a front and center aim; the statute has existed alongside the Hyde Amendment for 25 years and stands as a singular testament to the notion that no individual with a health emergency should be denied care.

In creating a new federal "right" of conscience, the bill threatens to fundamentally undermine EMTALA enforcement against hospitals that refuse to respond to emergency medical conditions involving pregnant women. Furthermore, in creating a federal right of action against the federal government to halt "actual or threatened" acts of "discrimination," the bill raises the specter of preemptive strikes by hospitals claiming

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[9] §1303(g)(2) as added.
[10] 42 U.S.C. §1395dd.
[11] Rand Rosenblatt, Sylvia Law, and Sara Rosenbaum, Law and the American Health Care System (Foundation Press, NY, NY, 1997). Ch. 1. See also 2010 manuscript, Sara Rosenbaum, David Frankford, Sylvia Law and Rand Rosenblatt, *Law and the American Health Care System*, reviewing revisions to EMTALA and more recent cases.
[12] 42 U.S.C. §1395dd(e)(1) (2008).

the right to withhold life-saving screening and stabilization treatment, or even the right to refuse to transfer a patient whose emergency medical condition signals the need for an abortion. Virtually any hospital that claims coverage under the new right of action could sue to enjoin the federal government from enforcing its EMTALA duties.

EMTALA has withstood enormous pressure over the years because of Congress' belief in the absolute importance of abiding by its core obligations on the part of a hospital industry that in 2010 accounted for one-third of the program's $509 billion in expenditures.[13] Indeed, so important are EMTALA's protections that at least one court has applied its requirements in a case involving an infant for whom treatment was judged medically futile, concluding that EMTALA's principles sufficiently powerful to override competing medical considerations.[14] To permit an amendment that strikes at these core principles would open EMTALA to against attack by those who would allow hospital emergency departments to make choices about who lives or dies and who is worthy of emergency medical care.

[13] Kaiser Family Foundation, *Medicare at a Glance* (2010) http://www.kff.org/medicare/upload/1066-13.pdf (Accessed Feb. 7, 2011)
[14] *In the Matter of Baby K*, 16 F. 3d 590 (4th Cir. 1994).

Mr. PITTS. Chair thanks the gentlelady and now for the final witness, Mr. Douglas Johnson.

STATEMENT OF DOUGLAS JOHNSON

Mr. JOHNSON. Mr. Chairman, before I begin I would just like to note that we are not getting any time information. This device is not working, so if you could give me some sort of 90 second warning.

Mr. PITTS. So sorry—we will correct that.

Mr. JOHNSON. I would appreciate it. Chairman Pitts, distinguished members of the subcommittee, I am Douglas Johnson, Federal Legislative Director for the National Right to Life Committee or NRLC. NRLC is the Federation of State Right to Life organizations nationwide. NRLC supports the Protect Life Act as well as the more comprehensive government wide approach incorporated in the No Taxpayer Funding for Abortion Act, H.R. 3.

The Protect Life Act could correct the new abortion expanding provisions that became law as part of the so called Patient Protection and Affordable Care Act or PPACA. That law contains multiple provisions that authorized subsidies for abortion as well as provisions that could be employed for abortion expanding administrative mandates. Some of these objectionable provisions are entirely untouched by any limitation on abortion. While others are subject only to limitations that are temporary, contingent, and/or riddled with loopholes. Federal funding of abortion became an issue soon after the U.S. Supreme Court decision Roe v. Wade and by 1976 the federal Medicaid program was paying for 300,000 elective abortions annually. If a woman or girl was Medicaid eligible and wanted an abortion then abortion was deemed to be "medically necessary" and was federally reimbursable. Unfortunately that pattern was generally replicated in other federal health programs.And so beginning in the late 1970's Congress applied restrictions to nearly all of them but this was done in a piecemeal, patchwork fashion. And many of these protections were achieved through limitations amendments to annual appropriation bills. This is a disfavored form of legislation. For one thing, the limitation amendments expire with the term of each appropriation bill which is never more than 1 year. Some of the pro-life policies have in fact been lost for varying periods of time because of their transient nature. For example, because of the actions of the 111th Congress and the Obama White House, today congressionally appropriated funds may be used for abortion for any reason at any point in pregnancy right here in the Nation's capitol. And that is being done, as reported in today's Washington's Post.

We believe that when Congress creates or reauthorizes or expends a health insurance program it should write the appropriate abortion policy into the law as was done with the SCHIP program when it was created in 1997. During the 111th Congress we strongly advocated that all programs created or modified by the health care bill should be governed by explicit permanent language to apply the principles of the Hyde amendment to the new programs.

I wish to underscore here what many have tried to obscure. The language of the Hyde amendment prohibits not only direct federal funding of abortion, but also funding of plans that include abortion.

I would refer to my written testimony in footnote 10 for the full text of the Hyde amendment and you will see that it refers to funds that go to any trust fund from which includes coverage of abortion. And this is explicitly defined to include the "package of services covered by a managed care provider or organization pursuant to a contract or other arrangement." Very similar language is found in the abortion related provisions that govern other federal health programs, for example, SCHIP and the Federal Employee's Health Benefits Program. This exact language is in footnote 12 of my written testimony.

I have also submitted to the Committee a 24-page affidavit that I executed that explains four of the major components of the PPACA that authorized subsidies for elective abortion. Its focus is primarily on 1, the pre-existing condition insurance program; 2, the federal tax credit subsidies for private health plans that cover elective abortion; 3, authorization for funding of abortion through community health centers; and 4, authorization for inclusion of abortion in health plans administered by the federal office of personnel management. And Mr. Chairman, it is not an exhaustive list.

To summarize, in the PPACA there is nothing on the way that remotely resembles the Stupak-Pitts amendment. Instead of bill wide language to permanently apply the Hyde amendment principles we find a hodgepodge of artful exercises and misdirection, bookkeeping gimmicks, loopholes, ultra-narrow provisions that were designed to be ineffective, and provisions that are rigged to expire. We find abortion authorizations that are permanent and limitations that expire.

As to President Obama's Executive order it is a hollow political construct. As discussed further in my written testimony and in the affidavit, it consists mostly of rhetorical red herrings, exercises in misdirection, and was characterized by the president of Planned Parenthood as a symbolic gesture.

[The prepared statement of Mr. Johnson follows:]

Testimony of Douglas Johnson

Federal Legislative Director

National Right to Life Committee

Before the Subcommittee on Health

Committee on Energy and Commerce

U.S. House of Representatives

on the *Protect Life Act of 2011*

February 9, 2011

SUMMARY

• Beginning with Medicaid, federal statutes authorizing funding of general health services and health coverage have been construed to authorize coverage of abortions essentially without restriction, except when Congress has explicitly prohibited such subsidies.

• The Patient Protection and Affordable Care Act (PPACA, Public Law 111-148) contains multiple provisions that provide authorizations for subsidies for abortion, both implicit and explicit, and also multiple provisions which may be used as bases for abortion-expanding administrative actions. The law lacks effective, bill-wide protective language such as the House of Representatives attached to its version of health care restructuring legislation on November 7, 2009 (the Stupak-Pitts Amendment).

• The first major component of the PPACA to be implemented, the Pre-Existing Condition Insurance Plan (PCIP) program, a 100% federally funded program, provided a graphic demonstration of the problem: The Department of Health and Human Services initially approved plans from multiple states that explicitly covered elective abortions. After NRLC blew the whistle on this development and a public outcry ensued, DHHS announced a discretionary decision that the PCIP plans would not cover elective abortions – but stakeholders on all sides of the issue acknowledged that coverage of abortions was not impeded by any provision of the PPACA, nor even addressed in Executive Order 13535.

• Executive Order 13535 is a hollow political construct – or, as described by the president of the Planned Parenthood Federation of America, "a symbolic gesture."

• There are, by conservative estimate, more than one million Americans who were born alive and are with us today, who would have been aborted if the Hyde Amendment had not been in place. The Guttmacher Institute has termed this a "tragic result," but NRLC regards it a major pro-life success story. The Hyde Amendment is the most successful domestic "abortion reduction" policy ever enacted by Congress.

Chairman Pitts, distinguished members of the subcommittee, I am Douglas Johnson, federal legislative director for the National Right to Life Committee (NRLC), a position that I have held since 1981.

NRLC is a federation of state right-to-life organizations nationwide. Since its inception, NRLC's organizational mission has been to defend the right to life of innocent human beings, where that right is threatened or denied by such practices as abortion, infanticide, and euthanasia.

Consistent with that mission, NRLC is opposed to government funding of abortion and government subsidies for health insurance plans that cover abortion. NRLC supports the Protect Life Act, as well as the more comprehensive, government-wide approach incorporated in the No Taxpayer Funding for Abortion Act (H.R. 3).

The Protect Life Act would correct the new abortion-expanding provisions that became law in March, 2010, as part of the so-called Patient Protection and Affordable Care Act ("PPACA," Public Law 111-148). That law contains multiple provisions that authorize subsidies for abortion, as well as provisions that could be employed for abortion-expanding administrative mandates. Some of these objectionable provisions are entirely untouched by any limitation on abortion, whether contained in the PPACA itself or elsewhere, while others are subject only to limitations that are temporary, contingent, and/or ridden with loopholes.

The PPACA also created multiple new streams of federal funding that are "self-appropriated" – that is to say, they will flow outside the regular funding pipeline of future DHHS appropriations bills[1] and therefore would be entirely untouched by the Hyde Amendment[2] (which controls only funds appropriated through the regular annual Health and Human Services appropriations bill), even if one assumed that the Hyde Amendment would be renewed for each successive fiscal year in perpetuity, which would be a reckless assumption.

BACKGROUND

Federal funding of abortion became an issue soon after the U.S. Supreme Court, in its 1973 ruling in *Roe v. Wade*, invalidated the laws protecting unborn children from abortion in all 50 states. The federal Medicaid statutes had been enacted years before that ruling, and the statutes made no reference to abortion, which was not surprising, since criminal laws generally prohibited the practice. Yet by 1976, the federal Medicaid program was paying for about 300,000 elective abortions annually,[3] and the number was escalating rapidly.[4] If a woman or girl was Medicaid-eligible and wanted an abortion, then abortion was deemed to be "medically necessary" and federally reimbursable.[5] It should be emphasized that "medically necessary" is, in this context, a term of art – it conveys nothing other than that the woman was pregnant and sought an abortion from a licensed practitioner.[6]

That is why it was necessary for Congressman Henry J. Hyde (R-Il.) to offer,

beginning in 1976, his limitation amendment to the annual Health and Human Services appropriations bill, to prohibit the use of funds that flow through that annual appropriations bill from being used for abortions.

Unfortunately, the pattern that we saw established under Medicaid was generally replicated in other federally funded and federally administered health programs: Where general health services have been authorized by statute for any particular population, elective abortions ended up being funded, unless and until Congress acted to explicitly prohibit it. In diverse federal health programs, federal funds were used to subsidize abortions, not because Congress had explicitly mandated or explicitly authorized subsidies for abortions, but because administrators and the federal courts interpreted any type of general language authorizing health coverage as implicitly authorizing and mandating abortion coverage. Moreover, administrators and courts accepted the premise that if a woman or girl was pregnant and sought an abortion, then that abortion was, by definition, "medically necessary" or otherwise a legal entitlement.

Many other examples could be given to illustrate this principle, but I will cite just one more here: In 1979, Congressman Hyde wrote to the Indian Health Service to inquire as to why that agency was paying for elective abortions. He received this response:

> You ask where the Indian Health Service is specifically permitted in authorizing legislation to pay for abortions. Neither abortion nor any other medical procedure or health service, nor the payment for such is specifically provided in authorizing legislation. The authorizing legislation for IHS is the Snyder Act (25 U.S.C. 13) which permits the expenditure of appropriated funds for the 'benefit, care, and assistance of the Indians throughout the United States' for a number of purposes

> including the 'relief of distress and conservation of health.'. . . All current requirements having been met, and procedures followed, we would have no basis for refusing to pay for abortions.[7]

Given this pattern, beginning in the late 1970s, there were many battles over whether to exclude abortion from one or another specific program. Over time, restrictions were applied to nearly all of them – in a piecemeal, patchwork fashion. Many of these protections were achieved, at least initially, through limitation amendments to various appropriations bills, and to this day, that is what many of them remain. They are called "limitation amendments" because they limit the expenditure of funds for a specific purpose – in this case, abortion – but this is a disfavored form of legislation. For one thing, there are procedural constraints, especially in the House of Representatives, which at times pose difficulties in offering detailed language that is contoured to a particular program. More importantly, these limitation amendments expire with the term of each appropriations bill, which is never more than one year. Unless each limitation is renewed by Congress and the President at least annually, it will lapse, and the program in question will revert to the default position of subsidizing abortion without restriction.

Some of these pro-life policies have indeed been lost for varying periods because of their transient nature. I will give you one quite current example. In 2009, President Obama proposed, in the White House budget recommendations, removal of a longstanding ban on the use of appropriated funds to pay for elective abortion in the District of Columbia – which is, of course, a federal enclave, placed under the exclusive

legislative authority of Congress by Article I of the Constitution. An appropriations bill incorporating this recommendation passed the House over our objections, was then wrapped into a huge omnibus funding bill, and enacted into law.[8] So today, because of the action of the 111th Congress and the Obama White House, congressionally appropriated funds may be used for abortion for any reason, at any point in pregnancy,[9] right here in the Nation's Capitol.

It is our position, therefore, that when Congress creates or reauthorizes a health or health insurance program, it should write the appropriate abortion policy language into the law itself. That is what was done, for example, when Congress created the State Children's Health Insurance Program (SCHIP) in 1997. It was generally recognized that this proposed program would end up funding abortions for children under age 18 without limitation if there was no explicit restriction, so such a restriction was written into the base statute. During more recent Congresses there were debates over various issues on bills to reauthorize SCHIP, but there was no fight over abortion policy, because that issue had been addressed explicitly when the program was created.

This is the approach that we advocated during the 111th Congress with respect to health care restructuring. NRLC did not take a position on many of the structural issues that dominated much of the debate, such as whether or not there should be a "public option" insurance plan. But we strongly advocated that all programs created or modified by the health care bill should be governed by explicit, permanent language to apply the

principles of the Hyde Amendment to the new programs. By "the principles of the Hyde Amendment," I mean no federal funding of abortion, and no federal subsidies for health plans that include coverage of abortion, with very limited exceptions.

I wish here to underscore what some people have tried hard to obscure: The language of the Hyde Amendment, as it has long been applied to appropriations within the Health and Human Services appropriations purview, prohibits *not only* direct federal funding of abortion procedures, but *also* provides, "None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended *for health benefits coverage that includes coverage of abortion*. . . . The term 'health benefits coverage' means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement."[10] [italics added for emphasis]

Nevertheless, during the 111th Congress, some critics of the Stupak-Pitts Amendment claimed that it would go far beyond the principles of the Hyde Amendment – that the amendment, as Congresswoman Nita Lowey (D-NY) said on the House floor on November 7, 2009, "puts new restrictions on women's access to abortion coverage in the private health insurance market even when they would pay premiums with their own money." This claim was rated flatly "false" by PolitiFact.com, which wrote, "In fact, women on the exchange who pay the premiums with their own money will be able to get abortion coverage. So we find her statement False."[11]

Phraseology similar to the Hyde Amendment language is found in the abortion-related provisions that govern other federal health insurance programs – for example, the laws that currently govern SCHIP and the Federal Employees Health Benefits (FEHB) Program.[12]

I would add that, when a federal program pays for abortion or subsidizes health plans that cover abortion, that constitutes federal funding of abortion – no matter what deceptive labels or gimmicks might be employed to conceal the reality. The claim, made by advocates of PPACA and its precursor bills during the 111th Congress, that a federal agency can send checks to abortionists to pay for abortions, but without employing public funds, amounts to a political hoax. The federal government collects monies through various mechanisms, but once collected, they become public funds -- federal funds. When government agencies use such funds to pay for abortions, that is federal funding of abortion.[13]

Beyond the question of abortion subsidies, during the 111th Congress, we also strongly advocated that health care legislation must contain robust protections for health care providers who do not wish to collaborate in providing abortions. Finally, we advocated strong language to prevent any of the multitude of administrative authorities created by the health care legislation from being used to *mandate* expansions of abortion "services."

The bill that initially passed the House of Representatives on November 7, 2009,

H.R. 3962 (111th Congress), fulfilled all those goals, Mr. Chairman. This was not true of the bill when it emerged months earlier from the Energy and Commerce Committee, however. The committee-reported H.R. 3962 contained some conscience protection language and some anti-mandate language, but it also contained explicit and permanent authorizations for federal government subsidies of abortion, both through a huge new premium-subsidy (tax credit) program and through a proposed "public option."[14] Fortunately, however, the corrective amendment that you offered on the House floor, in concert with Congressman Bart Stupak (D-Mi.), was adopted, 240-194. Your amendment to H.R. 3962 replaced those abortion-authorizing provisions with permanent language to prohibit *any component* of the bill from being used to subsidize abortion or health coverage of abortion, with exceptions for life of the mother, rape, and incest. (The key operative phrase in the amendment was, "No funds authorized or appropriated by this Act (or an amendment made by this Act . . .")

Unfortunately, the bill that came back from the Senate, the PPACA, contained vastly different abortion-related provisions – provisions directly at odds with the principles of the Hyde Amendment. I would place the blame for that, in the first instance, on the shoulders of President Obama, who lamented the House's action in adopting the Stupak-Pitts Amendment, and whose subordinates worked actively to block such language in the U.S. Senate – although the blame is fairly shared with the Democratic leadership in both houses.

We recognized from the outset, of course, that the President entered the fight over health-care restructuring with a long history of hostility to limitations on abortion of any kind, and consistent opposition to any limitations on government funding of abortion.

On July 17, 2007, then-Senator Obama appeared before the annual conference of the Planned Parenthood Action Fund. Speaking of his plans for "health care reform," Obama said, "In my mind, reproductive care is essential care. It is basic care, and so it is at the center and at the heart of the plan that I propose." He stated that, "What we're doing is to say that we're going to set up a public plan that all persons and all women can access if they don't have health insurance. It'll be a plan that will provide all essential services, including reproductive services." Under his plan, he explained, people could choose to keep their existing private health care plans, but "insurers are going to have to abide by the same rules in terms of providing comprehensive care, including reproductive care . . . that's going to be absolutely vital." [15]

The original bills introduced in the House and Senate by Democratic leaders in 2009 contained provisions that would have fulfilled every abortion-expanding component of Senator Obama's pledge. However, the president ultimately did not obtain, in the PPACA, *every* pro-abortion component that he had mentioned as his goals. For example, he did not get an explicit mandate that private insurers must cover abortions in every health plan.[16] [See PPACA §1303(b)(1)(A), 42 U.S.C. 18023] Nevertheless, the PPACA as enacted contains multiple components under which federal subsidies for

abortion are authorized, implicitly and even explicitly, and that predictably will result in such funding in the future -- unless the law itself is repealed, or unless the law is amended by enactment of the legislation that is the subject of this hearing, the Protect Life Act, or by enactment of a uniform, government-wide policy, as embodied in the No Taxpayer Funding for Abortion Act (H.R. 3, 112th Congress).

ABORTION-EXPANDING COMPONENTS OF PPACA

We offer here only the briefest summary of what we see as the objectionable components of the PPACA with respect to abortion subsidies. However, I submit with this testimony an affidavit that I executed, dated October 28, 2010, that explains four of the major components of the bill that authorize subsidies for elective abortion.[17] It is presented in the form of an affidavit because it is an adaption of an earlier and very similar affidavit that was requested as part of an administrative proceeding before a state regulatory body. This affidavit addresses only abortion subsidy issues. It does not address other serious abortion-related deficiencies of the PPACA, those being inadequate protections against abortion-expanding administrative mandates and gravely deficient conscience protection language, but the Protect Life Act would address those two concerns as well.

The affidavit focuses primarily on our objections to authorization for abortion coverage under the Pre-Existing Condition Insurance Plan program (affidavit paragraphs 37-49), federal subsidies for private health plans that cover elective abortions (paragraphs

50-54), authorization for abortion funding through Community Health Centers (paragraphs 55-57), and authorization for inclusion of abortion coverage in health plans administered by the federal Office of Personnel Management (paragraph 65). We note that this is not an exhaustive list – there are other components that also lack satisfactory abortion language, including those dealing with the Indian Health Service. In the affidavit, we cite many documents from sources outside our organization, which are also accessible on our website.

There is nothing in the PPACA that remotely resembles the Stupak-Pitts Amendment. There are certain apparent abortion limitations, but for the most part they are cosmetic. Instead of the bill-wide language that would have permanently applied the Hyde Amendment principles to the new programs, we find a hodge-podge of artful exercises in misdirection, bookkeeping gimmicks, loopholes, ultra-narrow provisions that were designed to be ineffective, and/or provisions that are rigged to expire.[18]

I would exempt from that negative characterization the provision [PPACA §1303(a)(1) 42 U.S.C. 18023] that allows individual states to pass legislation to keep abortion out of the health plans that participate in the exchanges in those states. We encourage state legislatures to avail themselves of this option. But, even where a state does this, it does not address the other fundamental problems with the PPACA – and 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.

EXECUTIVE ORDER 13535

The PPACA was unable to achieve House passage for a period of more than two months, in early 2009, in substantial part because a small group of House Democrats, most often identified with Congressman Stupak, refused to support the Senate-passed bill precisely because of the array of abortion-expanding components that I have described. Regrettably, a number of the members of this group, after efforts to obtain a vote on remedial language were unsuccessful,[19] abandoned their resistance and voted for the bill, proclaiming that the abortion problems were corrected by Executive Order 13535 ((75 Fed. Reg. 15599 (2010)), which was signed by President Obama on March 24, 2010.

Executive Order 13535 has the hallmarks of a primarily political document. It was carefully crafted to provide as much as possible in the way of political "optics," by which I mean rhetorical political "cover" for certain members of Congress, while at the same time containing as little as possible in "force of law" provisions that would offend the pro-abortion advocacy groups with which President Obama has long been allied.

The assessments of the Order made by some prominent advocates on the pro-abortion side of the debate are, I believe, consistent with our judgment. For example, Cecile Richards, the president of the Planned Parenthood Federation of America (PPFA), the nation's largest abortion provider, said that the Order amounted to "a symbolic gesture" (*USA Today*, March 25, 2010).

The language of Section 1 of the Order is purely discursive and rhetorical; it

contains no binding directives from the chief executive to his subordinates whatsoever. The two operative sections of the Executive Order (Sections 2 and 3) are focused on only two of the components of the massive law, and do not truly correct the abortion-related problems even with respect to those two components, for reasons described in detail in the affidavit referenced earlier. Still less does the Order establish any PPACA-wide or government-wide barrier to federal subsidies for abortion, as some have claimed.

The fourth and final section of the Order reiterates that the Order must be construed consistently with applicable laws and does not affect pre-existing agency authorities – which underscores why it is the language of the law that really matters here, and why enactment of remedial legislation is essential.

THE FIRST DEMONSTRATION

The first major component of the PPACA to be implemented, the Pre-Existing Condition Insurance Plan (PCIP) program, a 100% federally funded program, provided a graphic demonstration of the problem: The Department of Health and Human Services approved plans from multiple states that would have covered elective abortions. NRLC documented this and blew the whistle in July, 2010, which produced a public outcry, after which DHHS announced a discretionary decision that the PCIP plans would not cover elective abortions. Commentators on all sides of the issue were in agreement about one thing: Coverage of elective abortions within this new, 100% federally funded program was *not* impeded by any provision of the PPACA, and was not even addressed in

Executive Order 13535.

On the same day that DHHS issued its decision to exclude abortion from this program – July 29, 2010 – the head of the White House Office of Health Reform, Nancy-Ann DeParle, issued a statement on the White House blog explaining that the discretionary decision to exclude abortion from the PCIP "is not a precedent for other programs or policies [under the PPACA] given the unique, temporary nature of the program . . ." Laura Murphy, director of the Washington Legislative Office of the American Civil Liberties Union, said, "The White House has decided to voluntarily impose the ban for all women in the newly-created high risk insurance pools. . . . What is disappointing is that there is nothing in the law that requires the Obama Administration to impose this broad and highly restrictive abortion ban." ("ACLU steps into healthcare reform fray over abortion," *The Hill*, July 17, 2010.)

PUBLIC OPINION

Mr. Chairman, we are confident that the great majority of Americans are in agreement with the policy goals embodied in your legislation, and in the No Taxpayer Funding for Abortion Act. I will cite just a few of the many polls that demonstrate this. According to a Quinnipiac University poll from January 2010, 67% of Americans are opposed to allowing public funds to pay for abortion through health care. This included 68% of women (and 65% of men), and 47% of Democrats.[20] A 2010 Zogby/O'Leary poll found that 76% of Americans said that federal funds should never pay for abortion or

should pay only to save the life of the mother.[21] A September 2009 International Communications Research poll asked, "If the choice were up to you, would you want your own insurance policy to include abortion," to which 68% of respondents answered "no" and only 24% answered "yes."[22]

THE HYDE AMENDMENT AND "ABORTION REDUCTION"

Mr. Chairman, during his quest for the Democratic presidential nomination, then-Senator Obama and his campaign went to great lengths to emphasize his unblemished record of opposition to limitations on abortion, including opposition to parental notification laws[23] and bans on partial-birth abortion,[24] and including his support for repeal of the Hyde Amendment.[25] He even advocated elimination of the very modest federal support available for crisis pregnancy centers.[26] After securing the nomination, however, he adopted a rhetorical line of advocating government policies to reduce the number of abortions. For example, at the August 17, 2008 Saddleback Forum, Senator Obama said, "So, for me, the goal right now should be -- and this is where I think we can find common ground . . . how do we reduce the number of abortions?"

So let us talk about "abortion reduction." There is abundant empirical evidence that where government funding for abortion is not available under Medicaid or the state equivalent program, *at least* one-fourth of the Medicaid-eligible women carry their babies to term, who would otherwise procure federally funded abortions. Some pro-abortion advocacy groups have claimed that the abortion-reduction effect is substantially greater –

one-in-three, or even 50 percent. For example, a 2010 NARAL factsheet contains this statement:

> A study by the Guttmacher Institute shows that Medicaid-eligible women in states that exclude abortion coverage have abortion rates of about half of those of women in states that fund abortion care. This suggests that the Hyde amendment forces about half the women who would otherwise choose abortion to carry unintended pregnancies to term and bear children against their wishes.[27]

But even if we stick with a conservative 25 percent abortion-reduction figure, it means that well over one million Americans are walking around alive today because of the Hyde Amendment.[28]

Many of the voices raised against the Protect Life Act and the No Taxpayer Funding for Abortion Act think that those million-plus individuals, who now number among your collective constituents, should not have been born. Indeed, over the years, some critics of the Hyde Amendment policy have quite explicitly argued for federal funding of abortion as a cost-saving expedient.[29]

Whatever their motivations, if these groups and their congressional allies had succeeded in their efforts to block the Hyde Amendment, these million-plus children *would not* have been born. Their birth was, according to a 2007 Guttmacher Institute monograph, a "tragic result" of the Hyde Amendment:

> 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.[30]

Mr. Chairman, anyone who thinks that the million-plus Americans that walk among us today because of the Hyde Amendment, constitute a "tragic result," should vote against your bill. Those who believe otherwise, we respectfully submit, should vote for the Protect Life Act, and for the No Taxpayer Funding for Abortion Act as well.

We believe that the Hyde Amendment has proven itself to be the greatest domestic abortion-reduction law ever enacted by Congress. If the principles of the Hyde Amendment are applied to the PPACA, or to whatever legislation may ultimately replace PPACA, then the lifesaving effects that we have already seen will be multiplied, and this a goal that our organization regards as the furthest thing from a tragedy.

Thank you.

END NOTES

1. "Most of the funding for the big-ticket items that the GOP objects to . . . will be shielded from appropriators' knives because it was mandated in the law and will happen automatically." "Health Law Funding Is No Easy Target," *CQ Today*, January 10, 2011, page 1. See also Congressional Research Service memoranda of August 28, 2009, and August 31, 2009, at http://www.nrlc.org/AHC/CRStrustfundmemo.pdf and http://www.nrlc.org/AHC/CRSpublicoptionmemo.pdf, respectively.

2. NRLC memorandum, "Why the Hyde Amendment will not prevent government funding of abortion under H.R. 3200, the House Democratic leadership health care bill," September 3, 2009.
http://www.nrlc.org/AHC/NRLCmemoHydeAmendmentWillNotApply.html

3. Statement of the Department of Health, Education and Welfare, "Effects of Sec. 209, Labor-HEW Appropriations Bill, H.R. 14232," June 25, 1976.

4. The 1980 *CQ Almanac* reported, "With the Supreme Court reaffirming its decision [in *Harris v. McRae*, June 30, 1980] in September, HHS ordered an end to all Medicaid abortions except those allowed by the Hyde Amendment. The department, which once paid for some 300,000 abortions a year and had estimated the number would grow to 470,000 in 1980 . . ." In 1993, the Congressional Budget Office, evaluating a proposed bill to remove limits on abortion coverage from Medicaid and all other then-existing federal health programs, estimated that the result would be that "the federal government would probably fund between 325,000 to 675,000 abortions each year." Letter from Robert D. Reischauer, director, Congressional Budget Office, to the Honorable Vic Fazio, July 19, 1993.

5. As the Sixth Circuit Court of Appeals explained it: "Because abortion fits within many of the mandatory care categories, including 'family planning,' 'outpatient services,' 'inpatient services,' and 'physicians' services,' Medicaid covered medically necessary abortions between 1973 and 1976." [*Planned Parenthood Affiliates of Michigan v. Engler*, 73 F.3d 634, 636 (6th Cir. 1996)]

6. It has long been understood and acknowledged by knowledgeable analysts on both sides of abortion policy disputes that "medically necessary abortion," in the context of federal programs, really means any abortion requested by a program-eligible woman. For example: In 1978, Senator Edward Brooke (R-Ma.), a leading opponent of the Hyde Amendment, explained, "Through the use of language such as 'medically necessary,' the Senate would leave it to the woman and her doctor to decide whether to terminate a pregnancy, and that is what the Supreme Court of these United States has said is the law

of the land." In 1993, William Hamilton, vice president of the Planned Parenthood Federation of America, told Knight-Ridder Newspapers that "medically necessary" abortions include "anything a doctor and a woman construe to be in her best interest, whether prenatal care or abortion" (*Philadelphia Inquirer*, Sept. 8, 1993). The National Abortion and Reproductive Rights Action League (NARAL) defined "medically necessary" as "a term which generally includes the broadest range of situations for which a state will fund abortion" (*Who Decides? A Reproductive Rights Issues Manual*, 1990). A senior Clinton Administration health official told Congress, "When we're talking about medically necessary or appropriate [abortion] services we are also talking about all legal services." (Judith Feder, principal deputy assistant secretary for planning and evaluation, Department of Health and Human Services, Jan. 26, 1994.)

7. Letter from Emery A. Johnson, M.D., Assistant Surgeon General, Director, Indian Health Service, to the Honorable Henry J. Hyde, July 30, 1979. http://www.nrlc.org/AHC/INSlettertoHyde1979.pdf

8. Public Law No. 111-117, Consolidated Appropriations Act, 2010, Division C, Title VIII, General Provisions – District of Columbia.

9. The city council, a political entity that operates entirely under delegated congressional authority, apparently removed any trace of a limitation on abortion, at any point in pregnancy, in 2004.

10. The full text of the current version of the Hyde Amendment (spelled out in Pub. L. No. 111-117, Consolidated Appropriations Act, 2010, Division D, Title V, General Provisions) reads as follows:

> SEC. 507. (a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion. (b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion. (c) The term ''health benefits coverage'' means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement. SEC. 508. (a) The limitations established in the preceding section shall not apply to an abortion – (1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. (b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity,

> or private person of State, local, or private funds (other than a State's or locality's contribution of Medicaid matching funds). (c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds). (d)(1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions. (2) In this subsection, the term "health care entity" includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

11. PolitiFact.com, "Lowey says Stupak amendment restricts abortion coverage even for those who pay for their own plan" [rated "false"], November 9, 2009, http://www.politifact.com/truth-o-meter/statements/2009/nov/09/nita-lowey/lowey-says-stupak-amendment-restricts-abortion-cov/

12. The statute governing the State Children's Health Insurance Program (SCHIP) states that federal funds may not be used "to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion." [42 U.S.C. §1397ee(c)(7)] The appropriations law governing the Federal Employees Health Benefits (FEHB) program, which helps subsidize health premiums for all members of Congress and about eight million others, prevents the use of these subsidies for abortions "or the administrative expenses in connection with any health plan under the ... program which provides any benefits or coverage for abortions" [Public Law No. 111-117, Consolidated Appropriations Act, 2010, Division C, Title VI, General Provisions – This Act.] These laws contain exceptions similar to the Hyde Amendment.

13. See also NRLC memorandum, "Rebutting the 'private funds' myth," September 7, 2009, http://www.nrlc.org/AHC/NRLCmemoFederalFundsnotPrivateFunds.html, and Congressional Research Service, memorandum to Hon. Christopher H. Smith (R-NJ), "Questions Related to H.R. 3200, the America's Affordable Health Choices Act of 2009," October 9, 2009, http://www.nrlc.org/AHC/CRSpublicoptionfederalfunds.pdf.

14. "As for the House bill as it stands now, it's a matter of fact that it would allow both a 'public plan' and newly subsidized private plans to cover all abortions." FactCheck.org, "Abortion: Which Side Is Fabricating?," August 21, 2009. http://www.factcheck.org/2009/08/abortion-which-side-is-fabricating/

15. See PolitiFact.com, "Boehner says abortion access was always a key goal for Obama health plan," September 11, 2009, and "Planned Parenthood says Obama promised to 'put reproductive health care at the center' of health reform," November 10, 2009 [both statements rated "True"], at, respectively, http://politifact.com/truth-o-meter/statements/2009/sep/11/john-boehner/boehner-says-abortion-access-was-always-key-goal-o/ and http://www.politifact.com/truth-o-meter/statements/2009/nov/10/planned-parenthood/planned-parenthood-says-obama-promised-put-reprodu/.

16. Nevertheless, the PPACA grants administrative authorities to entities within the Executive Branch that might be employed to advance towards such a goal. See NRLC letter in opposition to the Mikulski Amendment, November 30, 2009, http://www.nrlc.org/AHC/MikulskiAmendLetter.pdf

17. The affidavit is posted on the NRLC website at: http://www.nrlc.org/AHC/DvSBA/GenericAffidavitOfDouglasJohnsonNRLC.pdf The primary documents cited in the affidavit are posted at: http://www.nrlc.org/AHC/DvSBA/Index.html

18. Similar assessments were issued by other knowledgeable analysts, including "Legal Analysis of the Provisions of The Patient Protection and Affordable Care Act and Corresponding Executive Order Regarding Abortion Funding and Conscience Protection," issued by the Office of General Counsel of the U.S. Conference of Catholic Bishops (USCCB) on March 25, 2010.

19. In what turned out to be a final effort to amend the Senate-passed bill, Rep. Stupak and ten others introduced H. Con. Res. 254 on March 19, 2010, an "enrollment correction" resolution, which if enacted would have amended the PPACA to prevent any component of the bill from subsidizing elective abortion; the language of this resolution was very similar to the anti-subsidy provisions of the Protect Life Act. However, Speaker Nancy Pelosi (D-Ca.) refused to allow a vote on this corrective measure. http://www.nrlc.org/AHC/DvSBA/HConRes254MoreEvidence.html

20. Quinnipiac University, conducted January 5-11, 2010, 1767 registered voters nationwide, margin of error: +/- 2.3 %. www.quinnipiac.edu/x1295.xml?ReleaseID=1413

21. Zogby/O'Leary, January 19-21, 2010, *The O'Leary Report*, August/September 2010, Volume 5, Issue 4, http://www.olearyreport.com/media/pdf/OLR_Vol5Issue4_AugustSeptember2010Final.pdf

22. International Communications Research, September 16-20, 2009, 1043 adults, margin of error: +/-3.0%.

23. See, for example, "Wash. Post's Solomon ignored Planned Parenthood support for Obama's abortion votes," Media Matters for America, December 14, 2007, http://mediamatters.org/research/200712140004.

24. As a state senator in Illinois, Obama was also directly responsible for killing legislation to extend legal protection to all infants born alive during abortions, which he saw as an infringement on abortion rights. See "Barack Obama's Actions and Shifting Claims on the Protection of Born-Alive Aborted Infants -- and What They Tell Us About His Thinking on Abortion," by Douglas Johnson and Susan T. Muskett, J.D., NRLC White Paper, August 28, 2008, http://www.nrlc.org/ObamaBAIPA/WhitePaperAugust282008.html.

25. See, for example, "Sen. Barack Obama's RH Issues Questionnaire," December 21, 2007, in which the Obama campaign provided this official written response: "Obama does not support the Hyde amendment. He believes that the federal government should not use its dollars 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." http://www.rhrealitycheck.org/blog/2007/12/21/sen-barack-obamas-reproductive-health-questionnaire.

26. "[Question:] Does Sen. Obama support continuing federal funding for crisis pregnancy centers? Why or why not? [Obama campaign answer:] No." *Ibid.*

27. "Discriminatory Restrictions on Abortion Funding Threaten Women's Health," NARAL Pro-Choice America Foundation factsheet, January 1, 2010, citing Rachel K. Jones et al., *Patterns in the Socioeconomic Characteristics of Women Obtaining Abortions in 2000-2001*, *Persp. on. Sexual & Reprod. Health* 34 (2002).

28. That the Hyde Amendment has resulted in at least one million births is recognized (and lamented) in materials produced by various pro-abortion advocacy groups. "Because of the Hyde Amendment, more than a million women have been denied the ability to make their own decisions about bringing a child into the world in the context of their own circumstances and those of their families." From "Whose Choice? How the Hyde Amendment Harms Poor Women," Center for Reproductive Rights, 2010, page 4, http://reproductiverights.org/en/feature/whose-choice-download-report. Some pro-abortion sources cite higher figures, e.g., "millions."

29. For example, during a House floor debate on June 27, 1979, Congresswoman Geraldine Ferraro (D-NY) argued, "The cost of putting an unwanted child through the system far outweighs the cost of these [abortion] procedures." Such reasoning was challenged by, among others, the Rev. Jesse Jackson, who during the early congressional debates over the Hyde Amendment wrote: "An open letter to Congress. As a matter of conscience I must oppose the use of federal funds for a policy of killing infants. The money would much better be expended to meet human needs. I am therefore urging that the Hyde Amendment be supported in the interest of a more humane policy and some new directions on issues of caring for the most precious resource we have – our children. Rev. Jesse L. Jackson, National President, Operation PUSH." [The original Western Union telegram, dated September 6, 1977, is preserved in NRLC archives.]

30. Here is the quote in context, from *The Heart of the Matter: Public Funding Of Abortion for Poor Women in the United States*, by Heather D. Boonstra, *Guttmacher Policy Review*, Volume 10, Number 1, Winter 2007:

> 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. . . . 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.

Sworn Affidavit

I, Douglas D. Johnson, being first duly cautioned and sworn, state as follow:

1. I am the Federal Legislative Director for the National Right to Life Committee ("NRLC"), having served in that capacity since 1981. NRLC was incorporated in 1973 in response to two United States Supreme Court decisions, *Roe vs. Wade* and *Doe vs. Bolton*, which invalidated the laws against abortion in all 50 states. NRLC is a federation of affiliated state organizations. NRLC seeks to foster government policies and laws that protect the right to life of all innocent human beings, including unborn children. NRLC maintains a lobbying presence on Capitol Hill and serves as a resource provider for state affiliates, local chapters, individual members, the press, and the public.

2. During much of the current 111th Congress, the primary focus of NRLC's legislative program was to resist enactment of health care legislation that would provide authority for federal subsidies for abortion and/or new authorities for federal regulatory decrees that would expand access to abortion. NRLC also opposed components of the proposed bills that would create mechanisms that will result in government-imposed rationing or denial of lifesaving medical treatments, but the rationing-related components of the legislation are not addressed in this affidavit.

3. In recent months, a number of organizations have sponsored advertising or issued other public communications in which they have asserted that the sweeping health care restructuring bill (H.R. 3590), "Patient Protection and Affordable Health Act" (PPACA), enacted

in March, 2010 (Public Law 111-148), authorizes "government funding for health plans that pay for abortion on demand," and authorizes "federal funding of abortion," "government funding of abortion," or "taxpayer-funded abortion." The purpose of this affidavit is to present some of the evidences that such statements are truthful and accurate, based on multiple provisions of the bill that was approved by the Senate on December 24, 2009 and by the House of Representatives on March 21, 2010, and enacted into law.

4. The PPACA also contains multiple provisions that provide authorities under which federal Executive Branch agencies may in the future force expansions in access to elective abortion through regulations or other discretionary agency actions, and/or under which courts may order such expansions, but these "abortion mandate" provisions are outside the scope of this affidavit, which addresses only provisions related to federal subsidies.

5. NRLC was supportive of the initial enactment of the "Hyde Amendment" in 1976, and has been instrumental in the annual renewal of that law. The "Hyde Amendment" is a provision, technically known as a "limitation amendment" or "limitation provision," that for years has been added annually to the appropriations bill for the federal Department of Health and Human Services (DHHS). This limitation provision prohibits the use of any funds that flow through that particular appropriations bill (1) to pay directly for abortions, or (2) to subsidize health plans that include coverage of abortions (with exceptions in both prohibitions for abortions to save the life of the mother, or in cases of rape or incest).

6. Starting early in the 111th Congress, in 2009, NRLC advised members of Congress on multiple occasions that under sweeping new health care restructuring legislation, such as was being advanced by Democratic leaders in both houses of Congresses, the Hyde Amendment

would not prevent future federal taxpayer funding of abortion, for two reasons, as enumerated in (7) and (8) below.

7. Each version of the health care restructuring legislation that was proposed by senior congressional Democrats and backed by President Obama's White House, including the "Patient Protection and Affordable Health Act" (PPACA) as enacted (Public Law 111-148), contained multiple provisions that created new legal authorities for -- or in technical parlance "authorized" – multiple new streams of federal funding, and each version also contained multiple provisions that directly appropriated large sums for new or expanded health programs. These "direct appropriations" were outside the regular funding pipeline of future DHHS appropriations bills and therefore would be entirely untouched by the Hyde Amendment (which controls only funds appropriated through the regular DHHS appropriations bills), even if one assumed that the Hyde Amendment would be renewed for each successive fiscal year in perpetuity.

8. The health care legislation also would create new or expanded authorities for certain health programs to which the Hyde Amendment did apply, but even in those instances, the Hyde Amendment alone would not provide adequate protection against federal funding of abortion, because most of the legal authorities for the programs implicating abortion policy created by the legislation would not expire, but the Hyde Amendment does expire. The Hyde Amendment is not a permanent law, but a temporary limit on the appropriations provided for a given fiscal year or portion thereof. The Hyde Amendment expires at least once per year, and will lapse on any occasion in which Congress fails to approve and/or the President fails to sign legislation renewing it for another year.

9. Because of the realities described in (7) and (8), NRLC informed members of

Congress that any health care restructuring bill that created new health programs and new funding streams must also include a permanent prohibition on the use of those programs and funds for elective abortion, and that the failure to include such protective language in the new law predictably would ultimately result in large-scale federal funding of abortion.

10. The version of the health care bill (H.R. 3962) that reached the floor of the U.S. House of Representatives on November 7, 2009, was 2,014 pages long. It contained multiple provisions that would have authorized federal subsidies for abortion, including but not limited to a section that explicitly authorized a new federal program operated directly by the federal government (the "public option") to pay for any type of elective abortion. When a federal agency pays for elective abortions, that is federal funding of abortion, whatever attempts may be made by some to disguise that reality.

11. Because H.R. 3962 was riddled with deficient abortion-related provisions, on the House floor, a comprehensive remedial amendment was offered by Reps. Bart Stupak (D-Mi.) and Joseph Pitts (R-Pa.). The Stupak-Pitts Amendment (Exhibit D) was supported by NRLC and numerous other pro-life organizations. The Stupak-Pitts Amendment did two things: (1) It surgically removed provisions of the bill that directly authorized abortion funding, except when necessary to prevent the death of the mother or in cases of rape or incest; and (2) it imposed a blanket prohibition on any provision in the bill being interpreted or employed to allow abortion subsidies. The prohibition contained in the Stupak-Pitts Amendment was bill-wide and permanent (i.e., not contingent on any requirement for perpetual annual renewal). The amendment stated in part, "No funds authorized or appropriated by this Act (or an amendment made by this Act) may be used to pay for any abortion or to cover any part of the costs of any

health plan that includes coverage of abortion, except in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself, or unless the pregnancy is the result of an act of rape or incest."

12. The Stupak-Pitts Amendment was adopted by a bipartisan vote of 240-194 (House Roll Call No. 884), after which the House approved H.R. 3962 and sent it to the Senate.

13. Because of the adoption of the Stupak-Pitts Amendment, H.R. 3962 as passed by the House did not include federal government funding of abortion, except in very narrow circumstances, and therefore a vote in favor of passing H.R. 3962-as-amended was not a vote in favor of federal funding of elective abortion.

14. However, H.R. 3962 was not the bill that was ultimately enacted into law. The bill that was ultimately enacted had many abortion-related elements in common with the version of H.R. 3962 that existed before the adoption of the Stupak-Pitts Amendment. The bill as enacted lacked any protective language remotely comparable to the Stupak-Pitts Amendment. It is truthful to say that any member of the U.S. Senate or the U.S. House of Representatives who voted for the bill that was actually enacted, the PPACA (now Public Law 111-148), voted to authorize federal funding of abortion, because the enacted bill contained multiple provisions that do in fact authorize (i.e., create legal authority for) federal funding of elective abortion and for health plans that cover elective abortion, and that predictably will result in such funding in the future -- unless the law itself is repealed, or unless the law is revised by a future Congress to include statutory language along the lines of the Stupak-Pitts Amendment.

15. Following adoption by the House of the Stupak-Pitts Amendment on November 7, 2009, many influential persons and organizations on the pro-abortion side of the debate expressed strong dismay at the House's action in approving the amendment, and expressed their determination that no such abortion-neutralizing language should win approval in the U.S. Senate. Among the public critics of the House's adoption of the Stupak-Pitts Amendment were President Barack Obama and House Speaker Nancy Pelosi (D-Ca.).

16. In this environment, a new version of the health care legislation was written, behind closed doors, by Senate Majority Leader Harry Reid (D-Nv.), and released to the public on November 18, 2009, with the new title of "The Patient Protection and Affordable Care Act" (hereafter, "PPACA"). This rewritten bill did not contain the House-approved Stupak-Pitts language. Rather, the abortion-related provisions that it contained were parallel, in many respects, to most objectionable abortion-related provisions of the original House bill, prior to the November 7, 2009 adoption of the corrective Stupak-Pitts Amendment.

17. On the Senate floor, Senators Ben Nelson (D-Ne.) and Orrin Hatch (R-Utah) offered an amendment (Senate Amendment No. 2962, Exhibit E) that was very similar to the Stupak-Pitts Amendment, in that it would have prevented any component of the bill from being used to subsidize abortions or insurance plans that cover abortion (except to save the life of the mother, or in cases of rape or incest). The amendment stated in part, "No funds authorized or appropriated by this Act (or an amendment made by this Act) may be used to pay for any abortion or to cover any part of the costs of any health plan that includes coverage of abortion, except in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an

abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself, or unless the pregnancy is the result of an act of rape or incest."

18. NRLC supported the Nelson-Hatch Amendment, but the amendment was tabled (killed) on a vote of 54-45 on December 8, 2009, and therefore did not become part of the enacted law as ultimately enacted.

19. Weeks later, the Senate considered a final package of revisions to the pending bill, known as a "manager's amendment." The manager's amendment left most of the abortion-related components of the bill unchanged, but inserted new language (sometimes referred to as the "Nelson-Boxer language") into the section creating a program to subsidize the purchase of health insurance by persons who meet certain eligibility requirements. (The new language is found in Section 10104 of the enacted bill, in Section 1303 as amended.) In a letter to members of the Senate dated December 20, 2009 (Exhibit F), NRLC characterized the new (and final) abortion-related language contained in the "manager's amendment," as follows: "Regarding abortion policy, the language of the manager's amendment is light years removed from the Stupak-Pitts Amendment that was approved by the House of Representatives on November 7 by a bipartisan vote of 240-194. The new abortion language solves none of the fundamental abortion-related problems with the underlying Senate bill, and it actually creates some new abortion-related problems. We view a vote for cloture on the amendment as a vote to advance legislation to allow the federal government to subsidize private insurance plans that cover abortion on demand, to oversee multi-state plans that cover elective abortions, and to empower federal officials to mandate that private health plans cover abortions even if they do not accept subsidized enrollees. . . . The abortion-related language violates the principles of the Hyde

Amendment by requiring the federal government to pay premiums for private health plans that will cover any or all abortions."

20. Notwithstanding such objections from NRLC and other pro-life organizations, the Senate adopted the "manager's amendment" on December 21, 2009.

21. In a letter to members of the U.S. Senate dated December 22, 2009 (Exhibit G), NRLC expressed its strong objections to multiple provisions of the final bill. Among other objections, the NRLC letter said that the Senate language "violates the principles of the Hyde Amendment by requiring the federal government to pay premiums for private health plans that will cover any or all abortions."

22. Notwithstanding objections from NRLC and other pro-life organizations, the Senate passed the PPACA on December 24, 2009, under the bill number H.R. 3590, and sent it to the House of Representatives.

23. Subsequently, at the urging of the White House, House Speaker Nancy Pelosi indicated her intention to force an up-or-down vote on the Senate-passed H.R. 3590, without allowing further amendments to be offered to it.

24. In a three-page single-spaced letter to U.S. House members dated March 19, 2010 (Exhibit H), NRLC again detailed the multiple abortion-expanding components of the pending Senate-passed bill, stating in part: "The bill is riddled with provisions that predictably will result in federal subsidies for private insurance plans that cover abortion (some of which will be administered directly by the federal government), direct federal funding of abortion through Community Health Centers, and pro-abortion federal administrative mandates. The sum of these provisions makes H.R. 3590 the most abortion-expansive piece of legislation ever to reach the

floor of the House of Representatives. . . . [T]he purported protections in the Senate bill are all very narrow, riddled with loopholes, and/or rigged to expire. There is nothing in the Senate bill remotely resembling the Stupak-Pitts Amendment, added to H.R. 3962 by the House of Representatives on November 7, 2009, which was an effective, bill-wide, permanent prohibition on subsidies for abortion under the programs authorized by the bill."

25. Similar assessments of the Senate language were issued by other knowledgeable analysts, including "Legal Analysis of the Provisions of The Patient Protection and Affordable Care Act and Corresponding Executive Order Regarding Abortion Funding and Conscience Protection," issued by the Office of General Counsel of the U.S. Conference of Catholic Bishops (USCCB) on March 25, 2010 (Exhibit I).

26. Enactment of the health care legislation was a top priority for President Obama and for House Speaker Nancy Pelosi (D-Ca.), and for many special interest groups, but during January, February, and early March, as widely reported at the time, there was not a majority in the House of Representatives willing to vote for the Senate-passed bill. One of the major impediments was the refusal of a group of House Democrats, led by Congressman Bart Stupak (D-Mi.), to support the Senate-passed bill because of its abortion-subsidizing and abortion-expanding provisions. All of the members of this "Stupak group" had voted to pass H.R. 3962 after the adoption of the Stupak-Pitts Amendment on November 7, 2009, but they were unwilling to support the Senate-passed bill because it contained pro-abortion provisions and did not contain a bill-wide prohibition on federal funding of abortion. Congressman Stupak and various other members of the "Stupak group" expressed these objections in numerous interviews in the news media during this period.

27. As late as March 19, 2010, Congressman Stupak, joined by ten original cosponsors, introduced a formal resolution (H. Con Res. 254) to fix the pro-abortion provisions in the Senate-passed health bill. This resolution, if enacted, would have removed objectionable language added to the Senate-passed bill by the Reid manager's amendment (dealing with the premium subsidy program), and added bill-wide, permanent prohibitions on any provision of the bill being used to authorize pro-abortion subsidies or administrative decrees. The original co-sponsors of this proposed amendment to H.R. 3590, whose names are printed on the first page of the bill along with that of Mr. Stupak, were Reps. Marion Berry (D-Ar.), Sanford Bishop Jr. (D-Ga.), Anh "Joseph" Cao (R-La.), Kathleen Dahlkemper (D-Pa.), Steve Driehaus (D-Oh.), Brad Ellsworth (D-In.), Marcy Kaptur (D-Oh.), Daniel Lipinski (D-Il.), Alan Mollohan (D-WV), and Nick Rahall (D-WV).

28. Regrettably, House Speaker Nancy Pelosi did not agree to allow a vote on the Stupak resolution/amendment. Regrettably, Mr. Stupak and some (but not all) of the other lawmakers in the "Stupak group" then abandoned their resistance and voted to send H.R. 3590 to President Obama for his signature, on March 21, 2010 (House Roll Call No. 165).

29. The bill, as passed, contained no revisions to any of the abortion-expanding provisions discussed in NRLC's letter of March 19. The bill, as passed, still contained all of the objectionable pro-abortion language that H. Con. Res. 254 would have stricken, and did not contain the bill-wide prohibition on federal funding of abortion that H. Con. Res. 254 would have inserted.

30. Any member of the House of Representatives who voted to pass H.R. 3590 on March 21, 2010, did in fact vote to authorize federal funding of abortion in multiple provisions

of the bill, as enumerated in the previously referenced documents.

31. The PPACA was signed into law by President Obama on March 23, 2010, and is now designated as Public Law 111-148.

32. No subsequent enactment by Congress has modified any of the provisions of the PPACA that implicate abortion policy as listed in the March 19, 2010 NRLC letter, nor have any of the provisions discussed in the paragraphs below been altered by any subsequent enactments.

33. In seeking to justify their decisions to vote to enact exactly the same bill that they had for months refused to support, Congressman Stupak and some of the other defectors leaned heavily on certain claims regarding the content of Executive Order 13535 ((75 Fed. Reg. 15599 (2010)), which was signed by President Obama on March 24, 2010. However, a federal executive order is a unitary act by a president of the United States, which is not voted on by members of Congress. There may be any number of administrative regulations, executive orders, and/or court decisions interpreting the multitudinous provisions of the PPACA, but what the members of the House "voted for" were the provisions of H.R. 3590.

34. One of the defectors, Congressman Steve Driehaus (D-Oh.), has asserted in a complaint filed with the Ohio Elections Commission: "Both the PPACA and Executive Order 13535 contain provisions ensuring that there will be no taxpayer-funded abortions as a result of the passage of the PPACA." However, the actual abortion-related language found in the PPACA falls very far short of supporting that assertion, and the language of the Executive Order, if it is deemed pertinent at all, also falls very far short of supporting that assertion. Executive Order 13535, in its operative sections, addresses only two of the abortion-related components of the bill. Regarding the premium-subsidy program, Section 2 of the Executive Order does little

more than reiterate the statutory language, under which federal tax-based subsidies will help pay for health plans that cover elective abortions, as explained in other paragraphs in this affidavit. In Section 3, involving Community Health Centers, the Executive Order purports to prohibit the use of funds appropriated under one narrow section of the Act for abortions – but the enforcability of this component of the order has been disputed, since it lacks a foundation in the language of the statute itself.

35. The PPACA, as enacted, was 906 pages long. It contained multiple provisions that authorize new programs or expand authorizations for existing programs that are authorized to cover abortion, either explicitly or implicitly. Some of these provisions are entirely untouched by any limitation on abortion in existing law or in the PCACA itself, and others are subject only to limitations that are temporary or contingent. Statutes authorizing or requiring government funding for health services, broadly defined, consistently are construed by courts to encompass abortion services except when Congress excludes abortion in explicit language. But the legislation as enacted contained no bill-wide abortion restriction comparable to the Stupak-Pitts Amendment that had been part of the House-passed bill. Thus, any House member who voted for the PPACA did indeed vote to authorize "taxpayer funding of abortion," not just in one component of the law, but under multiple programs and authorities created by the law.

36. What I describe is what the law actually authorizes, even though most of the provisions have not yet been implemented, and some will not be implemented until 2014 or even later.

37. However, one pertinent component of the PPACA has already been implemented, which is Section 1101 (42 U.S.C. § 18001) creating the Pre-Existing Condition Insurance Plan

(PCIP), also known as the "high-risk pool" program. This program is completely federally funded and may cover up to 400,000 people when fully implemented. The PPACA directly authorizes $5 billion in federal funds ("taxpayer funds") for this program alone. As NRLC noted in its letter to the House of Representatives dated March 19, 2010 (Exhibit H, on page 2, paragraph 2), the bill contained no restriction on the use of these funds for abortion.

38. Since Section 1101 mandated launching the PCIP program within 90 days of enactment of the law, the federal Department of Health and Human Services invited states that wished to operate the program in their respective states to submit proposals by June 1, 2010, and many states did submit proposals by that date or soon thereafter. During July, 2010, I and other NRLC staff persons examined the state-submitted proposals that were made available to the public. Most of the submitted state plans were not made available, but of those we were able to obtain, we found that three states had submitted and apparently received DHHS approval for plans that covered elective abortion (Pennsylvania, New Mexico, and Maryland).

39. Beginning on July 13, 2010, NRLC issued a series of statements to news media, objecting to the DHHS actions in approving state-submitted PCIP plans that covered elective abortion. (The initial NRLC release on the matter, focusing on the DHHS-approved PCIP plan for Pennsylvania, is Exhibit J.)

40. In a report published on July 22, 2010 report, www.FactCheck.org, a nonpartisan entity operated by the Annenberg Public Policy Center, examined NRLC's July 13 press release regarding the DHHS-approved PCIP proposal for Pennsylvania and concluded that NRLC was correct in asserting that it covered abortion. The FactCheck.org report is posted here: http://www.factcheck.org/2010/07/taxpayer-funded-abortions-in-high-risk-pools/ (Exhibit K).

41. The State of New Mexico explicitly listed "elective termination of pregnancy" as covered under the federal PCIP in that state, in a document provided on a state website to prospective enrollees (Exhibit L), as officials at the New Mexico agency confirmed to the Associated Press (Exhibit M).

42. On July 23, 2010, the Congressional Research Service (CRS), a nonpartisan research support agency for Congress, issued a report (Exhibit N) confirming that neither the Hyde Amendment nor any provision of the PPACA prevented the use of funds in the PCIP program from being used to cover all elective abortions. The CRS report also correctly noted that Executive Order 13535 was entirely silent on the PCIP component of the PPACA. The CRS report also correctly noted that the PPACA gives the Secretary of HHS authority to impose "any other requirements determined appropriate by the Secretary" specifically with respect to the high-risk pool program. The CRS report is posted on the internet at http://www.nrlc.org/AHC/CRSReportAbortionandHighRiskPools.pdf

43. In a press release dated July 14, 2010 (Exhibit O), DHHS spokeswoman Jenny Backus announced that "abortions will not be covered in the Pre-existing Condition Insurance Plan (PCIP) except in the cases of rape or incest, or where the life of the woman would be endangered." The statement did not suggest that anything in the PPACA or the Executive Order prohibited the use of the PCIP funds for abortion, and clearly implied otherwise.

44. On July 29, 2010, the federal Department of Health and Human Services issued a regulation specifying that it will not allow coverage of abortions under the PCIP in any state, except to save the life of the mother, or in cases of rape or incest. ((75 Fed. Reg. 45014 (2010)) (Exhibit P). DHHS did not assert that this decision was legally dictated by any provision of the

PPACA or by Executive Order 13535, but implicitly recognized that this was not the case, merely observing that similar restrictions were in force in "certain federal programs that are similar to the PCIP program."

45. On the same day the regulation was issued – July 29, 2010 – the head of the White House Office of Health Reform, Nancy-Ann DeParle, issued a statement on the White House blog explaining that the discretionary decision to exclude abortion from the PCIP "is not a precedent for other programs or policies [under the PPACA] given the unique, temporary nature of the program . . ." (Exhibit Q)

46. Many commentators for pro-abortion groups publicly criticized the DHHS action in excluding abortion coverage from the PCIP program, and pointed out that there is nothing in the PPACA or the Executive Order restricted the use of PCIP funds for abortion. For example, Laura Murphy, director of the Washington Legislative Office of the American Civil Liberties Union, said, "The White House has decided to voluntarily impose the ban for all women in the newly- created high risk insurance pools. . . . What is disappointing is that there is nothing in the law that requires the Obama Administration to impose this broad and highly restrictive abortion ban." ("ACLU steps into healthcare reform fray over abortion," *The Hill*, July 17, 2010.)

47. The entire series of events surrounding the implementation of the PCIP provides an early and graphic demonstration that the statutory language of the PPACA does authorize taxpayer funding of abortion; and that such funding is not precluded by the Hyde Amendment or any other existing law, or by any provision of the PPACA or of Executive Order 13535. The section of the PPACA creating the PCIP authorized coverage of general health services and did not exclude abortion; various states submitted plans that explicitly included elective abortion

and were approved by DHHS; and the Administration did not even claim that its ultimate decision to exclude elective abortion from the PCIP was compelled either by language in the law or by language in Executive Order 13535 (since no such language exists in either document). In response to political imperatives, DHHS ultimately drew on the discretionary administrative authority that the bill conferred specifically with respect to the PCIP program to shut off abortion funding in the PCIP – even as the senior White House health policy aide underscored that this would not be a precedent for implementation of other components of the PPACA.

48. NRLC and other organizations provided detailed analyses and advisories to the members of the House of Representatives, prior to the March 21, 2010 roll call by which H.R. 3590 was approved, warning that the bill contained multiple provisions that could be used to fund elective abortion. NRLC explicitly listed Section 1101 (creating the PCIP program) among the examples of such provisions. Assertions that a lawmaker who voted to enact H.R. 3590 voted to authorize federal funding of abortion are truthful and are validated by the example of the PCIP program – as confirmed by the Congressional Research Service and other analysts, such authority exists with respect to the $5 billion PCIP program.

49. While the abortion-funding authority created by the PPACA for the PCIP alone would suffice to demonstrate the truthfulness of such assertions, there are multiple additional provisions of the law which also provide abortion-funding authorities.

50. The PPACA, Section 1401 (26 U.S.C. §36B) establishes a new program under which federal tax-based subsidies will be used to assist tens of millions of Americans in purchasing health insurance. Under the House-passed bill, in order to qualify for such a federal subsidy, a private health plan would have been required not to cover abortions (except to save the

life of the mother, or in cases of rape or incest). (H.R. 3962, Engrossed in House of Representatives, §265.) Congress has long imposed just such a requirement with respect to the Federal Employees Health Benefits program (Public Law 111-117, Consolidated Appropriations Act, 2010, Division C, Title VI, General Provisions, 123 Stat. 3034, 3203) and the Medicaid program (Public Law 111-117, Consolidated Appropriations Act, 2010, Division D, Title V, General Provisions, 123 Stat. 3034, 3280). However, the PPACA contains no such prohibition. Rather, it contains language (in Section 1303 as amended, found in 42 U.S.C. §18023) that allows federal funds to subsidize private plans that cover all abortions. The language says that federal funds may be used to pay for any abortions that could be funded, in any future fiscal year, under the annual appropriations bill that funds the Department of Health and Human Services. This means that if Congress ever fails to renew the Hyde Amendment (which is a provision of the annual DHHS appropriations bill that expires annually), and thereby permits federal funding of abortion on demand under Medicaid, then the PPACA explicitly authorizes the new premium subsidy program to also pay for abortion on demand with federal funds. This language is in stark contrast with the NRLC-backed Stupak-Pitts and Nelson-Hatch amendments, which, if either amendment had been enacted, would have explicitly prohibited any funds authorized under any part of the massive health care law from funding elective abortion, regardless of what policy Congress and the President set for Medicaid in any future fiscal year through the DHHS appropriations bill.

51. With respect to the premium subsidy program created by the PPACA, Executive Order 13535 merely reiterates the provisions of the bill as outlined above. Under the Executive Order, federal funds will subsidize the purchase of private plans that cover elective abortion as

soon as the program is implemented, and also require the carriers to collect from each enrollee an additional payment to cover abortions. Some apologists for the law have asserted that this two-payment scheme does not amount to federal funding of abortion, but as we see it, when the federal government pays premiums for an insurance plan, it subsidizes what that insurance plan covers, notwithstanding any cosmetic bookkeeping requirements.

52. NRLC's analysis is consistent with that found in "Legal Analysis of the Provisions of The Patient Protection and Affordable Care Act and Corresponding Executive Order Regarding Abortion Funding and Conscience Protection," issued by the Office of General Counsel of the U.S. Conference of Catholic Bishops (USCCB) on March 25, 2010 (Exhibit I), which notes: "[U]nder Section 1303, the tax credits are still used to pay overall premiums for health plans covering elective abortions. This violates the principle reflected in the second part of the Hyde Amendment, which forbids use of federal funds for any part of a health benefits package that covers elective abortions. Omnibus Appropriations Act, 2010, Div. D, tit. V, §507(b)."

53. Moreover, nothing in the PPACA or in the Executive Order will in any way prevent private insurance carriers from using the federal tax-based subsidies directly to pay for coverage of all elective abortions on any future date in which Medicaid reimbursement for abortion is permitted because of failure to renew the Hyde Amendment. Indeed, such direct use of the federal funds to pay for unrestricted abortion coverage is explicitly authorized in the PPACA, and is made effective six months following the date that the Hyde Amendment lapses. The pertinent provision of the PPACA is found in Section 10104, which creates an amended Section 1303(b)(1)(B)(ii) (42 U.S.C. §18023), which reads, "(ii) ABORTIONS FOR WHICH

PUBLIC FUNDING IS ALLOWED. -- The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved."

54. Any lawmaker who voted for the bill, with Section 10104 and the amended Section 1303(b)(1)(B)(ii) contained therein, voted to authorize taxpayer funding of elective abortion without restriction, under a future contingency (i.e., non-renewal of the Hyde Amendment, even though the Hyde Amendment only applies directly to Medicaid and other programs unrelated to the premium-subsidy program). Even taken alone, this provision would be sufficient to justify an assertion that a vote for the bill was a vote to authorize federal funding of abortion. But again, there is more.

55. The PPACA, Section 10503 (42 U.S.C. §254b-2), directly appropriated $7 billion in new federal funding for Federally Qualified Community Health Centers (hereafter, "CHCs"). At least two pro-abortion advocacy organizations, the Reproductive Health Access Project and the Abortion Access Project, have active projects underway to persuade CHCs to provide abortions induced by the drug RU486. The $7 billion provided for CHCs are not touched by any restriction on their use for abortion in the bill itself or in existing law. NRLC highlighted this concern in a memorandum sent to members of the U.S. House of Representatives on February 12, 2010, updated on March 18, 2010 (Exhibit R).

56. Analysts at the U.S. Conference of Catholic Bishops (USCCB) concluded that the bill language, coupled with existing federal laws governing subsidies to CHCs, would be

interpreted by courts to not only authorize (allow) but also mandate provision of abortion services by federally funded CHCs. (See "Legal Analysis," Exhibit I.)

57. In support of its analysis, the USCCB circulated a letter from Robert A. Destro, professor of law at The Catholic University of America, dated March 20, 2010 (Exhibit S). Prof. Destro notes in the letter that he has been personally involved in abortion-funding litigation since 1977.

58. Congressman Steve Driehaus (D-Oh.) has asserted that Executive Order 13535 was "intended 'to establish a comprehensive, Government-wide set of policies and procedures . . . to make certain that all relevant actors – Federal officials, State officials (including insurance regulators) and health care providers – are aware of their responsibilities' under the PPACA." The quoted language is taken from Section 1 of the Executive Order. But the language of Section 1 is purely discursive and rhetorical; it contains no binding directives from the chief executive to his subordinates whatsoever. The two operative sections of the Executive Order (Sections 2 and 3) are very narrowly focused and do not establish any bill-wide barrier to federal funding of abortion – much less establish any "government-wide" barrier to federal funding of abortion.

59. The fourth and final section of the Order reiterates that the Order must be construed consistently with applicable laws and does not affect pre-existing agency authorities – which underscores why it is the language of the law that is pertinent here.

60. Congressman Steve Driehaus has asserted that the Order "actually prohibits the government, its agencies, and all relevant actors from using federal funds provided for under the law to pay for abortions." In addition, he has asserted that the Order "has the force of law

governing federal expenditures under the PPACA." These assertions are so overstated as to be highly misleading. There are no directives in the Order that apply to all, or even to most, of the provisions of the PPACA. The operative provisions that are actually contained in the Order are extremely narrow and highly qualified, as discussed above.

61. Mr. Driehaus has also quoted a statement, also found in Section 1 of the Executive Order, that the PPACA "maintains" current Hyde Amendment restrictions. This is typical of the rhetorical and non-substantive character of Section 1 of the Order. The Hyde Amendment is a provision that applies only to funds appropriated through the annual DHHS appropriations bill, with the pertinence to abortion policy being primarily the question of whether the federal Medicaid program (which is funded primarily through that bill) will pay for elective abortions during any given fiscal year. The PPACA contained multiple new authorities and direct appropriations that are entirely untouched by the Hyde Amendment, and therefore the Order's reference to "maintaining" the Hyde Amendment is no more than an artfully worded exercise in misdirection.

62. In my professional opinion, Executive Order 13535 has the hallmarks of a primarily political document. It has the appearance of having been very carefully crafted to provide as much as possible in the way of political "optics," by which I mean rhetorical political "cover" for certain members of Congress – the "Stupak group" defectors -- while at the same time containing as little as possible in "force of law" provisions that would offend the pro-abortion advocacy groups with which President Obama has long been allied.

63. Consistent with my professional opinion as expressed in paragraph (62) were the assessments of the Order made by some prominent advocates on the pro-abortion side of the

debate. For example, Cecile Richards, the president of the Planned Parenthood Federation of America (PPFA), the nation's largest abortion provider, said that the Order amounted to "a symbolic gesture" (*USA Today*, March 25, 2010)

64. Regarding the Order, the careful analysis by the Office of General Counsel of the U.S. Conference of Catholic Bishops (Exhibit I), dated March 25, 2010, observed, "Apparently cognizant of the constitutional prohibition on the Executive Branch's exercising legislative power, the Executive Order does not describe itself as creating any new restrictions with regard to abortion. Instead, the Order only purports to describe what the Act already provides, and to enforce those existing provisions. The main problem is that two of the operative provisions of the Order misdescribe what PPACA actually does. Correspondingly, the enforcement of those provisions in accordance with the Order's misdescription is highly likely to be held invalid as exceeding the President's authority, if challenged in court. Two other provisions of the Order do accurately describe features of PPACA . . . But they suffer from a different problem instead – though legally valid, those provisions fail to meet the standard of the Hyde Amendment regarding the ban on funding plans that cover abortion, mirroring the failure of the statute itself in this regard. Thus, none of the provisions of the Order represent valid fixes to those shortcomings of PPACA."

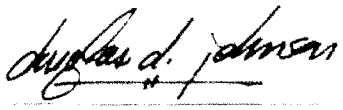
65. Section 10104 of the PPACA enacted revised language in Section 1334 (42 U.S.C. §18054) which establishes "multi-state" plans that will be administered by the federal Office of Personnel Management (OPM). The bill provides that "at least one" of the multi-state plans are subject to a restriction on abortion coverage, contingent on continuation of the Hyde Amendment, but this clearly authorizes OPM to mandate abortion coverage in any number of

additional multi-state plans. In this case, the abortion-covering plans will be both administered by a federal agency (which operates on taxpayer funds) and subsidized by the tax-based premium-subsidy program.

66. The four examples given in paragraphs numbered 37 through 65 above – involving authorization for abortion coverage under the Pre-existing Condition Insurance Plan (paragraphs 37-49), federal subsidies for private health plans that cover elective abortions (paragraphs 50-54), authorization for abortion funding through Community Health Centers (paragraphs 55-57), and authorization for inclusion of abortion coverage in health plans administered by the federal Office of Personnel Management (paragraph 65) – are provided for illustration. Any of the four examples given, taken alone, would provide ample basis to validate the truthfulness of an assertion that a vote for the bill was a vote to authorize federal funding of abortion and/or federal funding of health plans that cover elective abortion. But these examples do not represent an exhaustive list of all the provisions of the PPACA that may provide federal subsidies for abortion. Because of the absence of any bill-wide restriction on federal funding of abortion, and because even the narrow restrictions contained in the bill are temporary, there are other provisions that also may be employed in the future to provide federal funds for abortion, including those dealing with Indian health programs and health co-ops.

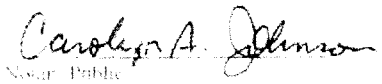
67. All of these authorizations for future federal funding of abortion would have been closed by enactment of the Stupak-Pitts or Nelson-Hatch amendments – but any lawmaker who voted to enact the bill without such an amendment did, in objective truth, vote to create legal authorization for taxpayer funding of abortion, through multiple funding pipelines and programs

I solemnly swear under the penalty of perjury under all applicable law that the foregoing is true and correct, to the best of my belief and knowledge. Executed this 28th day of October, 2010, in Prince George's County, Maryland



Douglas D. Johnson, Federal Legislative Director
National Right to Life Committee

Signed and sworn before a Notary Public this 28th day of October, 2010, in Prince George's County, Maryland.



Notary Public

My Commission Expires
December 8, 2013

Mr. PITTS. Thank you. Chair thanks the witnesses for their statements. Your entire written testimony will be made a part of the record and at this time we will go to questioning for the members of the committee. Chair recognizes himself for 5 minutes for questions. First for Professor Alvaré. If Catholic hospitals were to lose their tax exemptions and have to close their doors because they refuse to perform abortions what would be the impact on the playing——

Ms. ALVARE. Can't claim to be representative of Catholic hospitals. I do know that there is information that you can easily access regarding their services in poor areas. Just as one example that I brought with me today. One, the third largest Catholic hospital system in the United States, its statistics alone 19 States, 73 hospitals, 900—excuse me, $590 million in charity care and a great deal of loss as a result of that. Because of the charity care it is nonprofit and they regard themselves as having a particular commitment to the poor, to free clinics, to education, and research. These hospitals have empirically demonstrated that they provide the kinds of services to women and the poor in particular that are exemplary and are thought to be superior in many ways to other kinds of hospital systems.

Mr. PITTS. Thank you. Mr. Johnson, in your testimony you estimated that more than one million Americans are alive today because of the Hyde amendment limitations on government funding of abortions. What would be the effect of authorizing government funding of abortion nationwide as a routine method of healthcare?

Mr. JOHNSON. Mr. Chairman, this estimate is based on studies done by the Guttmacher Institute and other critics of the Hyde amendment and they have given figures. The lowest figure being the reduction of abortions among Medicaid eligible population has been on the order of one in four. There have been some estimates as high as one in two, that if one takes even the lowest estimate, the 25 percent figure and extrapolates that over the life of the Hyde amendment there are indeed more than one million Americans alive today because of that policy. So we have heard President Obama speak about his desire for abortion reduction. We believe the Hyde amendment has proven itself to be the greatest domestic abortion reduction policy ever enacted by Congress and yet it has been characterized by in a 19—rather a 2007 Guttmacher Institute monograph as a "tragic result of the Hyde amendment" these one million births. Mr. Chairman, we think it stands to reason that if the Hyde amendment is overturned or effectively circumvented by these mechanisms in the PPACA, the effect is going to be more abortions, not abortion reduction. We think that anyone who thinks that the million plus Americans who walk among us today because of the Hyde amendment constitute a tragic result should vote against your bill. But those who believe otherwise we respectfully submit should vote for it.

Mr. PITTS. To follow on, Mr. Johnson, given that President Obama and the 111th Congress greatly expanded the role of government in the private insurance market does it seem reasonable that Congress would correspondingly try to extend the Hyde amendment and similar measures to prevent taxpayer subsidies for elective abortions?

Mr. JOHNSON. These principles have been in place with respect not only to the Health and Human Services Appropriation Bill and Medicaid, but in a great many other programs as well including as I mentioned the Federal Employees Health Benefits Program which of course covers most members of Congress and their staffs, and about eight million others. For most with one brief interruption for the last 24 years, the 200 plus private plans that participate in that program have been required as a condition of participation not to cover any abortions except life of the mother, rape, and incest. It is not a bookkeeping scheme like you find in PPACA. It doesn't say they can—no, it says they can't participate in the program if they cover any abortions. And you know, the scenarios that we have heard spun out about how it is impossible for insurers to handle this, the IRS will never be able to administer it—the experience of the Federal Employees Health Benefits Program itself I think disproves these sorts of fanciful scenarios.

Mr. PITTS. In other words under the Federal Employee Health Benefits Plan—Program now, you can purchase abortion coverage with your own money. Is that correct?

Mr. JOHNSON. Within the program itself there is no abortion coverage. It is prohibited by the limitation on the Annual Appropriation Bill. Insurers are not required to cover any abortions to participate in the programs, but they are forbidden to cover any other than life of the mother, rape, and incest and that has been the case for almost a quarter of a century. Now, there is nothing of course to stop any private individual from going out and purchasing abortion coverage with their own resources on the private market if they choose to do so. I suspect from the data we have seen that very few people do that.

Mr. PITTS. Thank you. Chair thanks gentleman, and now recognizes the ranking member Mr. Pallone for 5 minutes for questioning.

Mr. PALLONE. Thank you. I want to ask each of the panelists just a yes or no answer. There is a lot of frustration by myself and on the democratic side of the aisle that you know we are in the midst of a recession, maybe we are getting out of it hopefully, but it is still out there, and that we should be spending our time focused on the economy and on jobs. And in all honesty just like the Health Care Repeal, I don't see that even if this bill passes the House it has any chance of garnering 60 votes in the Senate or being approved by the President. So I just wanted to ask you, is there anything in this legislation that creates jobs? Just a yes or no and then I will move on. Start with Mr. Johnson. Yes, or no, does this legislation in any way created jobs?

Mr. JOHNSON. Mr. Pallone, I have no competence to answer that question.

Mr. PALLONE. All right, Ms.——

Mr. JOHNSON. I would be——

Mr. PALLONE. Alvaré? I will just move on.

Ms. ALVARE. Nor do I. I am here to testify on conscience.

Mr. PALLONE. OK. And Ms. Rosenbaum?

Ms. ROSENBAUM. It doesn't appear to me that it does.

Mr. PALLONE. All right, thank you. Now let me ask—is it Alvaré? Is that how you pronounce it? Now, I am sorry, this is for Dr.

Rosenbaum and I am going to come to you if I have time. The EMTALA statute prohibits hospitals from dumping a patient who is medically unstable. If a patient arrives in a life threatening situation the hospital must treat them until her life is no longer in danger. The Health Reform Law made clear that the conscience protections that were written into law did not repeal or amend the basic EMTALA provisions requiring hospitals to treat a patient until she is stable. Now the Pitts legislation changes that. It says that EMTALA is subject to the abortion provisions. So Dr. Rosenbaum, what does that do? Does that mean if a pregnant woman's life is in danger and the medically indicated response is to terminate the pregnancy to save her life that the hospital can refuse her emergency care or refuse to transfer her to another facility that would perform such a life saving procedure?

Ms. ROSENBAUM. As long as the later amendment, this amendment is unclear, the impact of EMTALA, the impact of the amendment on EMTALA is similarly immeasurable at this point. To the extent that the statute raises questions about whether or not EMTALA applies, and also creates a federal right of action to seek an injunction against the actual or threatened enforcement of a federal law that discriminates against a hospital, an administrative agency and a court would face a very difficult situation in which they would have to reconcile the language of EMTALA which seems to be an obligation on the part of hospitals against an express authority now in the statute to be able to essentially to be able to essentially evade what is an EMTALA obligation which is of course stabilization or medically appropriate——

Mr. PALLONE. But my fear is that if this bill were to pass, and again, I don't see how that happens, but if it were to become law that you could have a situation where the hospital can refuse the woman emergency care——

Ms. ROSENBAUM. But what——

Mr. PALLONE [continuing]. Or refuse to transfer her to another facility that would perform the—save her life.

Ms. ROSENBAUM. It would appear that way. I mean, this is the problem. It is a later amendment that does not clarify how it is to be applied in an EMTALA situation. And so a court or an administrative agency would be faced with a very difficult question and it would seem to imply that the later legislation actually alters the EMTALA provision.

Mr. PALLONE. And so that could happen?

Ms. ROSENBAUM. Yes.

Mr. PALLONE. OK. Now let me ask Ms. Alvaré. You say that the bill before us today would protect individuals and entities who are not willing to provide all medical choices to women and their families even in life saving situations. Now, this is the conscience aspect. Why shouldn't these protections apply equally to all beliefs? In other words, why shouldn't we protect those who believe that they have a moral obligation to provide all medical service choices in this case, one that is legal in the country to a woman and families. I mean, I will give you an example. My concern is, Catholic hospital, I guess, religious hospital that doesn't believe in abortion. You know, administrator or doctor, or somebody makes a decision that because of the mother's life that they are going to perform the

abortion and it is contrary to the beliefs of that particular religious hospital, and then they fire them or they don't hire them because they say that they would perform an abortion in that circumstance. So why aren't we protecting that person so they can't be fired or they can't be discriminated against? Or would you protect them as well?

Ms. ALVARE. One thing is that our law, the Supreme Court has said it—whether in the Harris v. McRae or the Webster decision, our Supreme Court has said that government can favor life over abortion. It can favor bringing children into this world versus taking their life.

Mr. PALLONE. But the bottom line is then you wouldn't protect that person against that type of discrimination.

Ms. ALVARE. In 38 years of legal abortion there has never been a situation, not one, where a woman lost her life because she needed an abortion and didn't get one. So the idea that it is a medical choice is even contradicted by the evidence, let alone by statements by people like Dr. Guttmacher of Guttmacher Institute who said he really couldn't imagine a situation in which you couldn't deliver the child and protect the mother's life without that.

Mr. PALLONE. But it sounds like you wouldn't be in favor of passing a law that would do that, that would protect the person.

Ms. ALVARE. In 38 years since Roe v. Wade, there has never been a conflict. The Catholic Health Association letter that was referred to as coming in here today indicated that they had never had a conflict in 38 years.

Mr. PALLONE. No, but I am just asking you if you would be in favor of that kind of a law.

Ms. ALVARE. You would have to overturn EMTALA then because EMTALA itself and I have the provision with me—Section 1395DD(e) says when faced with pregnant woman and child you most "stabilize the woman and her unborn child". So I think you would have to first of all change what EMTALA says is emergency care in order to say we would have to kill to provide care. EMTALA says stabilize to provide care.

Mr. PALLONE. I don't think I am going to get an answer so we will move on.

Mr. PITTS. OK. Chair thanks the gentleman and recognizes the Vice Chairman of the Subcommittee, Dr. Burgess, for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman. Well, in fact, Mr. Pallone, I think you got your answer. EMTALA, if I understood the comments correctly actually specifies protection of the unborn. Does it not?

Ms. ALVARE. Yes, sir, it does. It is 42 U.S.C. 1395DD subsection E, it talks about if you are faced with a pregnant woman "the health of the woman or her unborn child is in serious jeopardy you must stabilize them both."

Mr. BURGESS. Well, it is interesting that you said in 38 years of law since the Supreme Court ruling in the early 1970s—I was thinking back and trying to remember the specific clinical situation that would have occurred that is being referred to here over and over again and in 25 or 28 years of medical practice, four of which at Parkland Hospital, a major downtown public health facility, it never happened. So I guess sometimes we do try to legislate to the

most extreme case, but we are trying to legislate to a case that no one can identify. Ms. Rosenbaum, Dr. Rosenbaum, you have referenced in your opening statement that you have cases from—I think you said from Catholic hospitals where care was compromised. Do you have such a body of case reports that you could supply to the committee? I don't necessarily need to hear about them today, but I would be very grateful if you would supply those clinical situations to the committee so that we might evaluate where those situations have occurred. Because apparently in the legal literature in 38 years there are not any. My own personal experience for almost 30 years there are not any. I just fail to see where are we trying to govern with this. And it is well established again in EMTALA and in federal statute that the life of the mother of course can be protected. So there are extreme problems that do occur, big pregnancy, cancer of the cervix, required radial therapy, well recognized that is going to be deleterious to the pregnancy but you do protect the life of the mother. OK. That—a rare occurrence, but it does happen and it is taken care of under current law, under PPACA, under the Executive order, under all existing conditions today. So again, if you have those circumstances I pray that you would share them with the committee.

Ms. ROSENBAUM. Certainly. There are both actually peer reviewed literature references and the case that arose in Arizona last summer involved a near—a woman who was on the verge of death and who was in an early stage of pregnancy. I would also note that EMTALA actually specifies that the obligation to save a life runs independently to the woman and/or her unborn child. So it is not a matter of only being able to save them as a unit. It is a matter of having to save whatever life——

Mr. BURGESS. Yes, let me stop you there because in present day practice of obstetrics in this country, having to choose between the life of one and the life of the other as a practical matter that just doesn't come up. It just doesn't. There are—yes, there are pregnancies that cannot be saved. We all recognize—heartbreaking when they happen. Yes, there are situations that the baby has to be delivered so early that it may have a tough go and may not survive. We all recognize when that happens, but it is just rare. I can't—and again, I am trying to think back in my own volume of clinical experience which was not insignificant. I cannot remember ever having to stand outside the patient's room with the family and say look, we got to make a decision here. It is one or the other. Which would you have me save? It just simply doesn't happen. And nothing that we are doing here today—I think, we may add just intellectual discussion, but as a practical matter I don't think we are affecting anything at all one way or the other again, either in PPACA, Executive order, EMTALA, or any existing statute. Let me just ask you, Ms. Alvaré one quick question. Some opponents of the legislation that is under consideration today seem to suggest that by denying taxpayer funding of termination of pregnancy that we are denying access to a basic form of health care. Is elective termination of pregnancy a basic form of health care?

Ms. ALVARE. I think I wish I had an M.D. in addition to my J.D. In the legal literature it has been increasingly said and the Supreme Court's decision in the Gonzales v. Carhart said it most ba-

sically. They referred to abortion as killing. The improvements in embryological knowledge, genetic knowledge, et cetera that lawyers use in order to come to a hearing like this and make our case, in order to make State legislation refer more and more to characteristics of unborn life that place it firmly within the context of being a member of the human family.

Mr. BURGESS. And I would just say the 38 years since Roe v. Wade the game changer has been the refinement of ultrasonography as a clinical tool. What became just something in theory in 1971 is very much reality today with the ability to look inside and make determinations about the health and condition of a baby well before the time of birth. These technologies didn't exist at the time of Roe. You talked about this procedure has been pushed almost of the periphery of the practice of medicine. And I think that is a big reason why. Thank you.

Ms. ALVARE. Thank you.

Mr. PITTS. Chair thanks gentleman. Chair recognizes the ranking member Mr. Waxman for 5 minutes.

Mr. WAXMAN. Thank you very much, Mr. Chairman. Ms. Alvaré just to follow up on that line of questioning, abortion is sometimes a medically necessary procedure, medical procedure. Do you agree with that statement?

Ms. ALVARE. Again, I would like to quote Dr. Guttmacher, the founder of the Guttmacher Institute. In 1967 when obstetric care was not even as good as it is now who said today it is possible for almost any patient to be brought through pregnancy alive unless she suffers——

Mr. WAXMAN. No, I really—excuse me. I really asked you the question. Do you think that it could be a legitimate medical procedure?

Ms. ALVARE. I have to rely on the doctors, sir, and looking at——

Mr. WAXMAN. And what does—the doctor says yes or no?

Ms. ALVARE. He says even if she suffers from a fatal illness such as cancer or leukemia, abortion would be unlikely to prolong much less save life. I can provide you with additional medical literature——

Mr. WAXMAN. Well, we do allow abortion under the Hyde language to save the life of the mother. Do you acknowledge that there could be circumstances where the life of the mother would be lost if a termination of a pregnancy didn't take place?

Ms. ALVARE. Not having been present when that was negotiated, I imagine that that is the kind of thing that in politics is said and is not necessarily have referenced to the medical literature. But in public debate and at public insistence they want the language of life of the mother whether it is——

Mr. WAXMAN. You would be against abortion under any circumstance. Is that an accurate statement?

Ms. ALVARE. I would not—yes, I would not say we could knowingly kill human life.

Mr. WAXMAN. OK. Well, I respect that point of view. I respect the idea of a conscience clause. I would not want you if you were a medical person to have to perform an abortion even though some people would say it would be appropriate under the circumstance. And that is why I support this conscience clause idea because a

Catholic doctor shouldn't be required to perform abortions if that individual feels that way. A Catholic hospital shouldn't be required to do it either. The Affordable Care Act is very clear on this point and does provide these protections for people with a conscience. But let me ask you this. If a doctor in good conscience or a nurse felt that they were morally required to provide an abortion to a victim of a rape who requests it would you respect that as a conscience clause protection?

Ms. ALVARE. Again, I prefer what the Supreme Court has said on this and I am glad they have, which is that the State can prefer life over abortion. And if a doctor feels that he or she wants to do that then probably they should steer clear of conscience driven health care facilities as a place of employment.

Mr. WAXMAN. Well, they have a different conscience than you.

Ms. ALVARE. They are free to do it elsewhere.

Mr. WAXMAN. They have come to a different conclusion than you do.

Ms. ALVARE. Yes.

Mr. WAXMAN. You want us to protect the conscience of someone out of adherence to the Catholic Church not to provide abortions. Would you respect the fact that someone with a different religious point of view or maybe even a Catholic as well who would say I think this would be morally reprehensible not to provide a victim of a rape, a rape a service to terminate the pregnancy. Now let me ask that to Ms. Rosenbaum because——

Ms. ALVARE. Could I respond to one thing?

Mr. WAXMAN. Sure.

Ms. ALVARE. I would also—I don't think this is just about Catholics. Morally pro-life atheists——

Mr. WAXMAN. Well it is not.

Ms. ALVARÉ [continuing]. I hope would get just as much protection.

Mr. WAXMAN. You are absolutely right, but people's conscience ought to be respected. It ought to be both ways. If we are going to say we want to respect the conscience of the person who doesn't want to do abortions, I think we have to respect the conscience of someone who feels it is morally required of them to perform that service. Let me ask you about the provision in this bill because it says State laws can allow insurance companies to refuse coverage of emergency contraception. Well now, let me go back. There is one provision in this bill that says State laws can do more than discriminate on abortion because they can look at the conscience on other issues as well. Originally it had conscience related to abortion but struck the abortion. It said whenever there is a conscience issue that conscience issue ought to be respected. I would like to know whether this can be read to say that State laws can allow insurance companies to refuse coverage of family planning and contraception because it offends the company's conscience.

Ms. ALVARE. Excuse me, sir, could you tell me which provision that is because I came with the Protect Life Act.

Mr. WAXMAN. Section 1303 of the Affordable Care Act dealt exclusively with treatment of abortion. And then this bill strike regarding abortion out. Ms. Rosenbaum, do you know—are you familiar with the provision?

Ms. ALVARE. I do know what you are talking about now.

Mr. WAXMAN. OK. Well I——

Ms. ALVARE. I am sorry, would you like me to answer that?

Mr. WAXMAN. I would like an answer, yes or no answer, because it seems to me they would be allowed—an insurance company would be allowed to say that you can't have family planning or contraception.

Ms. ALVARE. That might——

Mr. WAXMAN. It seems to me the State law can also allow insurance companies to refuse coverage of emergency contraception like a morning after pill. It seems to me this can be read to say that State laws could allow insurance companies or doctors who refuse treatment of people with AIDS because homosexuality or drug use offends their conscience. Or that we can allow insurance companies to refuse infertility services because it offends the company's conscience. Or not to pay for therapies that are derived from stem cell research because it offends their conscience. Ms. Rosenbaum, am I correct in reading that change as allowing those state laws?

Ms. ROSENBAUM. I agree the wording is altered to eliminate the reference to abortion.

Mr. WAXMAN. Yes. I find that troubling. Thank you, Mr. Chairman.

Mr. PITTS. Thanks to the gentleman. Chair recognizes the gentlelady from Tennessee, Ms. Blackburn for 5 minutes.

Mrs. BLACKBURN. Thank you, Mr. Chairman. Ms. Rosenbaum, I wanted to—there you are. Now I can see you. OK. Catholic hospitals since we were just looking at that. Should they be required to perform all the abortions that you would deem as medically necessary? Because it seems like we are debating and discussing medically necessary and you all continue to go to that provision. So do you think Catholic hospitals should be required to perform abortions that you yourself would deem as medically necessary?

Ms. ROSENBAUM. I think obviously there is a wide range of opinion on how the term medically necessary is used. I don't think—I am actually a very strong believer in a conscience clause and would just clarify that EMTALA itself certainly does not obligate a hospital to provide medically necessary abortions, however we define the term.

Mrs. BLACKBURN. OK. Let us talk then about medical students. Medical students that are opposed to abortion, should they be required to receive training in how to perform abortions?

Ms. ROSENBAUM. Again, it is my understanding that the various provisions, the various aspects of conscience clauses as we have come to understand them today are something that everybody believes in that are actually reflected both in underlying law and in the Affordable Care Act. But I think that is a different question than the very specific EMTALA obligation.

Mrs. BLACKBURN. OK. Do you agree with President Obama? He made a statement that he thinks the use of abortion should be rare. Would you share that view?

Ms. ROSENBAUM. As a mother and hopefully a grandmother I agree emphatically.

Mrs. BLACKBURN. OK. Mr. Johnson, good to see you. I want to ask you about a statement that I have read. It was made by Rahm

Emanuel, who had been the Chief of Staff over at the White House as we had the Pitts-Stupak language last year. And he was giving an interview with the Chicago Tribune with their editorial board. Have you seen that statement, sir? Do you know what I am ready——

Mr. JOHNSON. Yes, I have Congressman.

Mrs. BLACKBURN. OK. And I thought that it was just so telling when he said, and I am quoting here "I came up with an idea for how an Executive order to allow the Stupak Amendment not to exist in law." So you know, this is of concern to me when you see that kind of language. And I just ask you, sir, when you look at that is that Executive order addressing abortion funding insufficient to assure that taxpayers are not going to end up footing the bill for abortions?

Mr. JOHNSON. The Executive order is a hollow political construct. The president of the Planned Parenthood Federation of America described as "a symbolic gesture". I think these are two ways of saying the same thing. We could go through it section by section if we had time and I do in my affidavit that I referred to earlier which is available here and on our Web site. But in substance there is a great deal of rhetorical misdirection in the first section. The actual operative language only speaks to two of the many abortion implicating components of the PPACA itself. In one case it merely reiterates the objectionable language that allows the tax credits to be used to purchase plans that cover elective abortion and in the other case it purports to put a restriction on abortion funding through community health centers but there is no statutory basis for it and so it is doubtful that they could make that stick if it ever became an issue. The other provisions in the bill, in the PPACA itself which implicate abortion policy are not even addressed in the Executive order. And so we saw, for example, this summer the very first component of the packet to be implemented: the high-risk insurance pool program. Once we got a hold of some of the plans that had been approved by HHS we found three of those of the ones we were able to get explicitly covered elective abortion. And when we blew the whistle on this last July and a public controversy ensued, after about a week the administration said OK. They would employ their administrative discretion not to pay for abortion in that program. But they said and we said and the ACLU said and everybody agreed they were authorized to do so and they had already approved plans to do so. There is nothing in the bill to prevent it. It was authorized. There is nothing in the Executive order that even mentioned it. All of these events are recited in detail in my written testimony and in the affidavit.

Mrs. BLACKBURN. Thank you. Yield back.

Mr. PITTS. Chair thanks the gentlelady and recognizes the ranking member emeritus Mr. Dingell for 5 minutes.

Mr. DINGELL. Thank you Mr. Chairman. Ladies and gentlemen, I heard someone at the committee table—I don't remember who it was, say that there are a number of subsidies for abortion in federal law. Could you tell me where they are, please, starting with Mr. Johnson?

Mr. JOHNSON. There are subsidies——

Mr. DINGELL. For abortion.

Mr. JOHNSON. Are we talking about the PPACA or other law?

Mr. DINGELL. Well all right, let us take first of all the Health Care Reform Bill. Are there subsidies in there?

Mr. JOHNSON. Yes, we described them.

Mr. DINGELL. Where are they and what are they?

Mr. JOHNSON. In the written testimony I just gave one example: the high-risk insurance plan. The Administration in July was already approving State plans that covered elective abortion explicitly. They then backed off but they asserted and they were correct that they were authorized to do so by the statute.

Mr. DINGELL. All right now——

Mr. JOHNSON. They weren't mandated to do so, they were——

Mr. DINGELL. All right, Let us analyze that. When you subsidize something you pay more than the cost of it. Is that right? That would be a good definition isn't it?

Mr. JOHNSON. The cost of what, sir?

Mr. DINGELL. Well, if I am subsidizing abortion I am going to pay more than the cost of the abortion to the person that I am giving the money to. Is that right or wrong?

Mr. JOHNSON. I am not sure I follow you, sir.

Mr. DINGELL. Well——

Mr. JOHNSON. If that is——

Mr. DINGELL. In the farm bill we give a subsidy and there we subsidize farmers for producing goods. We essentially pay them to do that. So where in this—where in the Health Reform Bill is there where we subsidize it, where we pay people to have it?

Mr. JOHNSON. Well, that was——

Mr. DINGELL. Where we give them a financial inducement?

Mr. JOHNSON. This first example which would be the first in a long list I could give you if I had time——

Mr. DINGELL. All right.

Mr. JOHNSON [continuing]. Is 100 percent federally funded program. It is 100 percent federally funded. That is where it goes.

Mr. DINGELL. But 100 percent federal funded——

Mr. JOHNSON. To purchase the health coverage——

Mr. DINGELL. I am sorry?

Mr. JOHNSON [continuing]. For the population that qualifies for this particular program, the pre-existing condition program created by the PPACA. OK. Now, so we take it as a premise.

Mr. DINGELL. You are telling me it is a pre-existing condition prohibition pays a subsidy for people to get abortions?

Mr. JOHNSON. They were paying 100 percent of the cost of State plans.

Mr. DINGELL. One hundred percent of what cost?

Mr. JOHNSON. They were covering the cost of the health plan, sir. Entire cost——

Mr. DINGELL. One hundred percent——

Mr. JOHNSON [continuing]. Of the health plan is being paid by the Federal Government.

Mr. DINGELL. Well, maybe I am looking at a different session but I am curious. We don't—the government doesn't pay 100 percent of that. We simply say you got to pay—you say to the insurance company you have to give folks this—you have to give them coverage

and may not deny it because they have a pre-existing condition. What—how?

Mr. JOHNSON. No, that is—you are—that is a different part of the law.

Mr. DINGELL. All right. To what——

Mr. JOHNSON. I am talking about——

Mr. DINGELL. To what do you refer? I am having a hard time following you.

Mr. JOHNSON. I am talking about it is the high-risk pool program that pre-existing insurance——

Mr. DINGELL. All right, so the high—the pre-existing where does that subsidize?

Mr. JOHNSON. Section 1101.

Mr. DINGELL. What——

Mr. JOHNSON. This is for the qualified population the Federal Government pays 100 percent of the cost of their health coverage.

Mr. DINGELL. Of the health coverage. Do we pay 100 percent of the rest of the—wait, hold—do we pay——

Mr. JOHNSON. And the State plans were explicitly covering—pay for——

Mr. DINGELL. Just yes or no? Do we pay or?

Mr. JOHNSON. Yes. Of course.

Mr. DINGELL. We pay 100 percent of the cost of the abortion?

Mr. JOHNSON. When the government pays for health insurance it pays for what the insurance pays for, Mr. Dingell. And if you adopt the view that it is a bottom line issue. Look at back when Medicaid was paying for 300,000 abortions a year before there was a Hyde amendment. Now, every time they paid for one of those abortions they actually saved the cost of childbirth which is more expensive than the abortion. So you could say there was no bottom line impact and that the government wasn't actually subsidizing abortion when they were paying for 300,000 elective abortions a year. We think that——

Mr. DINGELL. Let us stay——

Mr. JOHNSON [continuing]. Would be tortured logic.

Mr. DINGELL [continuing]. With my question and not get off into rather odd dialectic here if you please. I am trying to understand if the Federal Government pays the cost of the overage so that the State may offer this particular benefit to people how is it then that they are subsidizing abortion? I am trying to understand how——

Mr. JOHNSON. I am not sure why you keep talking about the State. This is a 100 percent federally funded program.

Mr. DINGELL. OK. Well, there are actually several programs here, but all right, let us say it is 100 percent federal. Where—how is the Federal Government, if they pay 100 percent of that cost, subsidizing abortion?

Mr. JOHNSON. If the Federal Government is paying for somebody to enroll in this program in, say New Mexico which is one of the plans, and that plan covers elective abortion, then the Federal Government is paying for every abortion that is paid for by that plan. How could it be otherwise?

Mr. DINGELL. All right, what are the other subsidies?

Mr. JOHNSON. There are authorizations in the PPACA for a great deal—what seven billion in money to community health centers. These——

Mr. DINGELL. So do community health services—centers provide abortions?

Mr. JOHNSON. Some do.

Mr. DINGELL. How many?

Mr. JOHNSON. This was disputed. We don't know.

Mr. DINGELL. I have got seven of them in my District and I am not aware of one that does.

Mr. JOHNSON. There is a national project called the Reproductive Health Equity Project I believe which is devoted to trying to get them to adopt abortion as part of their regular——

Mr. DINGELL. Is that covered by the Hyde amendment?

Mr. JOHNSON. It is not, sir, because these funds are self-appropriated in the packet itself. Now, the President in his Executive order purports to say please don't use those monies for abortions but there is no statutory basis for it. The Hyde amendment only covers what flows through the HHS appropriations pipeline. The PPACA has a great many new pipelines self-appropriated at this——

Mr. PITTS. The gentleman's time has expired.

Mr. DINGELL. Thank you, Mr. Chairman.

Mr. PITTS. Gentlemen, the Chair recognizes the gentleman from Pennsylvania, Dr. Murphy for 5 minutes.

Mr. MURPHY. Thank you, Mr. Chairman. I hope I can—you can see me back there. I just want to clarify the stream and what is the law and not the law. Can federal money such as Medicare, Medicaid be used to purchase medical supplies at health clinics? Can that be used? Yes or no, anybody from the panel.

Ms. ROSENBAUM. Certainly Medicare and Medicaid pay for the supplies.

Mr. MURPHY. OK yes, OK. And so they can pay the rent and heating and utilities that clinics that perform a number of services including abortions?

Ms. ROSENBAUM. There would be no payment. I am——

Mr. MURPHY. But if it is the same building it would pay for the medical supplies and utilities and the rent et cetera where some types of medical procedures are covered, but also where abortions are also performed. Is that correct?

Ms. ROSENBAUM. You could not bill for a prohibited feature.

Mr. MURPHY. But if it pays the rent and utilities and the medical supplies you could use Medicare funds, Medicaid funds to pay for that where those abortions may also exist. Am I correct?

Ms. ROSENBAUM. No, you could not bill for a prohibited feature. And you could not pay for——

Mr. MURPHY. Can you—if an abortion takes place and there is medical equipment needed: sutures, scalpels, scissors, clamps, gauze, medicines, can some of those that are paid for in the clinic in one category filing or closet be also used for a woman who may be having an abortion?

Ms. ROSENBAUM. I still don't understand. You cannot bill for a prohibited feature.

Mr. MURPHY. When a clinic purchases supplies do they have two separate medical supply rooms? One that is paid for—the money could come from federal or say taxpayer dollars such as Medicaid and another entirely separate funding stream where supplies would come from? Are they kept entirely separate? Does anybody on the panel know? OK. I hold in my hand a federal grand jury report about a clinic in Philadelphia, first judicial district of Pennsylvania. It is 260 pages worth of shocking and horrifying descriptions of what took place at the Women's Medical Society. It is—and it has procedures and lists of things too gruesome to describe. Many babies who were born, who were viable and were left on a table until the doctor would come in and use scissors to sever their spine. The fellow Rhenus Clinic is up for many charges of murder although it is estimated this actually took place in the hundreds. Now, I want to show you a document here which is fairly important with regard to this that—with regard to how one billed for some of these services. And what it has on this document, it is very interesting the column of how things are paid for because it lists some of the prices. Let me see if I can find it here. It lists some of the prices for these services and in this column it says you know paid for by Medicaid and for—and then part was out of pocket expenses. Does anybody—here would help me find that paper. Anybody know how that could be?

Ms. ROSENBAUM. I presume you would have to ask the Pennsylvania Medicaid folks.

Mr. MURPHY. I mean the thing that is real difficult for me is we are told it is illegal and yet here is a clinic that has operated for quite a time billing Medicaid. I want to know how this is where it has on this price list and it is broken down by the age of the fetus from 6 to 12 weeks under discount price for Medicaid and cash it is $330. Thirteen to 14 weeks gestation is $440. When it is 21 to 22 weeks it is 1180 although the 23 to 24 weeks because it is a 3 day procedure of dilation for a partial birth abortion it is 1525. The prices go up according to the age of the baby. But it says Medicaid and cash and I don't understand how if we are saying federal taxes don't go towards paying for abortions I just want to make sure we are not living in a delusional world. Is it used or not?

Ms. ROSENBAUM. A State Medicaid program, a state Medicaid agency can use nonfederal share funding to pay for a broader range of services.

Mr. MURPHY. How do they do that? Do they mark the bills that come from the Federal Government and separate them into a pile?

Ms. ROSENBAUM. Yes. They literally segregate out claims that would be federally allowed.

Mr. MURPHY. So state taxpayer dollars——

Ms. ROSENBAUM. This is a——

Mr. MURPHY [continuing]. Are going toward this? But State taxpayer dollars can go toward these abortions?

Mr. JOHNSON. I have a different view on this point, Mr. Murphy.

Mr. MURPHY. Yes.

Mr. JOHNSON. First of all, it is not true that the Hyde amendment allows states to use matching funds in Medicaid for abortions other than life of the mother, rape, and incest. This is explicitly prohibited by the text of the Hyde amendment which again the

complete text is footnote 10 in my written testimony. But a state may set up a parallel program with entirely state funds. Technically it is not Medicaid——

Mr. MURPHY. Taxpayer funds.

Mr. JOHNSON [continuing]. As former administrator has pointed out—to cover whoever they want with entirely state funds. But Pennsylvania has not done so. Pennsylvania in fact has resisted even the expansion to the rape/incest back during the Clinton Administration. So I can't explain the document that you have in your hand. I think that does bear further investigation. And it really illustrates how particularly with respect to late abortions a lot of the things that were told, statistics and so forth are highly suspect. I mean, you are told that late abortions are quite rare. Well, even by the Guttmacher Institute figures there is at least 20,000 a year after the first half of pregnancy in the fifth month or later—maybe a lot more.

Mr. MURPHY. Mr. Chairman, I would just ask as part of what the committee takes action in researching this issue in terms of how that funding stream was done and look at this is it an example or not of how taxpayers funds were used to pay for abortions. Thank you. I yield back.

Mr. PITTS. Without objection. Thank you. The Chair recognizes the gentlelady from California, Ms. Capps for 5 minutes.

Mrs. CAPPS. Thank you, Mr. Chairman and before I get to my questions I want to ask unanimous consent to submit for the record statements from NARAL, an organization opposing this legislation.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mrs. CAPPS. Thank you. Previously my colleague Mr. Waxman was asking some questions and I want to follow up on one of his questions to you, Professor Alvaré. Should a health care provider whose conscience dictates that they should provide abortion services just like in Mr. Waxman's example of a woman who had been raped. If you from your lawyer's point of view from being an attorney and a professor of law, should that individual provider's conscience receive the same protection under the law that you support for those opposed to abortion? We are talking about the conscience clause here.

Ms. ALVARE. The first thing with respect to this particular legislation is that they are free to provide abortions in the United States. It remains legal. It remains legal throughout pregnancy and they are free to do it. I would not want legislation that particularly protects their conscience to do it within an institution that doesn't want to do it. They are free to do it anywhere they like except of course within an institution whether they are religious or just morally opposed to abortion. We prefer as a nation life over death. The Supreme Court has allowed States to do that and if they want to extent conscience protection particularly to people who do not want to provide abortions it is because those are the people being forced. People who want to provide abortions are not stopped from doing so.

Mrs. CAPPS. So you are referring to an anti-discrimination law?

Ms. ALVARE. People who want to provide abortions are not stopped from doing so. That is the state of our country right now.

Mrs. CAPPS. OK. Let me point out that you have asserted also that poor and vulnerable women are often treated by Catholic hospitals and that the protection of conscience and care for vulnerable women are not opposite values. But this is the situation that Professor Rosenbaum brought up. November of 2009, a 27-year-old pregnant woman brought to St. Joseph's Hospital, a medical center in Phoenix, Arizona suffering pulmonary hypertension. To quote the hospital in that case the treatment—her hypertension was exacerbated by the pregnancy and the treatment necessary to save her life required the termination of an 11 week pregnancy. This decision was made after consultation with the patient, her family, her physicians, and in consultation with the ethics committee of the hospital. Fortunately because of the doctor's actions in this case this woman lived. That is what you are referring to and then went home to care for her four children. Now in your testimony, Professor, you describe the need for institutions and medical providers to be able to choose against performing health care services that they find objectionable. Do you believe that if—that the hospital should have had the choice in a different situation or with a different set of committees and so forth to let this woman die without a treatment or referral?

Ms. ALVARE. Congresswoman, I think the hospital would disagree with your characterization. The details of this particular situation have never been fully, publicly verified——

Mrs. CAPPS. But you could answer my question as an attorney. Say the details were——

Ms. ALVARE. Well, they said it wasn't an abortion, Representative.

Mrs. CAPPS. Well, but it—the—then——

Ms. ALVARE. At the hospital.

Mrs. CAPPS. Then make this a hypothetical situation.

Ms. ALVARE. OK.

Mrs. CAPPS. As a professor of law in this kind of situation do you believe that a hospital with a conscience clause who chooses not to perform these procedures should let this woman die? Or someone who is hemorrhaging which is sometimes the case in a pregnancy and only has a few minutes to live and in some parts of this country there is not another hospital within the time that would be allotted.

Ms. ALVARE. Then if you believe that unlike what Guttmacher says——

Mrs. CAPPS. I am asking you to answer for yourself.

Ms. ALVARE. Yes, that—but it is premised on the question that you believe this situation could occur. Doctor and Representative Burgess has suggested it hasn't—38 years of legal abortion it hasn't.

Mrs. CAPPS. But the conscience clause should apply—it needs to apply.

Ms. ALVARE. Where we really need some conscience protection in a big way is at the health department officials that need investigating.

Mrs. CAPPS. But you are not answering my question, Professor.

Ms. ALVARE. No, I think I have with due respect that we don't have that situation. It is hypothetical. What is not hypothetical is

the dozens of women dying at abortion clinics like Dr. Gosnell's. We need protection for those women and the situation in Phoenix as you said you——

Mrs. CAPPS. Let me put it in another way. I don't want to interrupt you, but I—there is such little time. In your testimony you seem to indicate that an individual with life threatening emergency has time to Google all the available medical services and she could get to some other place to find a treatment for her life threatening hemorrhage. For this woman to receive the care she might need she would have to self—do you not think this is an incredibly unreasonable action to expect from a woman in that sort of condition?

Ms. ALVARE. I never referenced Googling hospital services in any of my testimony. There is nothing similar to that in my written testimony. What I am telling you is that when it comes to women dying in connection with abortion we have dozens and dozens and dozens of examples——

Mrs. CAPPS. But doesn't—but you——

Ms. ALVARÉ [continuing]. At abortion clinics but not in a hospital setting. None in 38 years.

Mrs. CAPPS. I yield back.

Mr. PITTS. Chair thanks the gentlelady and recognizes the gentleman from Georgia, Mr. Gingrey for 5 minutes.

Mr. GINGREY. Mr. Chairman, thank you. I want to refer back to a line of questioning that the ranking member brought up earlier. I don't think he is still here, but this is in regard to the questions over conscience protections and I am going to address this to Ms. Alvaré. Does the Pitts legislation, the Protect Life Act, does it provide any additional conscience protections that are not included in the Patient Protection and Affordable Care Act, sometimes referred to as "Obamacare." Or indeed President Obama's Executive order. And if so, why do you think those protections should be adopted through enactment of the Pitts legislation before us here today?

Ms. ALVARE. Thank you. A good deal of that is to preserve what we always had in the Hyde-Weldon legislation. For instance specific examples, the Affordable Care Act extended nondiscrimination protection with regard to health plans but not as against actions of government. The Stupak-Pitts amendment which was adopted by voice vote, by the full Energy and Commerce Committee in 2009 included those protections just like Weldon did. It was considered so uncontroversial that it included those on a voice vote. Additionally and this is where I would appreciate the opportunity to clarify what I believe was Congressman Waxman's fundamental misunderstanding of that piece of the Protect Life Act that talks about regarding abortion. He thought that by striking that language out of the Affordable Care Act and putting other language in we were actually allowing for hospitals to refuse to provide or health care providers, et cetera—any entity to provide this wide array of health care services that he listed. In fact, that was just the striking of a heading because the heading did not appropriately characterize what went underneath it. And in addition, it was connected with amending the Affordable Care Act to make sure that not only did it not preempt State laws on abortion, but it also didn't preempt those 47 States and the District of Columbia that already have conscience protection on the books. So his reading of that particular

piece of Protect Life Act I would say is not—would not be what the text is saying. And that what it was doing that the Affordable Care Act didn't do but now we would have under the Protect Life Act was to protect all those State's conscience protection clause.

Mr. GINGREY. So Ms. Alvaré, in just in summary from what you say, clearly your opinion is that what is in Patient Protection Affordable Care Act and also in the Executive order does not go far enough in regard to the conscience clause; therefore, the need of that provision, that section of the Protect Life Act in the Pitts bill.

Ms. ALVARE. On its face——

Mr. GINGREY. Yes.

Ms. ALVARÉ [continuing]. Textually speaking Protect Life Act does——

Mr. GINGREY. And I think that is a yes and I am going to accept that——

Ms. ALVARE. Yes.

Mr. GINGREY [continuing]. Because my time is getting limited. I did want to go to Mr. Johnson. And Mr. Johnson, some have suggested that the current existence of the Hyde amendment and the President's Executive order mean there is no need for the Pitts legislation. Does President Obama's Executive order support the Hyde amendment and does his Executive order address all of the concerns regarding federal funding of abortion?

Mr. JOHNSON. The reference in the Executive order, the Hyde amendment is just discursive. It is a form of misdirection. Of course, the bill doesn't repeal——

Mr. GINGREY. Let me interrupt you just for a second. I will let you answer. And I think that came up a little bit earlier. My colleague from Tennessee, Ms. Blackburn mentioned the interview that the former Chief of Staff to the President, Mr. Rahm Emanuel had in an interview with the Chicago Tribune, he essentially said that. Did he not? You go ahead.

Mr. JOHNSON. Yes, and that is why president of Planned Parenthood said it was just a symbolic gesture. By the way, I am sorry Mr. Dingell is not here anymore because my associate handed me the memo from the Congressional Research Service about the high-risk pool program that we were discussing a few minutes ago and it says—this is a memo from the CRS July 23, 2010, and I quote "Because the Hyde amendment restricts only the funds provided under the appropriations measure for the Departments of Labor, HHS, and Education, it would not seem to apply to the funds provided for the high-risk pools." And that is why the ACLU criticized the White House when they made the discretionary decision after the public controversy last July not to fund abortions in that particular program. They had the authority to do so under the PPACA. They decided not to because of the controversy.

Mr. GINGREY. Mr. Johnson, let me interrupt you just quickly. In the last 5 seconds I have do you think then that the Protect Life Act is an effort to codify, essentially to codify the language in the Stupak-Pitts amendment that was passed by this house in November of 2009?

Mr. JOHNSON. Yes, the bill was patterned very closely on the amendment that passed the house by——

Mr. GINGREY. With much Democratic support.

Mr. JOHNSON [continuing]. Two-hundred forty votes, which was one quarter of all the Democrats and no Republican voted against it.

Mr. GINGREY. Thank you. Yield back.

Mr. PITTS. Chair thanks the gentleman and recognizes the gentlelady from Illinois, Ms. Schakowsky for 5 minutes.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. I wanted to ask you Mr. Johnson, do you want to stick with your statement that the Federal Government pays 100 percent of the high-risk pools?

Mr. JOHNSON. Yes, and in fact that statement is up on the Secretary Sebelius's Web site.

Ms. SCHAKOWSKY. I have in my hand the Illinois plan, the Illinois Pre-existing Condition Insurance Plan and it says how is IPXP being funded. In addition to the federal funds, the IPXP will be funded by premiums paid by enrollees and here is the whole list of the money that is being paid by the enrollees. This is not a question. I want to say for the record that this is not 100 percent paid for by the Federal Government. And if I could just have a yes or no answer to this, did the National Right to Life Committee support the changes to the Hyde amendment that were originally included in this bill forcible rape and regarding incest if a minor?

Mr. JOHNSON. I can address that question, but not with a yes or a no.

Ms. SCHAKOWSKY. Well, it seems pretty simple. Did the organization support those?

Mr. JOHNSON. We supported the bill as introduced. We also support the current policy which is incorporated in the Hyde amendment. I believe that these—well, Congresswoman if you want my position then you will have to allow me to answer in my own way. We support the policy that is incorporated in the Hyde amendment. It is not perfect, but we do support it. And we supported the bill as introduced. It is not perfect either. You know we could discuss the history of how the language was——

Ms. SCHAKOWSKY. No, I—medical doctors on—however, my understanding of the National Right to Life constituent views of the term for—they said see it as what we are talking about as frivolous or—so let me ask you this. Is it elective when a woman has an abortion because she will go blind because of the use of all the——

Mr. JOHNSON. The term elective as it has been used the last couple of years and in testimony today is a kind of shorthand for abortions outside the scope of the Hyde exceptions, life of the mother, rape, and incest. It is not a moral judgment or an ethical judgment on these other circumstances. It is just a shorthand way——

Ms. SCHAKOWSKY. So in other words by that definition elective, if a woman would go blind as a result of pregnancy that would be outside of Hyde and that would be elective?

Mr. JOHNSON. That would be elective as the term has been used in some of this discourse as a form of shorthand. It does not—the circumstance you have just described is not to prevent the death of the mother as you have just stated. It is not rape. It is not incest.

Ms. SCHAKOWSKY. Right, OK. So is it elective then—I want to just get this on the record if a woman with an ectopic——

Mr. JOHNSON. I have answered your question.

Ms. SCHAKOWSKY. No, I am asking another question. Excuse me. If the—is it elective if a woman with an ectopic pregnancy has the embryo surgically removed while leaving the fallopian tube intact?

Mr. JOHNSON. What you have described many would dispute as any kind of an abortion, but if it is to be considered an abortion it would be considered an abortion to save the life of the mother and certainly allowed by Hyde. Indeed this was explicitly in the Hyde language back in the '70's I believe or at least in the conference report. But it has never been an issue.

Ms. SCHAKOWSKY. If—is it elective if a woman miscarries one of the twins she is pregnant with and terminates the pregnancy of the second fetus after doctors conclude there is no hope for survival?

Mr. JOHNSON. For whose survival, Congresswoman?

Ms. SCHAKOWSKY. For the—no hope for survival of the fetus.

Mr. JOHNSON. The Hyde amendment does not permit federal funding of abortion of a child because the child has a poor prognosis or a handicap. The criteria is if the life of the mother would be endangered if the pregnancy were be carried to term.

Ms. SCHAKOWSKY. So, no hope for survival does not constitute—that would be elective? No hope for survival.

Mr. JOHNSON. No hope for survival of the child for some time after birth? Is that what you are saying?

Ms. SCHAKOWSKY. That the child cannot perhaps survive the full nine months or could not survive after birth. Right.

Mr. JOHNSON. The Hyde amendment does not permit federal funding of abortion as a form of prenatal euthanasia.

Mr. PITTS. The Chair thanks the gentlelady and recognizes the gentleman from Louisiana, Mr. Cassidy for 5 minutes. You want to step back here? We will hold the five.

Mr. CASSIDY. Hi Ms. Rosenbaum. In full disclosure to everybody else, you and I have authored and coauthored a paper before.

Ms. ROSENBAUM. I have to put my mic down for that. We have indeed.

Mr. CASSIDY. Yes. Now, a couple things. I am approaching this as a physician because some of this discussion—a woman doesn't go blind from diabetes in pregnancy. The Renal-retinal syndrome is something that develops over years and so it is not something that would precipitously occur. And that is just one example how as a physician I have kind of approached this. When I read your testimony you quoted an article that you had written so I pulled it up. I have great respect for your writing. And one of the things you are talking about here is medically indicated and you say a woman has a car wreck, fractures her pelvis, loses the baby, would the hospital not be paid for fixing the pelvis because the baby was lost. Now frankly, that would most likely be to save the life of the mother, but I had never heard of a hospital having a problem in such a situation, a major motor vehicle accident. Have you?

Ms. ROSENBAUM. Let me just be sure I am following your question.

Mr. CASSIDY. I am reading your paper here—I am sure you are familiar with it. It is regarding the Stupak-Pitts amendment. It is actually about current law and not about what is proposed. And you say how will plan administrators distinguish between the abortion procedure and the rest of the treatment? Will the entire cost

of a course of treatment—example, surgery to repair a damaged pelvis following an automobile accident—be denied if abortion is part of the procedure. I have never heard of that happening. Have you?

Ms. ROSENBAUM. Here is the problem. The analysis which I reference and also gave sort of shorthand to in my oral statement focuses on the administrative choices made by health plans. When a particular treatment is excluded often they will say that other treatments that are related to the treatment——

Mr. CASSIDY. But see, for example, I am sure we have experience with Medicaid managed care.

Ms. ROSENBAUM. Yes, absolutely.

Mr. CASSIDY. If a woman comes in with sepsis following a whatever—an abortion that normally the Medicaid wouldn't pay for, she paid cash and had a complication and came to the hospital, I have never heard of a managed care plan not paying for the rescue, if you will, of the botched procedure. Have you?

Ms. ROSENBAUM. What I am writing about and testifying about is what is absolutely legally within the right of the——

Mr. CASSIDY. So it is not anything that empirically happened with a long experience with Medicaid managed care. Rather it is a what if?

Ms. ROSENBAUM. It is the legal implication of having an exclusion. This is once you have a benefit exclusion then other——

Mr. CASSIDY. But we have benefit exclusions in Medicaid managed care which is why I come back to that. Medicaid managed care does not cover abortion.

Ms. ROSENBAUM. Correct.

Mr. CASSIDY. But as far as I know I have never heard of it not paying for the rescue of somebody who has had a complication following a cash paid abortion. Have you—again, I just ask because I don't think you are fear mongering on purpose, but frankly it has that effect because I have never heard of that and that is as a practicing physician.

Ms. ROSENBAUM. Well, I think the issue in analyzing a bill like this is to identify for Members of Congress what the potential implications are. Now you could address the issue——

Mr. CASSIDY. Now I accept that. OK. So I think it is fair to say it hasn't happened and it is just a question of——

Ms. ROSENBAUM. No, we don't know, at least. There has been no documentation.

Mr. CASSIDY. I can promise that would hit the newspaper. But that said, and again I was struck because I have seen patients. Although I am a gastroenterologist. I know of such patients. Secondly, the ERISA market—there seems to be some concern you have that by doing this we are going to somehow destroy the insurance market for non- federally somehow connected plans. It is interesting that you suggest that a lot of people are going to drop their current coverage to go on a subsidized plan and I will note that we were assured that was not going to happen. But nonetheless, as you note in your paper we have a huge ERISA market. I mean, a huge 87 percent of the people are covered by ERISA and most of those folks have coverage. Maybe as a percentage it will

decline but really in absolute numbers it is huge. Are you saying that that will go away?

Ms. ROSENBAUM. No, no. The paper addresses what happens when the same health benefit companies that sell products in, let us say the exchange market, are also selling small group products, employer products in the non-exchange market. A company can only make so many variations on the product itself.

Mr. CASSIDY. But we certainly know that they do make a lot of product variations now. Now you mentioned, for example, that there is dental and vision. We all know that and you say that would be a smaller market. On the other hand I have no doubt there is an enterprising insurance company out there that will become the coverer for many other companies.

Ms. ROSENBAUM. The problem with this particular market is that if you follow both this bill and H.R. 3——

Mr. CASSIDY. Now by the way, we are talking actually by—this is about Stupak-Pitts.

Ms. ROSENBAUM. Yes, yes, yes.

Mr. CASSIDY. So you are describing now what would be the effect of this addendum, if you will, but rather what is the effect of the current Executive order as regards PPACA now. Correct?

Ms. ROSENBAUM. No, no, no. In fact, I would say this bill would bring health reform into line with what originally was Stupak-Pitts.

Mr. CASSIDY. OK. So the original kind of thing that passed by a huge bipartisan, this would bring it into align with where that was?

Ms. ROSENBAUM. This would substitute——

Mr. CASSIDY. Yes.

Ms. ROSENBAUM [continuing]. At least in part Stupak-Pitts for what was——

Mr. CASSIDY. They are clicking behind me. We are through. Thank you very much.

Mr. PITTS. Gentleman's time is expired. Chair recognizes the gentlelady from Wisconsin, Ms. Baldwin.

Ms. BALDWIN. Thank you, Mr. Chairman. Before I begin I would like to ask unanimous consent to submit for the record the testimony of Dr. Douglas Laube who is the Board Chair of Physicians for Reproductive Choice in Health.

Mr. BURGESS. Mr. Chairman, could I ask to see that before we have that unanimous——

Mr. PITTS. Could we request a copy of that?

Ms. BALDWIN. Well certainly.

Mr. BURGESS. While we are on the subject, can I see the paper that the previous questioner was referring to? If I could get a copy of that as well that would be great.

Mr. PITTS. No——

Mr. BURGESS. Thanks. No rush. I just——

Mr. PITTS. All right, the gentlelady is recognized for 5 minutes.

Ms. BALDWIN. And the result of my unanimous consent request? Have I——

Mr. BURGESS. Take a minute to read it. I don't mean to be rude. I am going to read while you are talking but I can listen while I read.

Ms. BALDWIN. All right. Earlier I expressed my dismay that our very first hearing of this subcommittee in this brand new session of Congress wasn't focused on the issues that are most important to my constituents. I would suggest all of our constituents—that being jobs. Many facets of which would be directly relevant to our subcommittee's jurisdiction. But instead on a bill that rolls back the right of women to make important life decisions. And I think that speaks volumes and I wonder what else we will see on this issue in the weeks and months to come. Will we see defunding of family planning and access to contraception? Will we see revisiting of the rape and incest exemptions? And on that topic, I am familiar with the chairman's bill as introduced. I believe it is H.R. 358 and another bill, H.R. 3. That one which is cosponsored by over half of the Republican conference. In both of those bills there is a redefinition of the rape exemption that would give insurance companies and health care providers new authorities. Perhaps you could even argue new responsibilities to decide if a woman has been forcibly raped and the authority to deny care to victims of incest. You know, it used to be that we told our young daughters and sons no means no. But now apparently no isn't sufficient. What happens if a rape victim is unconscious? What about somebody who has been given the date rape drug as it is known? Are these people no longer considered rape victims? Now, thanks to Americans and particularly American women who spoke out against these provisions, we are now considering a discussion draft of the Chairman's bill without these provisions. Although I don't have the discussion draft at my desk. I don't know if I am alone, but am I——

Mr. PITTS. Where is it?

Ms. BALDWIN. Were people provided with the discussion draft, because I would like to certainly confirm that that language has indeed been removed? But it doesn't appear to be at our desks with our materials. In any event, let me move on. We know that this language in this proposal is not new. During the debate last year on the health care reform bill, this language was proposed and ultimately again withdrawn. So I guess, Professor Rosenbaum, I would like to explore the impact of this proposed redefinition of rape and incest that was included in the legislation H.R. 358, a variation of what we are looking at today. Who would make these treatment and coverage decisions for victims of rape and if this redefinition were to occur how might it be applied in practice? It is deeply troubling to me.

Ms. ROSENBAUM. There would be—really two levels of decisionmaking. First of course there would have to be a structure by which the sellers of the products themselves could certify that they were in compliance with the definitions. And so in this case because we are talking about a tax advantage plan definition the IRS would have to define these issues. But then when it comes to individual claims, it would go through a claims appeals process. So if you were a woman who claimed to have had an abortion for a covered purpose, the plan might review the claim and decide that the medical justification, the supporting evidence was not strong enough and would have legal authority of course to deny the claim for that purpose. So it would be an evidentiary determination just

like any evidentiary determination. Then you would go through the appeals process.

Ms. BALDWIN. What about at the treatment stage? Is there any—what would come into play there in terms of what a young victim of rape would have to share in terms of demonstrating that she was forcibly raped?

Ms. ROSENBAUM. If the standard is a forcible rape standard then one could imagine everything from police reports which sometimes don't exist in these cases because of fears about coming forward. Other evidence, evidence of particularly brutal attack, physical tearing, all of the medical, clinical, law enforcement evidence that would surround presumably a forcible rape would come into play. And the insurer would be labeled as the bad guy but the insurer would be doing what it legally needed to do in order to adhere to the federal exclusion.

Ms. BALDWIN. Thank you and I would renew my unanimous consent request.

Mr. PITTS. Chair thanks the lady. There is no objection so with unanimous consent, so ordered.

Ms. BALDWIN. Thank you.

Mr. PITTS. Chair thanks the lady and recognizes the gentleman from Kentucky, Mr. Guthrie for 5 minutes.

Mr. GUTHRIE. Thank you, Mr. Chairman. My friend Mr. Cassidy was talking about this—the paper, Ms. Rosenbaum that you had and I guess what you were saying how is the physician going to—if there is an abortion procedure, there is complication of that and they are treated beyond that, how are they going to disentangle what was abortion related and what wasn't. That was the same question we had with insurance. If somebody goes into the exchange and they receive a subsidy to go into the exchange, whether they pay 80 percent, 50 percent, and some of the argument that was made on the floor, I guess in the Senate although we did pass Stupak-Pitts in the House, was how do you know what portion of that premium is going to be for abortion? How—what portion is going to be from the federal taxpayer? And without being able to disentangle that we said well, you can't disentangle it because it is all tied together. And therefore, the intent is to ban this to keep with our idea that the federal taxpayer shouldn't pay for people's abortions. And on that with Mr. Johnson—and I am going to try to get this quickly because I want to yield some time. With Chairman Dingell, or Mr. Dingell you were talking about the coverage. So even if you don't get 100 percent coverage in the high-risk pool, if you get some percentage of coverage in the high-risk pool or any exchange, if the exchange offers abortion coverage and then there is no way to disentangle just what I was saying, what is a federal dollar and what is a private dollar?

Mr. JOHNSON. Well, these are two different issues. I think Congresswoman Schakowsky and I were talking past each other a little bit. The high-risk pool program, yes, the client has to pay a certain amount in. Those become federal funds. Those become federal funds. That is why the secretary of HHS, on their Web site, says it is 100 percent federally funded. The state contributes nothing. The clients pay a certain fee just like in Medicare, but those then become federal funds. The notion that a federal agency can pay out

of the treasury for medical services, abortions, or any other and that that is the use of private funds is really a hoax. And we saw an attempt with the Capps amendment on a bill last year to make that claim where the—under the public plan, the secretary of HHS would have been paying for elective abortions out of the federal treasury and they said but that was private funding of abortion. That is a hoax and nobody would entertain it for a moment if you were talking about some context other than abortion.

Mr. GUTHRIE. I am going to yield the remainder of my time to Mr. Burgess.

Mr. BURGESS. I thank the gentleman for yielding. And in fact, Mr. Johnson when we had that discussion on the Capps amendment in the mark-up of the Patient Protection and Affordable Care Act in July of 2009 the Democrats own counsel characterized that as, he said it would be a sham if I recall correctly. It was late at night and after a lot of discussion, but I think many of us were startled when Mr. Barton asked the question and again the Democratic Counsel said no, that would be a sham.

Mr. JOHNSON. We cite in our testimony a host of authorities on this that these are public funds, federal funds once they are collected. The government collects money through diverse means: taxes, user fees, these premiums, and so forth. They are all federal funds once the government has them.

Mr. BURGESS. On just a couple of things that have come up. The issue of a pregnancy located in the fallopian tube—I just—there would not be a situation arise where that would not be the health of the mother invoked in treating that condition.

Mr. JOHNSON. Life of the mother.

Mr. BURGESS. Life or health of the mother with—life of the mother. Whether you use Methotrexate as a medical procedure or a surgical procedure but that has to be treated and everyone recognizes that. The paper that I asked permission to look at before we accepted it in the record does go through a litany of very hard rendering difficult situations. There is only one that is referenced in here that really would fall outside the emergency classification where it needed to be ten to two whether it is a hospital that provides this service or not. The doctor is obligated under EMTALA to provide that care, stabilize, transfer to another facility if the condition permits it, but only one of the six or seven cited here would actually fall into the category of elective. And the one that is elective, again, it is a tough story of someone with another child who is ill and decides not to carry their pregnancy. But that is hardly an emergency situation and one that can easily be stabilized and a proper caregiver found. Now, the other issue that is brought up in this paper is the issue about that the requirement of a rider would be unworkable, but in fact that is what insurance is. It is planning for the unplanned. And it does not seem to me to be unreasonable to ask for that to be one of the conditions. And again, the President is pretty clear in his Executive order I think. So we are just—Mr. Pitts, I congratulate you. You are trying to help the president and there are a lot of people who would say that that is an evidence of bipartisanship. So I welcome.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman from New York, Mr. Engel, for 5 minutes.

Mr. ENGEL. Thank you, thank you Mr. Chairman. Look, we are all really beating around the bush here and when we are talking about a right of a woman to choose or the right of abolishing abortion in any circumstances. These are very heartfelt and personal views and I don't denigrate anybody's view on this issue. But I really am very much chagrined that first thing out of the box in this Congress the majority is pushing forward on wedge issues such as abortion when we should be doing things like helping our economy, and getting people back to work, and getting unemployment down. That is as far as I can see what the election was about in November and it is very disconcerting to see these wedge issues being pushed to the fore. Let me get back to basics. Let me first ask Professor Rosenbaum because we have been back and forth on this, aside from the narrow exceptions of life, rape, and incest, does the Affordable Care Act allow federal funding for abortion services?

Ms. ROSENBAUM. It does not.

Mr. ENGEL. OK. So it is—your reading of it is a lot different from some of the testimony we have been hearing?

Ms. ROSENBAUM. I think—and every effort has been made to clarify any circumstance in which there was any question. I can find no evidence that anybody has not clarified that the same standards that we know in Hyde apply under the Affordable Care Act.

Mr. ENGEL. In your testimony you state that the Protect Life Act will affect women's ability to find a health plan that includes abortion and purchase it with her own funds. Can you explain what that implication would mean for a woman's access to health services?

Ms. ROSENBAUM. The effect of the Protect Life Act would be in my view given my familiarity with the way insurers behave in a marketplace is that the market for the kind of coverage that one would need to buy essentially totally outside of the tax advantaged coverage just would never materialize because the people who are going to get the benefit of the Affordable Care Acts tax advantage system are individuals who don't have disposable income. They are by definition without the means to buy coverage. That is problem number one. Problem number two is the problem that I alluded to in both the written testimony and the oral statement namely it is very difficult to buy supplemental coverage and have that supplement totally, separately administered. Because the whole nature of a supplement is that it works in tandem with the basic coverage. Under the Protect Life Act the only way a supplement can be offered is if it is offered entirely separately, administered separately from the underlying coverage and is the example actually that Mr. Cassidy provided before where you have a terrible car accident and you have several things going on at the same time: an injury and potentially an abortion. You could easily end up in a situation where both—with the full coverage has to work in tandem in order to work otherwise the supplement and the primary just both deny it.

Mr. ENGEL. Well, I think that this is another attempt to try to kill the Affordable Care Act and I am sorry that it uses—this legislation uses low-income and middle-income women as a political football. I just don't think it is right. Professor Alvaré, I want to

ask you a question. You talked a lot about the conscience clause and conscience protections for hospitals and doctors. I actually do agree with you on a number of things. I don't think that anybody who is opposed to abortion should be forced to perform one. And I don't think that hospitals that for moral or religious reasons don't believe in it should be forced to perform it. That is their conscience. You talked about the conscience of doctors or hospitals. But what about the conscience of the woman who is being affected? If in her conscience, if what she decides and she has to make a gut-wrenching decision, or if the family has to make a decision because of the woman's health why are we not respecting her conscience? Why only the conscience of the hospital or the doctor?

Ms. ALVARE. Thank you, sir. Under your definition of that being her conscience we do have over 1.2 million abortions a year with a hugely disproportionate number among the women you would consider to be vulnerable that we especially want to take care of. And if you are saying that—which I would not agree with—that abortion is part of that care, then I think you can rest assured in a rather sad way that the most vulnerable women are getting access to the most abortions. And the conscience protection for them is Roe, Casey, Stenberg, Gonzales which allows abortion on demand in the United States.

Mr. ENGEL. But you would eliminate that so where is——

Ms. ALVARE. Absolutely.

Mr. ENGEL. Where is respect for her conscience?

Ms. ALVARE. This bill does not eliminate that whatsoever and I would also bring up which I should have before and I am sorry the Church amendment which since 1973 has not only said that employers can't discriminate against doctors who don't want to do abortions, but also can't discriminate against doctors who do. Now, they can't do them at a religious or morally opposed hospital, but they are protected by federal law from—for doing them.

Mr. ENGEL. But you would eliminate it given your druthers, would you not?

Ms. ALVARE. Would eliminate?

Mr. ENGEL. Abortion under any circumstances. You said——

Ms. ALVARE. That is absolutely true, but this Act doesn't agree with what I say.

Mr. ENGEL. Even with rape and incest you would say a woman should be forced to go through a pregnancy if she was raped or if there was incest.

Ms. ALVARE. I would never punish the child for what other people did. But this bill doesn't come close to reducing abortion in the United States, sadly enough, unless it changes the federal bully pulpit to say abortion is not a preferred service in a way that I hope it will.

Mr. ENGEL. Mr. Chairman, before I relinquish, Mr. Towns before he left asked me if I would submit for him for the record—unanimous consent to submit testimony from the National Asian Pacific Women's Forum and the Center for Reproductive Rights. I have it here. I am doing it on behalf of Mr. Towns.

Mr. PITTS. Good enough. Could—we haven't seen that. Take a look at that.

Mr. ENGEL. Yes. Thank you.

Mr. PITTS. Chair thanks the gentleman and recognizes the gentleman from New York, Mr. Weiner for 5 minutes.

Mr. WEINER. Thank you, Mr. Chairman. Let us face it. There is a broad gulf. Mr. Engel is right on people's views of abortion and the Hyde amendment is one way to come to a conclusion on it. I don't believe that someone should be denied a medical procedure because of their income. I don't believe that someone who is more well-to-do who gets enormous tax breaks from the country that we don't attach to that tax break an agreement that they won't get a certain medical procedure. I don't believe we should distribute health care that way. I think it is inhumane and immoral. We have this Hyde amendment that is supposed to try to strike some kind of a middle ground that I am not completely happy with and members of the panel are not completely happy with. But let us agree on what we are saying here. We are not codifying the Hyde amendment. The Hyde amendment says that there is an exemption from the restriction of an abortion if a pregnancy is the result of a rape or an act of rape or incest. The bill that the sponsor would have liked to have us pass and probably will still succeed, a pregnancy occurred because a pregnant female is the result of a forcible rape changing the definition of rape because apparently some rape is more desirable in the eyes of the maker of the bill than others. And that includes a minor in active incest. So it can't be someone 19 is that age. So it is not at any effort here to codify the Hyde amendment. This is in an effort to expand the Hyde amendment. And well, frankly, someone caught him this time but they will work it in. They are the majority party. They can work this in at rules committee. We can count on seeing this language again expanding the Hyde amendment. Don't let anyone who supports this bill ever say to you I am for less government regulation. There is too much government regulation. You have got to be kidding. You can't vote for this thing and then say you are for less government regulations the mother of all government regulations. This is the regulation of an individual woman in a room with her doctor and Congressman Pitts apparently. I can't think of a bigger government regulation. So let us agree that in one hearing last week where we are against government regulation and another one this week we are for all kinds of government regulation. If you don't think it is a government regulation ask a doctor who has got to try to navigate this hearing. God bless the three of you, but it is complicated stuff because you are trying to shoehorn government into what is essentially a basic relationship that revolves around health care. It doesn't revolve around which funding stream is coming—of course this is complicated. Of course you guys have different view of this. And if you are a physician and I—you can't swing a dead cat around here without signing someone—well, I am speaking from a level of experience. I am a doctor, therefore I can tell you. I mean, stop that already. The bottom line about this is you are not any particular doctor for a particular client. I don't want anyone who is a doctor here in my operating room. You can just keep with your Congressman stick. It is more—that is better. I mean, what this is about is a fundamental philosophical agreement. And that is that if you are conservative and you believe in smaller, less intrusive government you have got to take a wild, wild, philosophical bank

shot to get back into supporting this bill. I don't know how you do it. I really don't know how you can ever say you are conservative believing you should have this much of government involvement in a medical decision in a conversation. And I do have to say this. I know we read the Constitution that first day we were here and I am glad we did. You have to also basically say if you support this you don't believe in a right to privacy for at least one half of the country. And that is the bottom line. Now some people don't. Some people believe to this day and you know the right to privacy as my lawyer friends or people who were lawyers and portraying lawyers the fact is that there is—does and there is not explicit right to privacy. But I think most Americans of all political stripes believe there is a basic right to privacy. Is there anything more basic, more basic than your body? Is there anything more basic privacy there? Well, not according to—not according to many people. And that is the conversation here. And if you are on the side of the—saying you know what? I think government should have a limit on where they go. I think there should be a limit beyond which they should not pass, this means you do not support this bill bottom line. If you believe there is no limit, you can go anywhere, you can get into any personal relationship the government wants to get involved in they can we have got a bill for you and we are going to have others. But I have to tell you something. I would say to my colleagues and friends that if you are going to wring your hands and gaze at your naval about how we reduce regulation in this country and how we get government out of business, try being in the business of health care watching this debate. Try dealing with an emergency room situation where a woman is coming in there and the doctor is saying you know what? I believe this is a medically necessary procedure. I want to do it. But wait a minute. I got to go through this first. I got to go—and let me—and someone get CSPAN 9 tapes back for me so I can see if I am allowed to do it. There is too much government regulation in this. And I think the best thing to do is we should say let doctors and their patients make these decisions. And as far as I remember listening to health care debate, so did my Republican friends way back when last week.

Mr. PITTS. Chair thanks gentleman. On the issue of the unanimous consent request, without objection.

[The information appears at the conclusion of the hearing.]

Mr. BURGESS. Mr. Chairman, was there a question in that soliloquy? Should we let our panel respond?

Mr. PITTS. Would one of the panelists like to respond to any of them? Mr. Johnson?

Mr. JOHNSON. I think you are forgetting someone, Mr. Weiner. What about this little girl here? This is from the Grand Jury Report. You talk about the privacy of the body? What about her body? You are forgetting someone. There is another human individual, a member of the human family who is involved here. That is why it is different than——

Mr. WEINER. When you say another, Mr. Johnson, are you stipulating that the woman has rights here?

Mr. JOHNSON. Of course the woman has rights including the right to life. But he unborn child is also a member of the human family.

Mr. WEINER. And Mr. Johnson, do you think that a bunch of members of Congress should make that determination where that line is?

Mr. JOHNSON. We think that the Congress makes laws for all members of the human family.

Mr. WEINER. Well that is a yes. You think 435 fairly well-to-do, mostly white men should make that decision?

Mr. JOHNSON. I think the elected representative of the American people should establish——

Mr. WEINER. Should make decisions for that woman and child?

Mr. JOHNSON. Can I finish my answers may I not?

Mr. WEINER. Well, it doesn't sound terribly enticing, no.

Mr. PITTS. Chair thanks gentleman. Chair recognizes the gentlelady from Colorado, Ms. DeGette for 5 minutes.

Ms. DEGETTE. Thank you so much, Mr. Chairman. I have quite a number of questions for all the witnesses so if you can try to keep your answers short I would appreciate it. Professor Rosenbaum, you have written extensively on issues around insurance law as part of your academic career. Correct?

Ms. ROSENBAUM. I have.

Ms. DEGETTE. Now, right now under current law—is your microphone on? We are having——

Ms. ROSENBAUM. It is.

Ms. DEGETTE. Under current law right now employers can—many employers can take tax credits for offering their employees insurance plans. Correct?

Ms. ROSENBAUM. It is deductible.

Ms. DEGETTE. And so they are getting a federal benefit for offering their employees insurance. Correct?

Ms. ROSENBAUM. Indeed.

Ms. DEGETTE. Right now?

Ms. ROSENBAUM. Yes.

Ms. DEGETTE. And the insurance plans that many employers offer to their employees include a full range of reproductive services including abortion coverage. Correct?

Ms. ROSENBAUM. That is correct.

Ms. DEGETTE. And the Hyde amendment as it is currently written even in the Affordable Care Act and the other bills does not preclude people from getting tax credits for offering insurance plans that offer a full range of reproductive services?

Ms. ROSENBAUM. Tax Advantage Plans are outside the Hyde amendment.

Ms. DEGETTE. Now, in addition, most insurance policies don't break out abortion services. They just say any medically necessary services. So if it is legal and it is necessary then the insurance will cover it. Correct?

Ms. ROSENBAUM. Correct.

Ms. DEGETTE. Now, Professor, the Hyde amendment says that no federal funds shall be used to pay for abortions with the exception of rape, incest, and the life of the mother. Correct?

Ms. DEGETTE. And that does not include indirect expenditures like tax credits or tax deductions. Is that right?

Ms. ROSENBAUM. It does not.

Ms. DEGETTE. So under this legislation, this Pitts bill, for the exchanges and then under the Smith bill which is also being examined what it would do, it would go far beyond the established law of current law which says no direct federal funds shall be used for abortion. And it would then define a whole different set of benefits that people get in the way of tax relief as somehow being federal funding. Is that correct?

Ms. ROSENBAUM. Correct.

Ms. DEGETTE. And so is it your opinion, Professor, that what that would do in essence would be to either if employers wanted to offer people plans in the exchange that offered abortion coverage they couldn't get the tax credits. Right?

Ms. ROSENBAUM. Correct.

Ms. DEGETTE. So then those employers would be paying higher taxes. Wouldn't they? Because they wouldn't get the——

Ms. ROSENBAUM. They offered a product that was not tax advantaged anymore.

Ms. DEGETTE. Right. So basically employers would be forced to purchase plans that didn't offer a legal medical service that they are offering now in order to get federal tax relief. Right?

Ms. ROSENBAUM. The other way of saying it is that plans—that companies would stop selling products that offered——

Ms. DEGETTE. Right. And so that is far beyond what the Hyde amendment says.

Ms. ROSENBAUM. Yes.

Ms. DEGETTE. OK. Than you very much. Now, Professor Alvaré, I wanted to ask you a question following up on what Mr. Dingell and several other people were asking you. Section 1303 of the Affordable Care Act talks about the treatment of abortion under the Act. But under the Pitts bill, this bill that we are talking about today, the words regarding abortion in Section 1303 are struck and instead the language that says protecting conscience rights is inserted. Correct?

Ms. ALVARE. That is correct and——

Ms. DEGETTE. Is it your understanding as sort of an ethicist that conscience rights could be talking about more issues other than abortion? For example, Catholic providers conscience rights around birth control and family planning and contraception—it could be interpreted that way couldn't it?

Ms. ALVARE. I don't think so, Congresswoman.

Ms. DEGETTE. Why not?

Ms. ALVARE. Because the purpose of that was to strike a heading that was not properly characterizing what went before it. And at the same time, to extend non-preemption to State laws not only regarding abortion and abortion coverage but conscience.

Ms. DEGETTE. So OK. So I am sorry, you can supplement your answer. I apologize. So you don't think so?

Ms. ALAVARE. That is all of it.

Ms. DEGETTE. OK. Mr. Johnson, I just have a couple questions for you. Now, you have been the head of the National Right to Life Committee since 1981. Correct?

Mr. JOHNSON. No, I am not the head of the National Right to Life Committee. I am the legislator.

Ms. DEGETTE. OK. I am sorry. You are the legislative director. Thank you for clarifying that. Do you support a constitutional amendment to overturn Roe v. Wade? Yes or no?

Mr. JOHNSON. Our organization has supported constitutional amendment——

Ms. DEGETTE. Do you support a constitutional amendment to overturn Roe v. Wade?

Mr. JOHNSON. Properly drafted, yes.

Ms. DEGETTE. Yes or no?

Mr. JOHNSON. I said if properly drafted.

Ms. DEGETTE. Yes or no?

Mr. JOHNSON. There have been many amendments and some we support. Some we don't.

Ms. DEGETTE. Do you support—OK. But you would overturn Roe v. Wade, right?

Mr. JOHNSON. We would overturn Roe v. Wade.

Ms. DEGETTE. Now, do you agree with Professor Alvaré that abortion should be outlawed. Correct?

Mr. JOHNSON. The position of the National Right to Life Committee——

Ms. DEGETTE. No, what is your position, sir?

Mr. JOHNSON. No, I represent the National Right to Life Committee.

Ms. DEGETTE. So you are not going to answer that question? Would that be correct?

Mr. JOHNSON. I am going to answer it. I am just testifying on the behalf of the National Right to Life Committee.

Ms. DEGETTE. OK. So what is their position? Do they support banning abortion?

Mr. JOHNSON. The exception that should be allowed is to save the life of the mother if there is indeed such a case. Which you have heard disputed.

Ms. DEGETTE. OK. So you would not support an exemption for rape. Correct?

Mr. JOHNSON. That is correct. Our policy practice would not be——

Ms. DEGETTE. And you would not support—you as an organization would not support an exemption for incest. Is that correct?

Mr. JOHNSON. That is correct.

Ms. DEGETTE. Thank you very much, Mr. Chairman. I appreciate your comity in letting me participate.

Mr. PITTS. Chair thanks the lady and recognize the gentleman from Ohio, Mr. Latta for 4 minutes.

Mr. LATTA. Thank you very much, Mr. Chairman. At this time I would like to yield 5 minutes to Dr. Burgess.

Mr. BURGESS. I thank the gentleman for yielding. Let us just come back to the issue we are here discussing today and it is not overturning Roe v. Wade. It is dealing with the aftermath that we were dealt in a very poorly drafted piece of legislation that was signed into law on March 23 of last year. And because of some of the unfinished business, the way that was pushed through so late in the night we are here today to make certain that we all understand what the parameters are, what is required of each of us, and what the Federal Government is going to be required to cover and

reimburse for. So I do think that while I might agree with Mr. Weiner and it hurts me to say this, but I might agree with Mr. Weiner on some points. And in fact with no thought to my personal safety I would go into an operating room if it were required to save his life even though I am licensed and uninsured. But at the same time what we are talking about here today is the use of federal funds, taxpayer dollars to fund this procedure. And there have been correctly some parameters and boundaries set around this since 1976. And we are here to help the President see the execution of his Executive order and make certain that the spirit of it is upheld not just this year, but next year and the year after. And even if there is a different president in the White House and a different set of Executive orders that the spirit of this Executive order will continue to be carried out. Now, let me just ask a general question, but probably it goes to Mr. Johnson. Does anyone really want to force someone to perform a procedure of termination of pregnancy if it is against their will to do so?

Mr. JOHNSON. Dr. Burgess, I have heard remarks from both sides here today about no one would want to do that. And I can only implore the members of the Committee who really want to explore that issue to read this document: Health Care Refusals. It is put out by the National Health Law Program, 2010. Professor Rosenbaum was on the advisory committee which according to the acknowledgments played a very active role. It is an amazing document. I just read it myself the other day for the first time. It is about 100 pages. And it is relentless in attacking all forms of conscience laws. They absolutely argue that it is an obligation that should be enforced both on institutions and individuals to perform abortions to provide abortions. This should be enforced through law, through malpractice law, through licensure requirements, and through diverse other means. There are even attacks on physicians who simply share their personal views about the sanctity of human life with their patients. That is deemed to be a breech of the ethics as defined by these people. The ACLU has a very active project as Mr. Dorflinger from the Catholic Bishops Conference testified before the other committee yesterday to try to compel Catholic hospitals to either get with the program on abortion or get out of town. They do want to basically drive people out of health care if you will not get with their program and ideology of collaborating and actively participating in killing unborn members of the species Homo sapiens. And if you think I am engaged in hyperbole, I implore you to read this report.

Mr. BURGESS. I thank you for bringing it to our attention. Certainly, Mr. Chairman, if the committee could be provided a copy of that I for one would be happy to look at it. Now, if—Mr. Johnson, if this bill does not pass—well, let me just ask you a question. Do you really think that hospitals are going to not allow emergency treatment for women who show up in the emergency room who are suffering a complication? And we have heard that professed by the other side but is that the intent of this legislation?

Mr. JOHNSON. I believe they are going to continue to comply with EMTALA and just with good medical practice which is to recognize that they have two patients and the law could not be more explicit. Professor Alvaré read it earlier. It says you seek to help to save

both the mother and her unborn child. It uses that term unborn child. And I don't see how any fair reading of that law could mean that that is a mandate to take the unborn child out in pieces. OK?

Mr. BURGESS. And I appreciate your answer. Just because I am about to run out of time, again, I want to stress that this law is to put the boundaries in place that the President asked for in the Executive order. This hearing, this legislation is not about overturning Roe v. Wade. It is not about doing anything other than helping the President accomplish his goal that taxpayer funding will not be used for the performance of elective termination of pregnancy. Thank you, Mr. Chairman. I will yield back my—I will yield back to the gentleman from Ohio.

Mr. PITTS. Chair thanks the gentleman. Every member was emailed with the hearing notice a copy of the discussion draft. If any of you did not have a copy we will be happy to provide it for you. That in conclusion I would like to thank all of the witnesses and all of the members that participated in today's hearing. I remind the members that they have 10 business days to submit questions for the record, and I ask the witnesses all agree to respond promptly to those questions. Again, I would like to thank Mr. Pallone, all the members for the civil tone of the hearing on such a controversial issue. The subcommittee hearing is adjourned.

[Whereupon, at 4:20 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. JOE BARTON

Thank you Chairman for holding this important hearing. As ChairmanEmeritus, I stand with Chairman Upton and Subcommittee Chairman Pitts in support of legislation to prevent federal funding for abortion or abortion coverage under the Patient Protection and Affordable Care Act (PPACA).

It has been 38 years since the United States Supreme Court, in Roe v. Wade, determined that the U.S. Constitution protects a woman's right to terminate her pregnancy. Three years after this legalization of abortion, the Supreme Court, in 3 related rulings, determined that states have neither a statutory or moral constitutional obligation to fund elective abortions or provide access to public facilities for such abortions[i]. In Harris v. McRae, the Court also indicated that there is no statutory or constitutional obligation of the states or the federal government to fund necessary abortions.

In the 111th Congress, during the debate of the various health care reform bills, public funding for abortions and the Hyde Amendment were hotly debated and discussed. Republicans were firmly told that federal dollars would not be used H.R. 3962, the Affordable Health Care for America Act, was to include the Stupak-Pitts Amendment which preserved the Hyde Amendment. The Patient Protection and Affordable Care Act, which is now law, does not include the Hyde Amendment. In fact, all the Patient Protection and Affordable Care Act requires is that at least one plan not cover abortions. The language requires that those who are enrolled in a plan that covers abortion make separate payments into an account that will be used for abortions, therefore creating public and "private" funds. However, just because the funds are put into another account does not mean they are not federal dollars subsidizing abortions. Regardless of what account these federal dollars to put into, they're still taxpayer dollars being used to pay for abortions. PPACA also includes language which could allow the Health Resources and Services Administration (HRSA) to define abortion as "preventative care."

While the House has voted to repeal PPACA, in its entirety, the Senate voted against a full repeal. So, now we are left with the task of repealing the sections of PPACA that we can and reforming others. I think the issue of abortion funding is one of the top priorities for repealing and reforming. American taxpayers should not

[i](Beal v. Doe, 432 U.S. 438 [1977], Maher v. Roe, 432 U.S. 464 [1977]; and Poelker v. Doe, 432 U.S. 519 [1977])

be forced to fund elective abortions, nor should doctors who have moral or religious objections be forced to perform abortions. I supported the Stupak-Pitts Amendment; I have also cosponsored the Protect Life Act.

I look forward to hearing from our witnesses and working to repeal these provisions of PPACA.

PREPARED STATEMENT OF HON. MARSHA BLACKBURN

Mr. Chairman, I would like to thank you for holding this hearing and I welcome our witnesses. I am pleased that this Subcommittee will examine federal funding of abortion services as provided by the Patient Protection and Affordable Care Act (PPACA).

I have long held the belief that unborn lives should be protected, and I do not condone the use of taxpayer dollars to support elective abortions. Furthermore, Congress should respect the right of conscience and not force individuals or organizations to violate their personal and moral convictions by having to support abortion services for fear of being penalized by federal or state governments.

The right of conscience has long been protected in this country under the Hyde amendment and is a tradition that this Committee should seek to restore to all health care professionals. Some may argue that the Hyde amendment is no longer necessary after President Obama signed an Executive Order banning the use of federal funding of abortions. However, as you will see in my questioning, even former White House Chief of Staff Rahm Emanuel has confirmed that this Executive Order will not prevent taxpayers from funding abortions in PPACA since the Executive Order does not "carry the force of law."

Mr. Chairman, I thank you for bringing this issue before the Committee today and I urge my colleagues to join me in ensuring that taxpayers do not fund abortion and the right of conscience is restored.

Thank you Mr. Chairman and I yield back the balance of my time.

Statement of Representative John D. Dingell
H.R. _, a bill to amend the Patient Protection and Affordable Care Act to modify special rules relating to coverage of abortion services under such Act.
House Committee on Energy and Commerce
Subcommittee on Health
February 9, 2011
1 pm, 2322

Welcome to our witnesses. Forgive me for being a little perplexed, but I feel a bit like I am in that movie Groundhog Day. You know, the one that where Bill Murray keeps waking up on groundhog day in Punxsutawney, Pennsylvania.

I could swear we have had this debate over abortion coverage in the healthcare law last year. I could swear we had several votes on this matter. In fact, I am certain we did and that ultimately the final healthcare bill upholds Hyde and moreover, that President Obama signed an executive order which reinforces the prohibition on the use of federal funds for abortion services under the Affordable Care Act.

Suffice it to say, as an author of the Affordable Care Act, I am satisfied that the laws current language is sufficient and believe that the bill before us goes too far. I voted against it when it came before us last year and if it should come up for a vote again, I will certainly vote against it again.

PREPARED STATEMENT OF HON. EDOLPHUS TOWNS

Mr. Chairman, Ranking Member Pallone, and distinguished colleagues—thank you for being here today to discuss Chairman Pitts' proposal to amend the Affordable Care Act regarding abortion coverage.

The proposed bill, the Protect Life Act, claims to unambiguously state that no federal funds will be used to pay for abortion services. However, under current law, this is already the case. It is already illegal to pay for elective or "therapeutic" abortion using federal funds. This Act does nothing to change that fact.

What the Act does do is impose unprecedented limitations on abortion coverage, while restricting access to abortion services for all women - not just those who purchase coverage through a state health-insurance exchange. It makes it virtually impossible for insurance companies in state health-insurance exchanges to offer abortion coverage, even to women paying entirely with their own money, and would forbid abortion coverage for millions of middle-and low-income women who will receive partial subsidies to purchase insurance.

In addition, the bill penalizes private insurers who offer comprehensive insurance products for sale in multiple states. It imposes crippling administrative burdens on plans that choose to cover abortion care. Namely, under this Act, if an insurance company offers a plan with abortion coverage, it must also offer a second, identical plan without abortion coverage, greatly increasing an insurer's administrative overhead. The likely outcome under this Act, is that a private insurance company would simply choose to not offer any health plans that cover abortion services.

Most importantly, the bill expands federal conscience protections, namely by overriding critical federal protections provided in the Emergency Medical Treatment and Labor Act (EMTALA). These protections were written with women in mind, and require that all patients, regardless of ability to pay, be provided life-saving, stabilizing treatment when they arrive at an emergency room. In the event that an abortion is medically necessary to save the mother's life, one will be performed in this narrow circumstance.

Overriding EMTALA in the name of "conscience" is a very dangerous precedent. The Protect Life Act would effectively change current federal law to allow hospitals to refuse treatment to a woman. Furthermore, it would allow, under the guise of "conscience" a hospital to refuse to refer a woman to another facility that would be able to save her life.

I am not against "conscience" laws. I am, however, against the use of these laws to allow doctors to watch their patients die.

I have serious concerns with this bill. I hope that Members on both sides of the aisle can work together, to ensure access to quality care for all.

Thank you, Mr. Chairman. I yield the balance of my time.

NHeLP
NATIONAL HEALTH LAW PROGRAM

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February 8, 2011

VIA HAND DELIVERY AND ELECTRONIC MAIL

The Honorable Joe Pitts
Chair – Sub-Committee on Health
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

RE: February 9, 2011 Hearing on H.R. _ "The Protect Life Act"

Dear Chairman Pitts and Members of the Energy and Commerce Committee, Sub-Committee on Health:

The National Health Law Program (NHeLP) strongly opposes, "The Protect Life Act," which would impose dangerous and unprecedented restrictions on women's access to abortion services, and, for the most vulnerable women, may put their lives at risk. The National Health Law Program is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people.

"The Protect Life Act" in fact endangers the lives of women most in need. It would permanently ban abortion coverage with only extremely narrow exceptions for low income women who access their health care in publicly funded programs, and would make insurance coverage for any women almost impossible to obtain. The Hyde Amendment discriminates against and disadvantages the women who may most be in need of abortion services. It robs low income women of the ability to make life decisions in the best interest of themselves and their families. The narrow exceptions of rape, incest and life endangerment put the most vulnerable women at risk – and this legislation would drastically limit those restrictions to the extent that even victims of rape or incest may be denied access to the services they need and to which they should be entitled.

In addition, this legislation would undermine the long-standing obligations of hospitals to provide emergency care as required by the Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA guarantees that none of us with an emergency medical condition can be turned away without stabilization and treatment, and can make the difference between life-saving treatment and death, especially for low income pregnant women. Maternal mortality is on the rise in the United States, and it is unacceptable to imagine that hospitals would be allowed to let a woman die rather than end a life-threatening pregnancy.

Low income women, and low income women of color already experience severe health disparities in reproductive health, maternal health outcomes, and birth outcomes. The "Protect Life Act" would exacerbate those disparities by denying women access to abortion services that may be necessary to protect their health and their lives.

Clinical guidelines and generally agreed upon medical practices are baseline practices that are accepted in the profession and codified in professional policies and position statements. Every person expects that the care they receive from their health care provider will meet those established standards of care. Accordingly, several leading health professional and medical societies in the United States and Western Europe have issued accepted standards of care for reproductive health (which include providing medically-accurate contraceptive information, services, and supplies, as well as abortion), particularly for women with emergent health issues and those who require preconception and interconception management of chronic health conditions.[1] Specifically, accepted standards of medical care advise that women suffering chronic conditions -- such as pregestational diabetes, lupus, and cardiovascular disease -- that could lead to adverse health and birth outcomes should avoid pregnancy until their condition is under control.[2]

Similarly, even when a woman has decided to carry her pregnancy to term, there are still a number of emergent medical conditions that may put her or her fetus at serious risk. As a result, access to safe and timely abortion services becomes critical. These conditions include, but are not limited to: premature rupture of membranes, preeclampsia and eclampsia, anencephaly (fetus incompatible with life), and chronic conditions for which pregnancy termination may be medically appropriate. In these situations, accepted medical standards and guidelines from the American College of Obstetricians and Gynecologists, Royal College of Obstetricians and Gynecologists of the United Kingdom, and the Cochrane Collaboration acknowledge that the patient must then decide to balance her health and life with the prospects of fetal survival. These standards and guidelines all recognize that a woman must make this decision. The guidelines then charge health providers with giving the patient complete and accurate medical information about her treatment options.

Last, existing law carefully balances the rights of patients to obtain needed health care services and the ability of providers to refuse to provide some forms of care. This legislation upsets that balance with a one-sided refusal clause that fails to protect the health and well being of patients, and extends conscience protection well beyond existing law. The broad language of this legislation opens the door to interfere with State laws that have struck that balance in the interests of patients and providers, and could allow anyone to object to providing any health care service, regardless of the potentially dire medical consequences to the patient. The American Medical Association notes, "[t]he patient's right of self decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice."[3] The "Protect Life Act" undermines the patient's ability to make such a choice by shielding health providers or

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[1] For example, the American College of Obstetricians and Gynecologists, The American Medical Association, The Royal College of Obstetricians and Gynaecologists of the United Kingdom, The World Health Organization, The U.S. Preventive Services Task Force, and The HHS Centers for Disease Control and Prevention.

[2] National Health Law Program, *Health Care Refusals: Undermining Quality Care for Women*, Standard of Care Project, 2010 (*citing* Johnson K., Posner SF, Biermann J, et al. Recommendations to Improve Preconception Health and Health Care – United States. A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care, MMWR Morbidity and Mortality Weekly Report Recommendations and Reports, 2006, 55: 1-23).

[3] American Medical Association. Health and Ethics Policies of the AMA: Policy E-08.08 Informed Consent. Washington, DC: American Medical Association; 1981 Issued March; 2006 Updated June.

entities from having to adhere to the medical standards that charge them with providing patients with sufficient information, referrals, or services about recognized treatment options that may include abortion.

Accordingly, we encourage this Sub-Committee, and your colleagues in the House of Representatives to protect the health of women and their right to quality and comprehensive reproductive health information and services.

Respectfully,

/s/

Emily Spitzer
Executive Director

NARAL
Pro-Choice America Foundation

"Protect Life Act" (H.R.358):
An Unacceptable Ban on Women's Access to Abortion Coverage

Testimony submitted by

Nancy Keenan
President

Also on Behalf of

NARAL Pro-Choice Arizona
NARAL Pro-Choice California
NARAL Pro-Choice Colorado
NARAL Pro-Choice Connecticut
NARAL Pro-Choice Maryland
NARAL Pro-Choice Massachusetts
NARAL Pro-Choice Minnesota
NARAL Pro-Choice Missouri
NARAL Pro-Choice Montana
NARAL Pro-Choice New Hampshire
NARAL Pro-Choice Ohio
NARAL Pro-Choice Oregon
NARAL Pro-Choice New Mexico
NARAL Pro-Choice New York
NARAL Pro-Choice North Carolina
NARAL Pro-Choice South Dakota
NARAL Pro-Choice Texas
NARAL Pro-Choice Virginia
NARAL Pro-Choice Washington
NARAL Pro-Choice Wisconsin

U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

February 9, 2011

Members of the Energy and Commerce Subcommittee on Health: 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 "Protect Life Act" (H.R.358), introduced by Rep. Joe Pitts (R-PA), a bill that falsely proposes to end public funding for abortion care. This bill is not about public funding. Regardless of one's view on this issue, the law is clear: federal funding of abortion is forbidden, except in very narrow circumstances. Instead, this bill is an attempt to reopen the contentious issue of abortion coverage and to dismantle entirely the Affordable Care Act.

Introduced as part of the effort to repeal and replace the health-care law, this bill would impose unprecedented limitations on privately funded abortion coverage and has the potential to restrict access to abortion services for most women, not just those who purchase coverage through a state health-insurance exchange.

An Effective Ban on Abortion Coverage in State Health-Insurance Exchanges

First and foremost, the Pitts legislation effectively would end abortion coverage for women in state insurance exchanges who use their own, private funds to pay for their insurance. It does so by making it highly unlikely that insurance companies will opt to offer this coverage: it forbids any plan offering abortion coverage from accepting even one subsidized customer, forcing insurers to choose between offering their product without abortion 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,[1] 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 Pitts bill also imposes crippling administrative burdens on plans that wish to cover abortion care. If the Pitts bill becomes law, insurance companies that offer abortion coverage—as 87 percent of plans currently do[2]—will face high costs, technical complexities, and duplicative administrative requirements.[3] Under the Pitts language, if an insurance company offers a plan with abortion coverage, it also must offer a second, identical plan without abortion coverage, greatly increasing an insurer's administrative overhead. For this reason, it seems clear that plans would be likely simply not to offer abortion coverage.

Even if insurance plans were willing to take on the increased administrative costs associated with offering this benefit, it is unclear what kind of market there would be for these plans.[4]

Because unintended pregnancies and pregnancies with health complications are unplanned, it is unrealistic to expect that many women would intentionally purchase comprehensive plans that include abortion care in anticipation of these circumstances. Moreover, because abortion coverage will be the only difference between the two plans, women who choose plans with that coverage will be easily identifiable. This likely could cause women to become concerned that their health data will not remain confidential and thereby discourage them from buying these plans.

The bill's purported solution of abortion-coverage "rider" policies for women who purchase plans through a state insurance exchange but seek abortion coverage is an equally 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.[5] The implication of these data is that, under the Pitts bill, abortion riders will likely not be available to customers.

Finally, it should be noted that the Pitts 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 Pitts bill, that do not contain exceptions to protect women's health endanger these women. The Pitts 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. [6]

- 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. [7]

- 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. [8]

- 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.

Effects on the Private-Insurance Market

Should the Pitts proposal become law, it not only would have implications for state health-insurance exchanges; it would have the potential to affect drastically coverage of abortion care on the entire private market. The Congressional Budget Office has estimated that approximately 30 million people will receive their insurance through a state insurance exchange under the new health-care law.[9] Looking to the future, the health-insurance exchanges are designed to grow, with the intent eventually to allow larger employers to join the system. [10]

As this happens, if the Pitts bill were to become law, more and more women would be unable to obtain coverage for abortion services: new plans – eventually including those offered to employees at large companies – would also become subject to the Pitts regulation.

Further, a report from the George Washington University Medical Center School concluded that as insurance exchanges grow they will have a greater effect on the health-insurance industry as a whole, eventually becoming the de-facto standard for benefits packages.[11] Consequently, the Pitts 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. Insurance coverage for abortion services would become a thing of the past – the sponsors' likely intent.

Hospitals Permitted to Refuse Abortion Care Even When a Woman's Life is in Danger

Threatening the lives of women nationwide, the Pitts bill allows hospitals to refuse to provide abortion care, or to refer a patient to a hospital that will, even when a woman's life is in critical danger. With regard to abortion care, the legislation overrides the Emergency Medical Treatment and Labor Act (EMTALA) by allowing hospitals to refuse services, thereby undermining a key provision in federal law that is meant to protect patients.

Congress enacted EMTALA in 1986 with the purpose of ensuring that all people, regardless of their ability to pay, could access emergency services.[12] EMTALA requires Medicare-participating hospitals that offer emergency services to assess whether a patient has an emergency medical condition, and to provide stabilizing treatment for any patient who presents with an emergency medical condition. Such required treatment includes provision of emergency abortion care to a woman whose life is in danger.

While the Affordable Care Act specifically preserved EMTALA and its requirement that hospitals provide necessary emergency services, the Pitts bill amends the health-care law to allow hospitals to refuse to provide abortion care – even for women in life-threatening situations. In nullifying EMTALA as it applies to abortion care, the Pitts legislation callously values the preferences of hospitals over the lives of women.

Redefining Rape and Incest

Beyond restricting access to abortion coverage in health-insurance exchanges, the original Pitts legislation sought to impose a restrictive and mean-spirited set of limitations on abortion care for survivors of rape and incest. Most federal laws that restrict access to abortion services allow exceptions for instances of rape or incest. The original language in the Pitts bill, however, would have limited these already-narrow categories so drastically that it ultimately would have denied private insurance coverage of abortion to survivors of statutory rape and to any incest survivor who is not a minor if they had obtained their insurance through a state exchange. Specifically, previous versions of the legislation limited exceptions to its ban on abortion coverage to include only victims of "forcible rape" and "incest with a minor." While the new version of the legislation dropped this offensive provision, its inclusion in the original version offers another indication of the bill's extreme and mean-spirited nature.

Multi-State Private Insurance Plans

Finally, while the Affordable Care Act currently requires that there be at least one multi-state plan that does not include abortion coverage, it permits all other multi-state plans to choose whether to offer such coverage.[13] In banning abortion coverage from all multistate plans, the

Pitts bill limits the benefits that private insurance companies are able to offer and would deny abortion coverage to even more women. Moreover, it goes against congressional intent to leave the choice of whether to cover abortion care to the insurers offering multi-state plans.[14]

Conclusion

The Pitts bill's effective ban on abortion coverage represents an intolerable, regressive policy and, for women, will utterly upend the promise of health reform. The Affordable Care Act does not prohibit private insurance companies from offering comprehensive health plans that include abortion coverage in the new health system. However, if the Pitts bill becomes law, private insurance plans in the exchange will be subject to unprecedented federal regulation of what plans can and cannot offer as benefits. Furthermore, permitting hospitals to deny abortion care to a woman whose life is in danger is unconscionable and reveals the extreme nature of this legislation. Through the Nelson provisions, the health-reform law already imposes other, unacceptable restrictions on abortion coverage; the Pitts bill is even more extreme and should be rejected.

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[1] CONGRESSIONAL BUDGET OFFICE, 111TH CONGRESS, Letter to Congressmen Dingell (2009) *at* http://www.cbo.gov/ftpdocs/107xx/doc10710/hr3962Dingell_mgr_amendment_update.pdf

[2] 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).

[3] *See,* Sara Rosenbaum et. al., *An Analysis of the Implications of the Stupak/Pitts Amendment for Coverage of Medically Indicated Abortions, at* 25 (Nov. 16, 2009), *at* http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_FED314C4-5056-9D20-3DBE77EF6ABF0FED.pdf (last visited Feb. 4, 2011)

[4] Sara Rosenbaum et. al., *An Analysis of the Implications of the Stupak/Pitts Amendment for Coverage of Medically Indicated* Abortion, *at* 25 (Nov. 16, 2009), *at* http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_FED314C4-5056-9D20-3DBE77EF6ABF0FED.pdf (last visited Feb. 4, 2011)

[5] Peter Slevin, *Insurers report on use of abortion riders,* Washington Post, Mar. 14, 2010.

[6] *Partial Birth Abortion Ban of 1995: Hearing on H.R.1833/S. 939 Before the Senate Comm. on the Judiciary,* 104th Cong. (1995) (testimony of Vikki Stella).

[7] THE NATIONAL CANCER INSTITUTE, *Breast Cancer and Pregnancy, Patient Information* (Sept. 19, 2002), *at* http://www.cancer.gov/cancerinfo/pdq/treatment/breast-cancer-and-pregnancy/patient/ (last visited Oct. 9, 2009).

[8] William Raspberry, *Abortion: A Tough Case*, WASH. POST, Aug. 31, 1998, at A21; Felice J. Freyer, *Hospital Agrees to End Tragic Pregnancy*, PITTSBURGH POST-GAZETTE, Aug. 30, 1998, at A3.

[9] CONGRESSIONAL BUDGET OFFICE, 111TH CONGRESS, Letter to Majority Leader Reid (2009) *at* http://www.cbo.gov/ftpdocs/107xx/doc10731/Reid_letter_11_18_09.pdf

[10] P.L. 111-148, 111th Cong. (2010) § 1312(f)(2)(B)(i).

[11] Sara Rosenbaum et. al., *An Analysis of the Implications of the Stupak/Pitts Amendment for Coverage of Medically Indicated Abortions*, *at* 9 (Nov. 16, 2009), *at* http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_FED314C4-5056-9D20-3DBE77EF6ABF0FED.pdf (last visited Nov. 24, 2009)

[12] 42 U.S.C. § 1395dd.

[13] P.L. 111-148, 111th Cong. (2010) § 1334(a)(6).

[14] P.L. 111-148, 111th Cong. (2010) § 1334(a)(6).

February 9, 2011

Members of the Subcommittee
U.S. House of Representatives
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Members of the Subcommittee:

The National Asian Pacific American Women's Forum (NAPAWF) is the only national, multi-issue Asian and Pacific Islander (API) women's organization in the country. NAPAWF's mission is to build a movement to advance social justice and human rights for API women and girls. Since its founding, NAPAWF has supported access to reproductive health care. We believe that health care is a human right and we should provide health care that protects a woman's life and strengthens our families, protects the patient-doctor relationship, and allows personal decisions about proper medical care to be made by a patient and her doctor, rather than by politicians.

As a result, we oppose HR__ Protect Life Act for going against the will of the majority of Americans and imposing restrictions that go beyond current standards to expand barriers to women's access to abortion services. Introduced as part of the effort to repeal and replace the health-care law, this bill would impose unprecedented limitations on privately funded abortion coverage and has the potential to restrict access to abortion services for most women, not just those who purchase coverage through a state health-insurance exchange.

An Effective Ban on Abortion Coverage in State Health-Insurance Exchanges

The Pitts ban would bar insurance plans in the new exchanges from providing abortion coverage if a single person receiving premium assistance credits enrolls. Because a great majority of individuals on the exchanges will receive subsidies, the Pitts ban would therefore essentially ban coverage of abortion in the exchanges for everyone – including those paying for coverage entirely with private dollars.

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Although the bill offers up the ability for women to purchase "abortion riders," it is irrational to ask women and families to plan for an unplanned pregnancy by purchasing separate, supplemental coverage. Moreover, women receiving premium assistance cannot afford healthcare insurance, let alone a second insurance policy.

Banning coverage of abortion in the new health-care system creates unfair barriers for low-income women to exercise their constitutional right to receive abortions. The Affordable Care Act currently has restrictions in place that prevent federal funds from being used to cover abortion. HR__ Protect Life Act imposes restrictions that go beyond the Hyde Amendment restrictions, disproportionately impacting low income women. 11.1% of all Asians and Pacific Islanders live below the poverty level, compared with 8.3% of non-Hispanic whites. Moreover, 67% of Laotians, 66% of Hmong and 47% of Cambodians in the U.S. live in poverty.

Currently, 36% of APA women under age 65 have no health insurance, and Korean Americans are the most likely racial or ethnic group to be uninsured. Additional federal law created a 5-year bar on Medicaid benefits for immigrants entering the country after August 1996. States may offer Medicaid coverage for reproductive health care services to post-enactment immigrants but they must do so at their own cost. Currently, less than half of states opt to use their own funds to provide any coverage during the waiting period. In 2001, more than 60% of poor immigrant women of reproductive age were uninsured.

Because of these restrictive federal laws, many API and immigrant Asian women are denied abortion coverage, even in states in which Medicaid pays for abortion. This causes a significant financial barrier that is disproportionately felt by low income women.

The Pitts Bill Intensifies a Discriminatory Refusal Policy

Current law amply protects healthcare providers who entertain religious or moral objections to the provision of abortion services. The Affordable Care Act left all of these laws intact, and as well as adding a new, one-sided provision barring health plans from discriminating against healthcare providers or facilities because of their refusal to "provide, pay for, provide coverage of, or refer for abortions." Despite the policy attention to refusal, those who choose to provide abortion services are routinely harassed, intimidated, and discriminated against, as documented in a 2009 report published by the Center for Reproductive Rights.

The Pitts refusal provision does nothing to protect the men and women who provide abortion services. Women seeking abortion services must often overcome significant hurdles in finding a provider – from the Guttmacher Institute: "87% of all U.S. counties lacked an abortion provider in 2008; 35% of women in the U.S. live in those counties." Against this backdrop, the Pitts bill would both dramatically expand and make permanent a dangerous, discriminatory refusal policy that undermines women's access to healthcare.

The Pitts Bill Would Allow the Denial of Emergency Care, Threatening Women's Lives

Threatening the lives of women nationwide, the Pitts bill allows hospitals to refuse to provide abortion care, or to refer a patient to a hospital that will, even when a woman's life is in critical danger. With regard to abortion care, the legislation overrides the Emergency Medical Treatment and Labor Act (EMTALA) by allowing hospitals to refuse services, thereby undermining a key provision in federal law that is meant to protect patients.

Congress enacted EMTALA in 1986 with the purpose of ensuring that all people, regardless of their ability to pay, could access emergency services.12 EMTALA requires Medicare-participating hospitals that offer emergency services to assess whether a patient has an emergency medical condition, and to provide stabilizing treatment for any patient who presents with an emergency medical condition. Such required treatment includes provision of emergency abortion care to a woman whose life is in danger.

The Pitts bill amends the health-care law to allow hospitals to refuse to provide abortion care – even for women in life-threatening situations. In nullifying EMTALA as it applies to abortion care, the Pitts legislation priorities the values of hospitals over the lives of women.

Conclusion

If the Pitts bill becomes law, private insurance plans in the exchange will be subject to unprecedented federal regulation of what plans can and cannot offer as benefits. Furthermore, permitting hospitals to deny abortion care to a woman whose life is in danger is unconscionable and reveals the extreme nature of this legislation. Through the Nelson provisions, the health-reform law already imposes other, unacceptable restrictions on abortion coverage; the Pitts bill is even more extreme and should be rejected. HR__

Protect Life Act imposes unreasonable restrictions that go farther than the Hyde Amendment to prevent women from accessing abortion services. These barriers disproportionately impact low-income women and women of color by unfairly impeding access to abortions, a right that has been upheld by the US Supreme Court. NAPAWF opposes these unfair restricts to comprehensive health care and urges the House Judiciary Energy and Commerce committee to prevent this harmful legislation from moving forward.

Respectfully,

Miriam W. Yeung, MPA
Executive Director
National Asian Pacific American Women's Forum

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