



Center for Reproductive Rights
Supplemental Testimony

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

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

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

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

Unsafe abortion occurs around the world and in the U.S. when legal or financial barriers prevent women from accessing services in an appropriate medical context. As both our work around the world³ and a recent global Guttmacher Institute survey bear out,⁴ erecting barriers to abortion access does not significantly reduce the number of abortions, or make them more "rare," as suggested by testimony.⁵ Instead, barriers merely

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

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

Despite its status as healthcare, attacks on abortion service providers remain distressingly commonplace. Even in the U.S., abortion providers are routinely subjected to harassment, intimidation and violence. Our 2009 study⁸ found that anti-choice protestors personally threatened healthcare workers, both staff and doctors, pursuing them at home, seeking to publish their names and faces so that they could be more effectively targeted, and interrupt them in their work through constant surveillance and disturbance. Clinic staff and physicians experience picketing, stalking, smear campaigns, and harassing leafleting at their residences and other threats to themselves and their families. As the murder of Dr. Tiller in 2009 shows, providers are also targeted for assassination.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- In *Mueller v. Allen*, for example, the Supreme Court rejected an Establishment Clause challenge to a tax-deduction program for private schools, despite the fact that 96% of the beneficiary parents sent their children to religious schools.¹⁵ In rejecting the challenge, the Court explained that the “private choices of individual parents” vitiated the government’s role, and that “no ‘imprimatur of state approval’ can be deemed to have been conferred.”¹⁶
- Similarly, in *Witters v. Wash. Dep’t of Servs. for the Blind*, the Supreme Court upheld vocational scholarships that paid for students to study at religious institutions to become pastors, holding that “[a]ny aid ... that ultimately flows to religious institutions does so only as a result of the genuinely independent and private choices of aid recipients.”¹⁷
- And in *Zobrest v. Catalina Foothills Sch. Dist.*, the Supreme Court upheld a federal program permitting sign-language interpreters to interpret in religious schools.¹⁸ In so doing, the Court noted that “[b]y according parents freedom to select a school of their choice, the statute ensures that a government-paid interpreter will be present in a sectarian school only as a result of the private decision of individual parents.”¹⁹

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

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

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

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

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

Indeed, the utter lack of boundaries around the claims of anti-choice opponents²⁶ amply demonstrates the inexhaustibility of their arguments. To the extent that a single federal dollar, spent on anyone, supports a healthcare system in which abortion care is available, it appears anti-choice forces would claim that dollar is a “subsidy” for abortion that violates taxpayers’ selectively sensitive sensibilities. The only system that would satisfy such all-inclusive criteria is one totally lacking in abortion coverage or services in either the private healthcare market or federally supported healthcare. While this may be their goal, it would be contrary to the clear and demonstrated medical needs of American women and contrary to constitutional principle.

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

2) Refusal provisions cannot trump patient protections for women.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Congress should emphatically reject these dangerous legislative proposals.

Endnotes

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

¹⁸ 509 U.S. 1 (1993).

¹⁹ *Id.* at 10 (emphasis added).

²⁰ *Zelman v. Simmons-Harris*, 536 U.S. 639, 649 (2002) (citations omitted) (emphasis added).

²¹ *Id.*

²² *See, e.g., Steele v. Indus. Dev. Bd. of Metro. Gov't Nashville*, 301 F.3d 401, 416 (6th Cir. 2002) (upholding the issuance of tax-exempt bonds to support private religious university because “The nature of the aid conferred by the tax free revenue bonds is not direct aid”); *see also Am. Jewish Cong. v. Corp. for Nat'l and Comm. Serv.*, 399 F.3d 351 (D.C. Cir. 2005) (AmeriCorps payments to participants teaching in religious schools is permissible because participants’ decision on where to teach represents a “true private choice”).

²³ Center for Reproductive Rights, *Whose Choice? How the Hyde Amendment Harms Poor Women* 28-29 (2010), available at http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Hyde_Report_FINAL_nospreads.pdf

²⁴ *See, e.g., id.* at 35.

²⁵ See Doerflinger Testimony at 8 (“...using the coercive power of government to enlist the unwilling aid of taxpayers ... who disagree with them”).

²⁶ *See, e.g.,* Testimony of Douglas Johnson, Federal Legislative Director, National Right to Life Committee, Testimony Before the U.S. House of Representatives – Committee on Energy and Commerce – Subcommittee on Health, at 13, Feb. 9, 2011, available at http://republicans.energycommerce.house.gov/Media/file/Hearings/Health/020911_Health_ProLife/Johnson.pdf (hereinafter “Johnson Testimony”) (arguing that even if a state bans coverage on its exchange, “the taxpayers in such a state will still be paying to subsidize abortion-covering insurance plans in other states, and the other abortion-expanding components of the law”).

²⁷ *See* Doerflinger Testimony at 2 (“Even public officials who take a ‘pro-choice’ stand on abortion have supported bans on public funding as a ‘middle ground’ on this contentious issue – sometimes observing that it is not ‘pro-choice’ to force others to fund a procedure to which they have fundamental objections.”); *id.* at 8 (“What this legislation does is place abortion coverage more in the arena of *individual choice* for women . . .”).

²⁸ Alvare Testimony at 2.

²⁹ *See* Craig P. Griebel, M.D. et al., Management of Spontaneous Abortion, 72 Am. Fam. Physician 1243, 1246 (Oct. 2005) (standard of care for miscarriage is immediate uterine evacuation); National Health Law Program, *Health Care Refusals: Undermining Quality Care for Women*, 48 & n. 189 (2010) (hereinafter *Health Care Refusals*) available at http://www.healthlaw.org/images/stories/Health_Care_Refusals_Undermining_Quality_Care_for_Women.pdf.

³⁰ Royal College of Obstetricians and Gynaecologists, The Management of Early Pregnancy Loss, Guideline 25, Oct. 2006, at 1.

³¹ Craig P. Griebel, M.D. et al., Management of Spontaneous Abortion, 72 Am. Fam. Physician 1243, 1246 (Oct. 2005).

³² *Health Care Refusals*, 48 & n. 189.

³³ *Id.*

³⁴ *See* United States Conference of Catholic Bishops. Ethical and Religious Directives for Catholic Health Care Services. Washington, DC: United States Conference of Catholic Bishops (available at www.usccb.org/bishops/directives.shtml) (hereinafter “Ethical and Religious Directives”); Lori R. Freedman, et al., *Where There’s a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 Am. J. of Pub. Health 1775 (2008).

³⁵ Ethical and Religious Directives.

³⁶ *Id.*

³⁷ *Health Care Refusals* at 52.

³⁸ Catholic hospitals are not the only religious institutions that deny women the medical standard of care. *See* Ramesh Raghavan, A Question of Faith, 297 JAMA 1412 (2007) (describing a Baptist hospital that refused to treat his wife’s miscarriage because she had not yet developed a life-threatening infection).

³⁹ *Health Care Refusals* at 47.

⁴⁰ Lori R. Freedman, et al., *Where There’s a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 Am. J. of Pub. Health 1774 (2008).

⁴¹ Alvare Testimony at 7; *see also* Doerflinger Testimony at 7.

⁴² Lois Uttley and Ronnie Pawelko, “No Strings Attached: Public Funding of Religiously-Sponsored Hospitals in the United States,” 5 (2002).

⁴³ *Health Care Refusals* at 47.

⁴⁴ *See* Doerflinger Testimony at 7; Alvare Testimony at 7.

⁴⁵ David Foster, *Research Brief: Differences in Health Systems Quality Performance by Ownership* (Thompson Reuters, August 9, 2010) at <http://100tophospitals.com/assets/100TOPSystemOwnership.pdf> (cited in Doerflinger at 7 n.14.)

⁴⁶ Doerflinger Testimony at 10 (emphasis added). *See also* Letter from Catholic Medical Association to Chairman Pitts (Feb. 10, 2011) (stating that refusal must apply in “all circumstances,” including with respect to “emergency abortions”).

⁴⁷ Centers for Medicare & Medicaid Services, 42 C.F.R. § 482.55, Condition of participation, Emergency services.

⁴⁸ *See, e.g.*, Doerflinger Testimony at 5, Alvare Testimony at 7.

⁴⁹ Letter from Sister Carol Keehan, President and CEO, Catholic Health Association to Chairman Pitts (Feb. 9, 2011).

⁵⁰ 42 U.S.C. § 1395dd(e)(3)(B).

⁵¹ 42 U.S.C. § 1395dd(e)(1).