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In a document titled *What's Wrong with the Senate Health Care Bill on Abortion: A Response to Professor Jost*, dated March 12, 2010, the United States Conference of Catholic Bishops respond to an earlier memorandum that I circulated demonstrating that the House and Senate bill are essentially equivalent on pro-life issues. On January 20, 2010, the Secretariat of Pro-Life Activities of the USCCB issued a longer memorandum entitled *Issues of Life and Conscience in Health Care Reform: A Comparison of the House and Senate Bills*. The Secretariat's statement sets out in detail both the provisions of pending health reform legislation that the Secretariat finds to be consistent with a Catholic pro-life position as well as those that it finds troublesome.

This memorandum responds to the USCCB's characterization of the Senate bill in both of these documents. I have the greatest respect for the Secretariat and for the Bishops whom it advises, their dedication to the sacredness of life, and the seriousness with which they have approached the task of reforming the American health care system in a manner that is consistently pro-life. Nevertheless, their characterization of the Senate bill contains several inaccuracies.[1] The Senate bill is in fact far more pro-life than the Secretariat acknowledges, as has now been recognized by the Catholic Health Association[2] and other pro-life organizations, leaders, and theologians. This memorandum addresses issues raised by the Senate bill relevant to the concerns of pro-life Americans, and in particular analyzes the Bishops' characterization of the Senate bill. It concludes that the Senate bill is essentially as pro-life as the House bill, indeed more so on some issues. Pro-life members of Congress should, therefore, be supportive of the Senate bill.

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[1] One of these inaccuracies is the claim that I opposed the Stupak amendment in an earlier post on the Health Affairs website. As can be readily seen by reading the post, http://healthaffairs.org/blog/2009/11/09/the-house-health-reform-bill-an-abortion-funding-ban-and-other-late-changes/, I did not oppose Stupak in this post; I rather described the Stupak Amendment, as I had been asked to do by Health Affairs.

[2] AP, "Catholic hospitals support health care bill," 3/13/10, http://www.google.com/hostednews/ap/article/ALeqM5ig2n-N48bvgGAWA-wHlMPQpOdinQD9EDUFGG0

To begin, pro-life members of Congress should support health reform because expanding access to health care, particularly to those who cannot now afford it, is fundamentally pro-life. The statement of the Secretariat does not mention the fact that studies have shown that as many as 45,000 Americans die prematurely each year because of lack of access to health insurance, but this conclusion was reached recently by a Harvard School of Public Health School study extrapolating from earlier work done by the Institute of Medicine. The Catholic Bishops as well as other Christian denominations and people of faith, have long recognized that the fact that many people, currently almost 50 million, lack access to health insurance in a country as rich as ours is not only a very serious problem, but also one that challenges our commitment to the sanctity of life. These bills do not address this problem perfectly, but would extend health insurance to 30 million Americans, and to that extent they are fundamentally pro-life.

Second, on many issues both bills address the concerns of pro-life Christians equally, as the *Response* in part recognizes:

- The Senate bill (1303(b)(2)(A), like the House bill (265(a)), explicitly prohibits the use of premium affordability tax credits or cost-sharing reduction payments to pay for abortions that are not covered by Medicaid (i.e. abortions in cases of rape and incest or in cases of physical threat to the life of the mother). (Whether the Senate bill does so equally effectively is a question addressed below).
- The Senate bill (1303(b)(4)), like the House bill (304(d)), prohibits qualified health plans from discriminating against providers or facilities because of their unwillingness to provide to pay, provide coverage, or refer for abortion. The Senate bill also requires the Office of Personnel Management to assure that at least one of the multi-state plans does not cover non-federally-covered abortions.
- The Senate bill (1303(c)(1)), like the House bill (258(a)), explicitly does not preempt any state laws regulating abortion.
- The Senate bill (1303(c)(2)(A)(i)), like the House bill (258(b)(1)(A)), explicitly does not change federal law regarding conscience protection or willingness to provide abortion.
- The Senate bill (1303(b)(1)(A)(i)), like the House bill (222(e)), provides that qualified health plans may not be required to provide abortion as an essential benefit.
- The Senate bill, like the House bill, leaves federal funding for other programs, such as the Medicaid and Medicare subject to the Hyde amendment, as they have been for decades. It provides no funding for new programs that cover abortions, and indeed, specifically provides that funds authorized for the new school-based health center program cannot be used to pay for abortions.
- Neither bill will in any way effect abortion coverage offered through employment-related plans not purchased through the exchange, which will continue to cover the vast majority of Americans, and in all likelihood continue to offer abortion coverage. These plans are, of course, subsidized by federal tax deductions and exclusions to the tune of over $200 billion a year, our largest federal subsidy for abortion. Neither bill touches this subsidy in any way, except insofar as the Senate bill imposes an excise tax on high cost plans, which may be those most likely to cover nonessential health services, like abortion.

Third, on some issues of concern to pro-life Christians, the Senate bill is stronger than the House bill. Pages 10 through 12 of the *Issues of Life* memo acknowledges that the Senate bill is stronger than the House bill on end-of-life issues and on clear opposition to assisted suicide and euthanasia and discrimination against providers that refuse to participate in it. Second, the memo at page 13 notes that the Senate bill, but not the House bill, includes $250 million for support for pregnant and parenting teens, provisions modeled on the Pregnant Women Support Act, which has been supported by the Bishops.

While the Secretariat *Issues of Life* memo does recognize these differences, it amazingly fails to mention the provision found in the Senate bill that one would have thought would have been most strongly supported by pro-life Christians. Section 1303(a) permits states to totally outlaw abortion coverage in policies issued through the exchange. No such provision is found in the House bill. Their response to my memo states that section 258(a) of the House bill, which provides that state abortion laws are not preempted, also allows states to prohibit abortion coverage. But the Stupak amendment itself explicitly authorizes qualified health benefit plans to offer supplemental abortion coverage. This could be read to guarantee health plans the right to offer supplemental abortion coverage through the exchange, regardless of state law. The CBO estimates that 6 million Americans will obtain their insurance through the exchange without receiving federal subsidies. The Senate provision would allow states that have strong anti-abortion policies to ban all abortion coverage for these people as well as for those who receive federal subsidies. The House bill does not explicitly permit this.

The Senate bill is also stronger than the House bill from a pro-life perspective in that it expands the adoption tax credit and adoption assistance programs to make adoption a more attractive and available alternative (10909).

In what respects, then, is the House bill more pro-life than the Senate bill? First, the *Issues of Life* and the *Response* memo contend that, although the Senate bill, like the House bill, prohibits the federal government from requiring coverage of abortion as an "essential health benefit," the Senate bill may otherwise require abortion coverage. There are several problems with this argument. First, under section 1302, the "essential health benefits" that cannot include abortion are precisely those benefits that a qualified health plan must provide under federal law. Saying that a plan cannot be required to cover abortion as an essential health benefit means that it cannot be required to cover abortion.

The memo contends, however, that a plan could be required to cover abortion as a preventive service for women under 2713(a)(4). This section refers to the comprehensive guidelines of the Health Resources and Services Administration, apparently the Women's Health USA guidelines. These do not address abortion. But in any event, preventive services are one of the services covered by the "essential health benefits," which cannot include abortion. Finally, and decisively, 1303(b)(1)(A)(ii) simply says a plan may decide whether or not to cover abortion, period. This cannot mean anything other than that plans cannot be required to cover abortion.

The Bishops' memos also take issue with the way in which the Senate bill assures that public funds do not cover abortion as compared to the way the House bill does it. This seems to be the Bishops' central objection to the Senate bill. Both bills provide that federal funds will not pay for abortions (other than those involving rape, incest, or physical life endangerment). The House bill does this explicitly, the Senate bill by subjecting the premium subsidies and cost sharing reductions to the Hyde Amendment, which has been adopted by the House and Senate every year since 1976. The House bill, as amended by the Stupak amendment, further provides that the abortion coverage will only be available to persons who receive federal subsidies by purchasing a supplemental policy that must be paid for with private or state funds. The Senate bill, by contrast, provides that plans that offer abortion coverage may not pay for that coverage with federal funds and must collect separately from the enrollee or the enrollee's employer a separate premium to cover the full cost of abortion coverage, not considering any reductions in the cost of coverage attributable to not having to cover the cost of prenatal care, delivery, and post-natal care. The funds provided by this separate premium must be kept strictly segregated from the funds that cover other services, and these accounts must be audited by state insurance commissioners using GAAP, OMB, and GAO accounting standards to assure this strict separation. Under both bills, federal funds cannot pay for abortion; a separate privately-paid premium must fully cover the cost of abortion. Under the House bill, two pieces of paper must be issued. Under the Senate bill only one piece is needed (although in fact abortion coverage will be offered as a rider, so two pieces will in fact issue).

Several objections are raised to the way in which the Senate handles the separate funding, none of which really hold water. It is objected that everyone who is a member of a plan that includes abortion coverage will have to pay for abortion coverage whether they want it or not, and that every plan member will have to pay at least a dollar for this coverage. Under 1312(a), consumers who purchase coverage as individuals can choose any plan, with or without abortion coverage, available through the exchange. If they are covered by their employer through the exchange, they may choose any plan within the tier covered by their employer, including, of course, a plan that does not cover abortions.

Under 1334(a)(6), the OMB is responsible for assuring that there will be at least one plan available through every exchange that does not cover abortions (other than those allowed under the Hyde amendment). The *Response* memo claims that this is a change from current policy, because none of the plans that currently contract with OMB for the Federal Employees Health Benefits Program may cover abortion. But as is very clear from section 1334, the OMB program created by the Senate bill is different from and entirely distinct from the FEHBP program. The 1334 OMB program is intended to broaden the options that are available to enrollees through the exchanges, making local insurance markets more competitive. In effect it builds on the exchanges themselves to assure that individuals in the small and non-group market have a variety of tax-subsidized options available. If there is any change here, it is a change that will make abortion less available. While employee-benefit plans (including small employer plans), currently subsidized by tax deductions and exclusions, often provide abortion coverage, the Senate

bill, like the House bill, assures that federal tax credit will never pay for abortions, whether coverage is purchase through an OMB plan or otherwise through the exchange.

In fact many plans that do not cover abortion will be available through the exchange. No federal law currently requires bakeries to sell bread. But of course they all do. Similarly, markets will assure that there will be many plans available to people who do not want to pay for abortion coverage. In states where abortion coverage through the exchange is outlawed under 1303(a), no plans will offer abortion coverage. In states where coverage is legal, couples beyond child-bearing age, single men, and many women and couples of child-bearing age who have moral objections to abortion will insist on not having to write two checks and not having to pay for coverage they do not want. Even women and couples who have no moral objection to abortion are unlikely to purchase coverage. Almost 90 percent of abortions are now privately financed, and few women expect that they will want an abortion and thus plan ahead by purchasing coverage. It is likely that few women or couples of child-bearing age will go through the trouble of selecting a plan that covers abortion and paying two checks for it. This is particularly likely to be true for women with employer coverage, who may be embarrassed to let their employer know that they are choosing abortion coverage.

Indeed, it is likely that few plans will offer abortion coverage at all. Those that do will invariably offer an identical plan without coverage for the majority of their market, which does not want to choose abortion coverage. Many plans currently offer abortion coverage, often without their enrollees knowing it, as one would assume was true with the Republican National Committee's plan, because the insurers believe it will save them the costs of childbirths. But once abortion becomes a separate service that must be fully paid for by a separate premium, coverage for it will likely become rare.

It is argued that the Senate bill makes enrollees pay for other enrollees' abortions. Of course, by definition, a person who buys health insurance pays for someone else's health care. That is the nature of insurance pooling. But only those who choose to purchase abortion coverage will pay for other enrollees' abortions, expecting that the others will pay for their own if they choose to have one.

It is also argued that the Senate approach allows federal money to be used to pay for plans that cover abortions. The essential point is that the Senate bill does not allow federal money to be used to pay for abortions. Federal Medicare and Medicaid funds currently help to pay for hospitals that pay for abortion, but they do not pay for abortions. This is directly analogous to the Senate approach.

Finally, much has been made of the odd "not less ... than $1 dollar per enrollee per month" provision of the Senate bill. This charge is a minimum, as plans must charge a premium that covers the full actuarial cost of abortion services, without any consideration of costs the insurer may save by not having to pay for prenatal care, postnatal care, or childbirth through the underlying plan. The cost of abortion services for the limited population that will choose this benefit will certainly be more than a dollar. This provision simply requires that something must be charged for abortion coverage; it

cannot be offered for free. Similar "at least $1" provisions are sprinkled throughout the United States Code when Congress has intended to say that the cost of something that must be covered by a user and cannot be provided for free.

Several other arguments are raised against the Senate bill. Both memos claim that the appropriations for community health centers and the National Health Services Corps are not made subject to the Hyde amendment, and thus will be used to pay for abortions. Community Health Centers provide pre- and post-natal care to one in eight child-bearing women in the United States, and have made it possible for many women to bear children who might otherwise have decided not too. With 15 million more poor Americans being added to the Medicaid roles under the Senate bill community health centers will become even more important.

Community health centers have never provided abortions and have no intention of providing abortions. Indeed, they cannot legally provide abortions. The Federal Regulations, 42 C.F.R. 50.301, 50.303, which date back to the 1970s, prohibit "any programs or projects supported in whole or in part by federal financial assistance, whether by grant or contract, appropriated to the Department of Health and Human Services and administered by the Public Health Services," from the performance of abortions except for cases of rape, incest, or physical life endangerment of the mother. This includes community health center and the National Health Services Corps, which are both supported by funds appropriated to the Department of Health and Human Services and administered by Public Health Service.

Moreover, funds appropriated for community health centers and the National Health Services Corps under the Senate bill are not segregated funds, they are explicitly enhanced funding that will flow into a pool of funding for these programs that is otherwise subject to the Hyde amendment. Any community health center that attempted to use its funding to provide abortions would be in violation not just of the federal regulations, which have the force of law, but also of the Hyde amendment, as they would have no way to segregate the Hyde-appropriated funds from the funds appropriated by this Act. The failure to explicitly apply Hyde to this funding was likely an oversight in the rush to settle on the wording of the manager's amendment, as earlier in the bill, funding for school-based health centers and for Indian health services was explicitly made subject to the Hyde amendment. But the fact that these funds will not be allowed to be used for abortion is clear. The cases cited by the Bishops, which interpret earlier law and different regulations under the Medicaid program, have no relevance here.

It is contended that the Senate bill does not explicitly prohibit discrimination by the federal government or federal programs or state or local governments receiving federal funding against providers that refuse to provide abortions, as does the House bill (259). Indeed, the *Response* memo asserts that my claim that it does, is "based on a confusion." But section 1303(c)(2) of the Senate bill explicitly states that the bill is not intended to have any effect on federal laws prohibiting discrimination against providers who refuse to provide, pay for, cover, refer for abortion or (going beyond the House bill) "to provide or participate in training to provide abortion." The federal law to which it clearly refers is

the Hyde amendment, which, like the House bill, prohibits discrimination in federal and federally-assisted state and local programs against individual or institutional providers that are unwilling to provide abortions (as well as to other federal statutes prohibiting discrimination, such as 42 USC 238n, which forbids discrimination in physician training). Hyde is the only federal law that comprehensively covers these issues, so it is certainly the legislation the Senate bill refers to. Both the House and Senate bills, therefore, offer equal protection of providers and professionals against discrimination or violation of their conscience.

Finally, the Bishops express a concern that with respect to this issue of discrimination against providers in public programs and with respect to prohibiting federal funding, the Senate bill relies on the Hyde amendment while the House bill explicitly adds the Hyde amendment language to the bill itself. Hyde has been adopted every year since 1976. It is an indelible part of American law. There may come a time when Congress rejects the Hyde amendment, thus opening up the Medicaid and Medicare programs to fund abortion. Any Congress that was so determined to fund abortion would no doubt also amend the health reform legislation to provide that premium subsidies could also be used to purchase abortion. Realistically then, the Senate bill's reference to the Hyde amendment and the House bill's explicit inclusion of it, is a distinction without a difference. By preserving the Hyde Amendment's restrictions in every respect, the Senate bill also preserves the status quo on abortion.

In sum, if one examines the abortion provisions of the House and Senate bills carefully, in their totality, they are equivalent. Each has its strengths and weaknesses with respect to pro-life concerns. At this point in time, however, we do not have the choice between the House and Senate language. The Democrats no longer have a filibuster-proof majority in the Senate, and therefore the Senate bill must be the platform for the health reform bill. Changes in the legislation can only be made through a reconciliation bill, which requires only a 51 vote majority in the Senate. But reconciliation can only deal with revenues and outlays of the federal government, which does not include the abortion issue, since by definition federal money cannot under either bill be spent for abortion. The Republicans have made it clear that they will block any changes from being made to the Senate language through reconciliation. The Bishops statement that the House should simply substitute the House language for the Senate language in the reconciliation process simply demonstrates a misunderstanding of the Senate procedures that constrain action at this time.

The choice we face, in sum, is the Senate bill or our current health care system. The Senate bill will undoubtedly save many lives through extending insurance coverage to people who cannot afford insurance. It will also in all likelihood make abortion coverage less common than it is now, since people will have to explicitly choose and pay extra for it.

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