



## Secretariat of Pro-Life Activities

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### **Issues of Life and Conscience in Health Care Reform: An Analysis of the “Patient Protection and Affordable Care Act” of 2010**

On March 23, 2010, the “Patient Protection and Affordable Care Act” was signed into law by President Obama (Public Law 111-148). This version of health care reform legislation was approved by the U.S. Senate (Senate substitute for H.R. 3590) on December 24 by a vote of 60 to 39, then by the House of Representatives on March 21 by a vote of 219 to 212.<sup>1</sup>

The Catholic bishops’ conference wrote numerous letters to Congress in 2009 and 2010, reaffirming the Church’s strong support for expanding access to health care in ways that respect the life, dignity, health and consciences of all. Such authentic health care reform, the bishops said, is “a public good, moral imperative and urgent national priority.”<sup>2</sup> The bishops repeatedly cited three specific moral criteria for acceptable reform legislation: Affordability of health coverage, especially for those most in need; fairness to immigrants regarding access to health care; and respect for human life (from conception to natural death) and for rights of conscience. This particular analysis focuses on how the final Act deals with the third criterion, respect for life and conscience.

On these issues the bishops’ conference had said that health care reform legislation must maintain the “status quo” on federal abortion policy – that is, current longstanding policies on abortion and abortion funding in other federal programs must be maintained in this new program as well. This is a matter not only of political discretion but of moral principle. Catholic teaching calls for opposition to a law that, on a fundamental issue such as the direct taking of innocent human life, would make governmental policy worse than before. We may support (or allow the passage of) legislation that improves the order of justice, even if the new law does so imperfectly or incompletely; we may not do so when the law will create new fundamental evils or substantially expand the scope of a present evil.<sup>3</sup>

This “status quo” principle does not mean that the legislation should seek to maintain all unjust situations in the private sector which occur due to the absence of corrective law. For example, when insurance companies and private employers choose the

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<sup>1</sup> A “Health Care and Education Reconciliation Act” (H.R. 4872) also received final approval from both chambers of Congress on March 25, and was signed into law on March 30 (Public Law 111-152). This budget bill made further changes in the new health care reform law, but the only change that is relevant to this analysis is a further increase in funding for Community Health Centers, discussed below.

<sup>2</sup> United States Conference of Catholic Bishops, Letter of Dec. 22, 2009 to U.S. Senate, at [www.usccb.org/healthcare/letter-to-senate-20091222.pdf](http://www.usccb.org/healthcare/letter-to-senate-20091222.pdf). For the Conference’s letters and other materials on health care reform see [www.usccb.org/healthcare/](http://www.usccb.org/healthcare/).

<sup>3</sup> See Pope John Paul II, Encyclical letter *Evangelium vitae* (1995), nos. 72-3.

kind of health coverage they will offer, many of them choose to force people to purchase elective abortion coverage whether they want to or not. This is a current injustice, but it is not one currently practiced by (or with the active involvement of) the federal government. Indeed, the goal of health care reform is to change the empirical “status quo,” to expand consumer choices so that “health insurance becomes a buyer’s market, not a seller’s market”<sup>4</sup> – that is, to take power away from insurance companies and give it to the individual. The Act transforms the “status quo” of the private market in numerous ways to meet this goal, ranging from the coverage of pre-existing conditions to premium amounts and the defining of basic benefits. To the extent that the Act expands the corrective role of the federal government in all these areas, yet chooses to leave insurers and employers with the unilateral power to force people to pay for other people’s abortions, this does not maintain the legal “status quo” but selectively maintains an injustice and may even expand the federal government’s role in it.

### **Federal Abortion Funding and Government-Sponsored Coverage**

Longstanding policy in all other major federal health programs is that federal funds may not be used for elective abortions, or for entire benefits packages that include such abortions. This policy is reflected in the Hyde amendment to the annual Labor/Health and Human Services appropriations bill (governing Medicaid, Medicare and other major programs), in the Smith amendment to the annual General Government appropriations bill (governing the Federal Employees Health Benefits Program), and in a permanent provision of the Children’s Health Insurance Program first enacted in 1997, among other laws.<sup>5</sup>

Because the health care reform legislation authorizes and appropriates new funds outside the bounds of the usual appropriations bills, it requires its own specific provision reflecting this policy. For example, the Act provides income-based federal subsidies or credits to make health coverage affordable for millions of Americans who cannot currently obtain such coverage through an employer. It also provides for insurance “exchanges,” organized by state, where health plan issuers can compete for new customers (including some who lack employer-based insurance but do not qualify for a subsidy).

An amendment offered by Rep. Bart Stupak (D-MI), approved by the House in November but ultimately removed from the final Act, would have conformed this Act to current law on abortion funding. The amendment stated that no funds authorized or appropriated by the 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.” As in the provisions governing other federal programs for many years, exceptions were made for cases of rape or incest or when the pregnant woman’s life is in danger. Individuals who purchase a health plan with the help of a federal subsidy could purchase broader or elective abortion coverage only as “separate supplemental coverage” paid for entirely with nonfederal funds.<sup>6</sup> Health plan

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<sup>4</sup> See remarks of Sen. Christopher Dodd (D-CT), in *Congressional Record*, Nov. 30, 2009, page S11994.

<sup>5</sup> See [www.usccb.org/prolife/issues/healthcare/abortion\\_funding\\_102309.pdf](http://www.usccb.org/prolife/issues/healthcare/abortion_funding_102309.pdf).

<sup>6</sup> Throughout this analysis, the phrase “elective abortion” will be used to refer to abortions that have long been ineligible for federal funding in major health programs (all abortions except for cases of rape, incest, or

issuers could sell such supplemental coverage to anyone, keeping these premiums separate from the premium funds that combine with federal funds to purchase an overall plan. They could also sell health plans that include elective abortions to non-subsidized purchasers on the exchange, as long as they offered the identical plan without such abortions to subsidized purchasers.

By contrast, the final Act contains no permanent policy of its own on directly funding abortion coverage in subsidized health plans. Instead it tracks the annual Hyde appropriations rider, by allowing federal funds (in the form of advanceable and refundable tax credits) to be used only for abortions that are eligible for federal funding under the Hyde amendment in a given year.<sup>7</sup> While the Hyde amendment has allowed abortion funding only for cases of life endangerment and rape/incest for many years, a reference to this annual rider is potentially far less secure than a permanent provision.

More fundamentally, contrary to the policy of the Hyde amendment and regardless of what it may provide in any year, federal subsidies (in the form of such premium tax credits) may be used to help pay for overall health plans whose issuers have decided to include elective abortions. A “segregation of funds” policy requires each purchaser of a plan that includes elective abortions to make two premium payments each month: one payment for abortion coverage, and one to be combined with federal funds to pay for the rest of the plan. The payments for abortion coverage are to be used “exclusively” for that purpose, and kept in a separate account that is monitored to ensure that other funds do not supplement it (secs. 1303(b)(2)(B), 1303(b)(2)(C)). This new federal requirement for a separate “abortion surcharge” paid by all enrollees in these plans clearly violates the status quo in federal abortion policy.

Notwithstanding the “segregation of funds” provision, federal subsidies will be used to help expand access nationwide to abortion coverage. Federal funds will make overall health plans affordable for millions of new customers, who will then pay a nominal fee for full access to elective abortions – not to be estimated at less than “\$1 per enrollee, per month” (sec. 1303(b)(2)(D)(ii)(III)). In plans that include such abortion coverage, abortions obtained by those who want them will be subsidized by the premium checks of those who object to abortion -- who must pay the abortion fee in order to keep a health plan they want or need for other reasons.

The issue of whether to treat abortion as the norm is most acutely raised when discussing coverage provided or supervised by the federal government itself. For example, for many years elective abortions have been excluded from all health plans provided through the Federal Employees Health Benefits Program (FEHBP).

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danger to the life of the mother). The term is used here as shorthand for a longstanding federal policy, not as expressing a medical or moral judgment.

<sup>7</sup> The Act explicitly recognizes this particular premium credit as a form of federal funding that is subject to the Hyde amendment’s restrictions on funding abortions. See sec. 1303(b)(2)(A)(i). The deficiency is that the Act prevents only the use of such funds to help pay for specific abortion coverage, not their use to help pay for a health plan that includes such coverage as in other federal health programs.

The new Act authorizes the Office of Personnel Management (OPM), the same federal agency that manages the FEHBP, to contract with private issuers to offer at least two “multi-state plans” in each state. The contracts will be modeled on those now signed by issuers offering coverage in the FEHBP, and the benefits for each plan will be uniform in all states (sec. 1334). The OPM Director must ensure that in each state, at least one of these multi-state plans excludes coverage of elective abortion (sec. 1334(a)(6)). The other plan may offer such abortions, with the same “segregation of funds” policy as other health plans. This is deficient compared to the current FEHBP program, which excludes elective abortions from all plans that OPM contracts for or that use federal subsidies.

Moreover, even the Act’s restriction on direct federal funding of abortion itself covers only the use of federal funds such as premium tax credits to help purchase qualified health plans. Other sections of this bill authorize and appropriate funds outside the bounds of the annual appropriations bills (hence outside the scope of the Hyde amendment and similar appropriations riders), and contain no restriction of their own. For example, a provision creating a “Community Health Center Fund” appropriates \$7 billion over five years for “enhanced funding” of community health centers nationwide (expanded to \$9.5 billion in the budget reconciliation bill passed by Congress immediately after enactment of the Act),<sup>8</sup> and approximately \$1.5 billion to help fund the National Health Service Corps, in addition to a separate \$1.5 billion for construction and renovation of community health centers themselves (sec. 10503). This seems to create a new and expansive funding stream for health care services, not covered by any restraint on use of the funds for elective abortions.<sup>9</sup>

There is one clear exception to this general concern. The Act authorizes a new program for promoting “school-based” health centers, which will (among other things) dispense contraceptive drugs and devices to minors.<sup>10</sup> However, the Act states that federal funds for this program “may not be used to provide abortions.” Sec. 4101(b), creating new 42 USC 399Z-1(f)(1)(B). The Act also states, in its definition of a “school-based health center,” that such a center “does not perform abortion services” (Id., new 42 USC 399Z-1(a)(3)(C)). This seems to prevent clinics receiving federal funds from providing abortions even with other funds. It is not clear that the Act prevents these clinics from providing abortion referrals, with or without federal funds.

### **Abortion Mandates and the Conscience Rights of Enrollees**

The Act forbids the federal government to use this Act to mandate any abortions as part of the “essential health benefits” offered by qualified health plans; the decision

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<sup>8</sup> Public Law 111-152, sec. 2303 (see note 1 supra).

<sup>9</sup> For more on this specific problem in the Act, see [www.usccb.org/healthcare/communityhealthcenters.pdf](http://www.usccb.org/healthcare/communityhealthcenters.pdf). President Obama issued an executive order March 24 to address abortion issues in the new Act; for a legal analysis explaining why this order does not correct statutory problems created by the Act, see [www.usccb.org/healthcare/03-25-10Memo-re-Executive-Order-Final.pdf](http://www.usccb.org/healthcare/03-25-10Memo-re-Executive-Order-Final.pdf).

<sup>10</sup> The distinct concern about new programs in this Act promoting contraceptive services, particularly to minors, is discussed separately below.

whether to provide abortion coverage as part of such essential benefits is to be made by the issuer of the health plan (sec. 1303(b)(1)).

The specific statement that abortion may not be required as part of such a plan's "essential health benefits" leaves open the possibility that plans may be required to include elective abortions by mandates arising from other provisions. For example, the Act includes a mandate that health plans cover any "preventive services" for women that are provided for in "comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph" (sec. 2713(a)(4)). During debate on this language, some Senators raised a concern that "preventive" services for women could be construed to include abortion. This concern was not addressed in the final language.

A more basic problem arises from the Act's decision to allow insurance companies receiving federal subsidies to choose to include elective abortion coverage, as these insurers will require all enrollees to pay premiums for other people's abortions. Of course many private companies choose to include such abortion coverage now. But the federal government would now allow the companies to practice such coercion in federally subsidized plans, and facilitate this arrangement by requiring each enrollee to pay a separate premium each month solely for these abortions.

This "segregation of funds" mechanism actually heightens the problem of conscience arising from abortion coverage. When Americans are required to pay taxes or even general health premiums that may (among many other things) help subsidize abortions or other objectionable activities, the argument can be made that such funds are used primarily and overwhelmingly for acceptable and even laudable purposes; the person may even hope that none of his or her actual funds will end up helping to pay for an abortion. But the federal requirement of a distinct "abortion premium," used exclusively for elective abortions, eliminates these ambiguities. Millions of Americans acquiring health coverage due to this legislation could be required to pay a separate fee directly and exclusively for other people's abortions. The legislation states explicitly that each issuer choosing to provide abortion coverage "shall... collect from each enrollee in the plan (without regard to the enrollee's age, sex, or family status) a separate payment" for elective abortions, depositing that payment into a separate account used "exclusively" for such abortions (Senate bill, sec. 1303(b)(2)(B)). The bill's text actually seems to forbid any leeway by an insurer in accommodating a conscientious objection to such abortion payments.

It may be argued that individuals may still choose to purchase a plan on the exchange whose issuer chose not to include abortion coverage. But there is no guarantee that such a plan, or the health care providers who agree to accept patients under it, will be readily available, or that it would meet the particular health needs of that individual and his or her family in other ways. The Act even seems to go out of its way to interfere with an informed choice by consumers regarding abortion coverage. It forbids the insurer to notify potential purchasers that its plan includes elective abortions except as part of the "summary of benefits and coverage explanation" routinely provided at the time of enrollment (sec. 1303(b)(3)(A)); and such notification (as well as the issuer's advertising, and any other information provided by the Exchange or otherwise specified by the Secretary) may provide information "only with respect to the total amount of the combined payments" for

elective abortions and for all other services. In short, it seems most purchasers will not even realize they are paying for abortion coverage, much less how much they will be called upon to pay for it, until they have enrolled and are actually being billed.

### **Conscience Rights for Health Care Providers on Abortion**

The Act provides that no health plan offered through an exchange “may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions” (sec. 1303(b)(4)). This forbids discrimination by a health plan itself against pro-life health care providers within the plan.

Absent from the final Act, however, is a provision to protect health care entities (including HMOs and health plans) that decline involvement in abortion from being discriminated against by federal agencies or programs, or by state or local governments receiving federal funds under this Act. This important protection is currently provided by the Weldon amendment on conscience rights that has been part of the annual Labor/HHS appropriations bills since 2004. The bill approved by the House in November 2009 would have applied the Weldon amendment’s principles to the new funding and new health plans authorized by the health care reform legislation; but this language was rejected in Senate committee and did not survive in the final Act.

As with the anti-mandate provisions protecting health plans mentioned above, conscience clauses for providers may be in tension with the Act’s other provisions. For example, the Act has a provision stating: “Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Social Security Act (popularly known as ‘EMTALA’)” (sec. 1303(d)). EMTALA itself does not seem to pose a problem – it calls on emergency care providers treating pregnant women to seek to stabilize the health condition of mother and child, and has never been used to require anyone to perform an abortion. The concern remains that a state could try to evade the Act’s conscience protections by deeming some abortions to be “emergency services.”

### **Respect for Other State and Federal Laws**

The Act includes a provision on non-preemption of state laws and non-interference with other federal laws relating to abortion (sec. 1303(c)). This language has some deficiencies or potential loopholes. For example, the provision says this new Act will not preempt state laws on funding or coverage of abortion, or laws on procedural requirements for abortion (such as notification or consent in the case of a minor)(sec. 1303(c)(1)). But it does not mention state conscience laws, or state laws that actually restrict or prohibit abortion (e.g., current laws against partial-birth or late-term abortions).

Another clause in this provision states that the Act will have no effect on federal laws regarding “conscience protection,” as well as laws on nondiscrimination against those who are unwilling to be involved in abortion (sec. 1303(c)(2)). But because this part of the provision is titled “No effect on federal laws regarding abortion,” it is unclear whether it

intends to cover all conscience protection laws or only those that pertain to abortion. There is no mention here of federal laws on abortion funding or coverage, or federal laws restricting abortion itself.

### **Broader Issues of Conscience Protection and Religious Freedom**

Despite efforts by Catholic and other advocates, the Act includes no general protection for conscience rights beyond the contexts of abortion and, as discussed below, assisted suicide.

The Act includes provisions that promote or could promote coverage for contraception, sterilization and other services to which Catholics and others may have moral objections. The mandate for “preventive services” for women mentioned above is one example. The Act also creates a broad definition for what constitutes an “essential health benefit” for qualified health plans, including categories such as “ambulatory patient services” and “prescription drugs,” with additional requirements to be specified by the Secretary of Health and Human Services. The Secretary is to ensure that the scope of such benefits “is equal to the scope of benefits provided under a typical employer plan” (sec. 1302(b)). Because a “typical” employer plan arguably covers contraception and sterilization, this could become a mandatory model for Catholic institutions which until now have been free to exclude such services from their employer health plans in accord with Catholic moral teaching.

Ironically, the Act does contain some provisions respecting religious freedom, but these are of no help to Catholics or others who may have moral objections to specific procedures. It provides a “religious conscience exemption” for members of a “recognized religious sect or division thereof” who object to making payments into the health insurance system generally (e.g., the Amish), so they will be exempt from the tax levied by the Act against individuals without acceptable health care coverage. Sec. 1501(b), further amended by sec. 10106(c), creating sec. 5000A(d)(2)(a) of the Internal Revenue Code of 1986. The Act’s reauthorization of the Indian Health Care Improvement Act includes several provisions to ensure that behavioral health programs for Indians will respect and promote “the traditional health care practices” and respect the “cultural values” of the Indian tribes to which patients belong.<sup>11</sup> And a new program for “Elder Justice,” aimed at preventing and addressing abuse and neglect of seniors, has a provision to ensure that nothing in the program “shall be construed to interfere with or abridge an elder’s right to practice his or her religion through reliance on prayer alone for healing” (sec. 6703(a)(1)(C), creating sec. 2012(b) of the Social Security Act). Thus far, Amish, Native American, and Christian Science religious beliefs have protection under these bills but the conscientious moral convictions of Catholics do not.

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<sup>11</sup> Sec. 10221(a) by reference enacts into law the Indian Health Care Improvement reauthorization reported out by Senate committee in December 2009 (S. 1790, 111<sup>th</sup> Congress). Sec. 181 of that Act rewrites Title VII of the underlying Act (“Behavioral Health Programs”). In the new Title VII see in particular secs. 705(d), 711(b)(5), 712(a)(2)(A)(v), and 723(b)(2).

The Act's neglect of religious conscience rights on issues such as contraception and sterilization coverage, in particular, is a clear departure from current federal policy. The "Church amendment" (42 USC §300a-7), the most extensive federal law on conscience rights in health care, has been in effect since 1973, protecting conscientious objection to both abortion and sterilization (and in some cases other procedures as well) in various federal programs. The Federal Employees Health Benefits Program requires health plans in the program to provide coverage of prescription contraceptives; but it exempts religiously affiliated health plans from the requirement, and protects moral and religious objections to such drugs and devices by individual health care professionals within all plans in the program. Finally, the annual appropriations bill providing funds for the District of Columbia has long stated that any mandate for contraceptive coverage enacted by the District government should include an exemption for moral or religious objections.<sup>12</sup> Catholic health care providers, employers and health plans deserve the same respect in health care reform legislation.

### **Contraceptive Programs, Particularly for Minors**

As noted above, the Act will expand coverage for contraceptive services as part of broader categories of services. In this respect it does not differ from many existing federal health programs, although the legislation will raise new conscience rights concerns if (as expected) these services are defined at the administrative level as part of the "essential health benefits" for qualified health plans. The following provisions deserve specific mention because they are directed to school-age children, or focus on contraceptive services as an entry point for accessing other health care.

The debate over contraceptive programs has become especially visible as part of the national debate on how government can help reduce abortions, particularly among young Americans, a goal President Obama has said he supports. Some support expanded contraceptive programs, saying they can help reduce abortion rates; others point to growing evidence that these programs often do not have that effect, raising the concern that they can aggravate the problem by confirming young people in a lifestyle of inappropriate and risky sexual behavior.<sup>13</sup>

The Act takes the former position, through two new programs aimed at school-age children and youth. First, the legislation creates a new program for promoting "school-based health centers" that, among other things, can provide contraceptives to minors (sec. 4101(b)). As noted above, these clinics are barred from providing abortions.

Second, the Act creates a new program of federal grants for "comprehensive" sex education programs – that is, programs which promote abstinence to young people but also instruct in the use of contraceptives for those who are or may become sexually active (sec. 2953, creating new sec. 513 of the Social Security Act). Under this new grant program for "Personal Responsibility Education," states will be allotted funds based on their

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<sup>12</sup> For texts and citations see [www.usccb.org/prolife/issues/abortion/crmay08.pdf](http://www.usccb.org/prolife/issues/abortion/crmay08.pdf).

<sup>13</sup> For an overview of some of this evidence see [www.usccb.org/prolife/issues/contraception/contrafactsheet.pdf](http://www.usccb.org/prolife/issues/contraception/contrafactsheet.pdf).

applications reporting their pregnancy and birth rates among youth and their plans for reducing these. It is troubling that this section refers to a goal of “reducing pregnancy rates and birth rates” among youth. *Id.*, new sec. 513(a)(1)(C)(II). Each program, in addition to being “medically accurate and complete,” must educate adolescents on “both abstinence and contraception” as ways of reducing pregnancies and sexually transmitted diseases. *Id.*, new sec. 513(b)(2). This section appropriates \$75 million a year over five years for the program. However, immediately following this provision in the Act is a brief section providing a five-year reauthorization (with no appropriation of funds) for the existing federal “abstinence education” program in Title V of the Social Security Act. *Id.*, sec. 2594. Thus, the Act does not allow dedicated abstinence programs to be eligible for funding under the new program, but does allow such education to continue as a separate program – albeit without any assurance that funds for abstinence education will actually be appropriated, as this must occur through the usual appropriations bills.

Finally, the Act allows states to expand Medicaid eligibility for family planning services (sec. 2303). This Medicaid provision is worth noting because it extends coverage to this newly eligible class of women solely for “family planning services and supplies,” which may include “medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting” (sec. 2303(a)(3)).

This same provision had been part of Congress’s economic stimulus legislation a year ago, in January 2009 – but was removed as too controversial, after House Speaker Nancy Pelosi (D-CA) publicly defended the family planning provision as a way to “reduce costs” for state and federal governments.<sup>14</sup> The proposal has returned as part of health care reform legislation – where it should be equally controversial, as it implies a greater priority on keeping lower-income women from reproducing than on meeting their basic health needs. It also seems designed to make women resort to Planned Parenthood and other “family planning settings” as their entry point into the health care system.

### **End-of-Life Issues and Assisted Suicide**

Early reports that this legislation would include provision for “advance care planning” consultations between physicians and Medicare patients provoked intense public debate in the summer of 2009. Charges that the government would sponsor “death panels” to persuade elderly patients to die before their time were, to say the least, exaggerated. At the same time, valid concerns were raised: The living wills and other advance directives discussed in such consultations have proved to be, at best, of more limited help than supporters had hoped; the federal government that funds Medicare could be said to have mixed motives for promoting documents that may limit the provision of life-sustaining treatment; and the question arises whether such discussions and documents could be used to

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<sup>14</sup> See Teddy Davis, “Contraceptive Measure Dropped From Stimulus,” ABC News, January 27, 2009, at <http://blogs.abcnews.com/thenote/2009/01/contraceptive-m.html>.

present and promote physician-assisted suicide as a valid end-of-life option, particularly in states that have legalized the practice. Provisions on this topic therefore merited scrutiny.<sup>15</sup>

The final Act does not include the provisions that gave rise to the “death panels” charge. Instead it includes a helpful provision forbidding discrimination against an individual or institutional health care provider that “does not provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing” (sec. 1553). This objective definition of lethal medical procedures is further clarified by excluding from the definition any withholding or withdrawal of medical treatment or nutrition and hydration; abortion; or the use of any item for pain relief that may increase the risk of death but is not provided for the purpose of causing death. Sec. 1553(c).

This definition with disclaimers is taken directly from the Assisted Suicide Funding Restriction Act of 1997 (Public Law 105-12), which has successfully excluded assisted suicide from all federal health programs for over a decade – including matching federal-state programs like Medicaid, where a state like Oregon may have its own inadequate legal definition of assisted suicide. The provision’s other features are modeled closely on the Weldon amendment mentioned earlier, which as an appropriations rider has prevented government discrimination against health care providers that decline involvement in abortion since 2004; as noted, that amendment, applied to its original context of abortion, was not included in the final legislation. So in the area of conscience rights, the Act marks an improvement on assisted suicide though it falls short on abortion. The Act’s conscience provision on assisted suicide has a broad scope, forbidding discrimination by the federal government, any state or local government or health care provider receiving federal funds under the Act, and any health plan created under the Act.

The issue of advance directives is raised in the Act as part of a new insurance program for covering attendant services for people with disabilities, the Community Living Assistance Services and Supports (CLASS) Act. The Act creates a new Title XXXII of the Public Health Service Act for this program (see sec. 8002(a)(1)). A beneficiary may use cash benefits paid into a Life Independence Account to obtain, among other things, “assistance with decision making concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives or other written instructions recognized under State law” in case of a later inability to make health care decisions (Id., creating new Sec. 3205(c)(1)(B) of the Public Health Service Act). The Act also provides that the beneficiary can ask to be assigned an “advice and assistance counselor” who, among other things, will provide information on these same topics (Id., creating new Sec. 3205(e)). These provisions speak broadly of documents and instructions “recognized under State law,” without the clarifications on assisted suicide that the Act elsewhere seeks to provide as discussed above. However, because this is a federally funded program under the Public Health Service Act, use of the program to promote such practices

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<sup>15</sup> For an attempt at a balanced overview of the controversy see Richard M. Doerflinger, “Health Care Reform and a Dispute About Dying,” Life Issues Forum syndicated column, August 21, 2009, at [www.usccb.org/prolife/publicat/lifeissues/082109.shtml](http://www.usccb.org/prolife/publicat/lifeissues/082109.shtml).

could be forbidden by the existing Assisted Suicide Funding Restriction Act mentioned above.

### **Life-Affirming Assistance for Pregnant Women**

This analysis indicates that on a number of basic issues – federal funding of abortion, preventing government abortion coverage mandates, and conscience protection on abortion – the health care reform act is very deficient. This overview should not conclude without noting that the Act includes helpful provisions on life-affirming support for “pregnant and parenting teens and women,” and on adoption assistance. These provisions were included in the Senate’s final “manager’s amendment” at the urging of Senator Robert Casey (D-PA), and are modeled closely on the “Pregnant Women Support Act” (S. 1032) that he has sponsored with support from the U.S. Conference of Catholic Bishops. Grants from a new Pregnancy Assistance Fund may be used to help pregnant and parenting college students and teens, as well as pregnant women who are victims of domestic violence or abuse (secs. 10211-14). In addition, the federal tax credit for adoptive families is increased, and made refundable for lower-income families (sec. 10909).

Programs like these can help alleviate the burdens on teens and women who may otherwise feel social and economic pressure to resort to abortion. They are well worth enacting into law. At the same time, ample experience suggests that in a country with legalized abortion, the public policy decision with the most dramatic impact on abortion rates is a government’s decision whether to provide public funds for abortion.<sup>16</sup> Legislation using federal funds and federal authority to provide elective abortion coverage to millions of people who do not have it now – potentially including millions of people who object to such coverage -- would drastically expand our government’s role in promoting abortion as a routine part of health care. Future efforts to improve the new law should include efforts to include the language on federal funding and conscience rights regarding abortion that the House had approved in November 2009, retain and expand the Act’s provisions on support for pregnant women, and add language to ensure that broader rights of conscience and religious freedom are not undermined by legislation that should be crafted to respect the life, health and conscience of everyone.

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<sup>16</sup> A study of 2000 data, for example, showed that low-income women in states with Medicaid funding of abortion have more than double the abortion rate of low-income women in states without such funding (89 vs. 35 per 1000 women). See R. Jones et al., "Patterns in the Socioeconomic Characteristics of Women Obtaining Abortions in 2000-2001," *Perspectives on Sexual and Reproductive Health* 34 (2002): 226-235 at 231; [www.guttmacher.org/pubs/journals/3422602.pdf](http://www.guttmacher.org/pubs/journals/3422602.pdf).