



Center for Reproductive Rights
Testimony

Before the Subcommittee on Select Revenue Measures
Committee on Ways and Means
United States House of Representatives

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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.

H.R. 3 interferes with private healthcare choices. It does so by imposing draconian tax penalties on small businesses and middle-class families; by making the existing harmful and discriminatory bans on abortion coverage more intractable; by encroaching on the private lives of government workers; and by heightening dangerous refusal provisions that are at odds with prevailing standards of care, and out of step with international and human rights law. Congress should emphatically reject this extreme proposal.

Abortion is an Essential Part of Reproductive Healthcare.

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

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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 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.

H.R. 3 Would Impose an Abortion Tax.

H.R. 3 is a radically broad bill – essentially, an Abortion Tax – and is clearly intended to prevent all women from obtaining health insurance coverage for abortion services – including insurance paid for with private dollars or provided by employers in the private marketplace. H.R. 3 creates burdensome new tax penalties that will raise taxes on millions of Americans and is designed to make coverage of abortion unavailable through private health insurance policies – stripping away coverage that millions of women currently have.

In particular, H.R. 3 targets small businesses and middle-income families. H.R. 3 would: ban tax credits for businesses that provide health plans that include abortion coverage, including the new Small Business Health Tax Credit, which was created to make health insurance affordable for small businesses and their employees;⁸ deny Health Coverage Tax Credits to workers whose jobs have been outsourced if their health insurance plans include coverage for abortion; and impose a ban on abortion coverage for women who purchase health insurance with premium assistance under the Affordable Care Act.⁹

Tax Credits are Not Federal Funding.

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 credit transforms a

private purchase into a government expenditure subject to any number of governmental regulations. This far-reaching claim is as false today as it was during the fight over the Affordable Care Act (ACA). Indeed, the idea that tax credits or exemptions constitute federal funding should raise all manner of alarms, especially for religious institutions.

Government expenditures are distinguishable from tax subsidies or credits. As Lester Salamon explains in his treatise, *The Tools of Government*, any government expenditure and the resulting provision of a service by a government agency is a *direct* policy tool, because there is no difference between the entity authorizing, funding, and delivering the service – in each case, it is the government.¹⁰ In contrast, a tax credit is an *indirect* tool, marked by a separation between the government (that authorizes the tax expenditure) and individual citizens and private companies that will actually provide the services.¹¹

Moreover, when a government provides a service directly, it controls how, when, and where its funds are spent. But in the case of a tax credit, a private individual – and not the government – is in control of how money is spent.

In the case of the Affordable Care Act, there is no direct government expenditure on abortion. Instead, women are eligible for tax subsidies when they purchase a private health insurance plan, which in turn may pay for abortion services at private hospitals. This private choice attenuates the government's involvement.

The Supreme Court has consistently upheld the distinction between direct policy tools that are attributable to the government and indirect policy tools that are attributable to private, individual choices. 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.”¹² Based on that distinction, the Court upheld a voucher program in which the majority of students enrolled in religious schools.¹³

The Supreme Court has highlighted the public funding/private funding distinction in numerous other Establishment Clause cases – repeatedly holding that indirect government expenditures that are mediated by private individuals are not government funding. 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.¹⁴ 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.”¹⁵

- 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.”¹⁶
- And in *Zobrest v. Catalina Foothills Sch. Dist.*, the Supreme Court upheld a federal program permitting sign-language interpreters to interpret in religious schools.¹⁷ 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.”¹⁸
- Since the Supreme Court’s landmark voucher case in 2002,¹⁹ circuit courts of appeals have similarly found that private choice renders private an otherwise impermissible government expenditure.²⁰

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 credit.

H.R. 3 Would Make Harmful Restrictions More Intractable.

H.R. 3 also punishes all women who depend on the government for healthcare coverage or who get their insurance through federal employment. H.R. 3 would make bans on abortion coverage for women enrolled in Medicaid, federal employees, women in the military, Peace Corps volunteers and many others even more intractable. Most of these restrictions have no home in permanent law; instead, they are re-enacted each year in annual appropriations bills. H.R. 3 would make these damaging restrictions permanent.

Although the damage that would be done by H.R. 3 extends far beyond the codification and re-codification of these discriminatory policies, this effect alone would be tragic as these denials of coverage have a tremendously harmful impact on the women they target. For example, as our 2010 report documents, the ban on abortion coverage for women enrolled in Medicaid has forced women 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 will be able to

access the care they need.²¹ The struggle to raise funds forces many women to delay obtaining abortion services; others are forced to carry unwanted pregnancies to term.

These restrictions – although often most disastrous for women with the least means – know no socio-economic boundaries. Restrictions on coverage for federal employees forced one woman to pay thousands of dollars after confronting incredibly difficult circumstances. After terminating a wanted pregnancy because she learned that her fetus had no brain and no chance of survival, she discovered that her federal insurance did not cover the procedure. In the midst of her grief, she was handed a \$9,000 bill.²² H.R. 3 guarantees that more women will suffer similar injustices.

H.R. 3 would also deny home rule to the District of Columbia, forcing the District to remove abortion coverage from its own local Medicaid program. The District now uses its own funds to provide coverage for medically necessary abortions.

H.R. 3 Could Encroach on the Private Lives of Government Workers.

And in yet another egregious encroachment on individual rights, H.R. 3 could even prevent a federal employee from doing volunteer work – in his or her own private time – that includes provision of abortion services. That sort of government-dictated stranglehold on private life would not be tolerated with respect to other healthcare services. The men and women who are employed by government agencies and institutions are not conscripted into indentured servitude. As private individuals, they have private lives that must be secure from governmental overreach. Any suggestion that restrictions on the private lives of government employees somehow relates to “federal funding” strains credulity.

H.R. 3 Would Heighten Dangerous Refusal Provisions.

Current law amply protects healthcare providers who entertain religious or moral objections to the provision of abortion services. Since 1973, the Church Amendment has provided that no individual may be discriminated against because they performed or refused to perform an abortion based on their religious beliefs or moral convictions. Other federal laws bolster opt-outs specifically for those who refuse to provide abortions services.²³ The Affordable Care Act left each of these laws intact, and as well as adding a new, one-sided provision barring health plans from discriminating against healthcare providers or facilities because of their *refusal* to “provide, pay for, provide coverage of, or refer for abortions.”²⁴

Women seeking abortion services, however, must often overcome significant hurdles in finding a provider – from the Guttmacher Institute: “87% of all U.S. counties lacked an abortion provider in 2008; 35% of women in the U.S. live in those counties.”²⁵

Against this backdrop, H.R. 3 heightens dangerous refusal provisions that are at odds with prevailing standards of care, and out-of-step with international and human rights law.²⁶

H.R. 3 Lacks Patient Protections

The refusal provision in H.R. 3 goes far beyond protecting individual conscience. Instead, it allows corporations to interfere with the doctor-patient relationship, regardless of the doctors' own beliefs or the patients' medical needs. It is a basic tenet of ethical healthcare provision that patients must be presented with accurate and complete information about their medical options in order to make decisions about their healthcare. H.R. 3 denies women that fundamental right.

This provision is out-of-step with international human rights standards and norms. International standards require that there must be a balance between health and conscience and require a recognition that the health of the patient is of primary importance.²⁷ So, while practitioners have a right to respect for their conscientious convictions regarding lawful procedures and should not suffer from discrimination on the basis of their convictions, refusal clauses must reflect prevailing standards of medical ethics that make patient's health care the primary consideration.

Refusal clauses may not be overbroad,²⁸ and providers must promptly tell patients that they refuse to provide certain health services and patients are entitled to be referred immediately, in good faith, for procedures that providers object to undertaking.²⁹ Despite growing international consensus on these standards, H.R. 3 does not include a single patient protection to ensure that patients receive a full range of medically indicated treatment options or even all of the relevant information that they need to make decisions about their care.

H.R. 3's "Non-Discrimination" Provision Discriminates against Abortion Providers

A one-sided anti-discrimination clause is troubling because it ignores the real threats to providers of abortion services. Those who choose to provide abortion services are routinely harassed, intimidated, and threatened, as extensively documented in our 2009 report.³⁰ They also face serious employment discrimination. For example, one physician, the head of an ob-gyn residency program in Arizona was removed from his position simply for supporting training opportunities for residents who wanted them.³¹ Another physician, a prominent family doctor, was asked to resign his position as the chair New York Medical College's Family Medicine program after a local newspaper published remarks he made about his decision to lease space to a clinic that would provide abortions.³² Persistent harassment and discrimination, including

retaliation that prevents residents from even being offered the opportunity to receive training in abortion services when requested has led to a shortage of abortion providers.

H.R. 3 does nothing to protect the men and women who provide abortion services or otherwise support their provision. The lopsided refusal provision violates a fundamental principle of American law by allowing discrimination based on viewpoint, and is inconsistent with the concepts of balance and fairness that undergird our legal system.

H.R. 358 Would Eliminate Abortion Coverage in the Health Insurance Exchanges.

H.R. 358 would reach into uncharted territory by imposing substantial burdens on the private insurance marketplace. By prohibiting any funds authorized or appropriated by the Affordable Care Act from going toward “any *part* of the costs of any health plan that includes coverage of abortion,”³³ H.R. 358 would bar insurance plans in the new exchanges from providing abortion coverage if a single person receiving premium assistance credits enrolls. Because a great majority of individuals on the exchanges will be subsidized, H.R. 358 would therefore essentially ban coverage of abortion in the exchanges for everyone – including those paying for coverage entirely with private dollars. Insurers are unlikely to offer a product that a majority of potential customers are barred from purchasing.

In addition to those constraints, H.R. 358 imposes significant new administrative burdens on any plan in the exchanges that could hypothetically offer a full range of reproductive healthcare. The bill would require an insurance company offering a plan with abortion coverage to offer a second plan “identical in every respect except that it does not cover abortions.”³⁴ Insurers that tried to continue to offer abortion coverage — as most plans currently do³⁵ — would face high costs, technical complexities, and duplicative administrative requirements,³⁶ making it very likely that H.R. 358 would force plans to stop offering abortion insurance coverage.

Although the bill offers up the ability for women to purchase “abortion riders,” it is irrational to ask women and families to plan for an unplanned pregnancy by purchasing separate, supplemental coverage. Moreover, women receiving premium assistance cannot afford healthcare insurance, let alone a second insurance policy. Most importantly, history shows that insurers simply do not offer “rider” coverage even when they are able to do so.³⁷

This ban impacts the millions of unsubsidized individuals and small business employees expected to participate in the insurance exchanges. Over time, these restrictions will affect more and more women, as the health insurance exchanges are designed to grow over time to encompass the large-employer market.³⁸

H.R. 358 would also decrease – or even eliminate – abortion coverage in the private market. A George Washington University Medical Center School report found after analyzing the similarly onerous Stupak-Pitts ban that “the treatment exclusions required . . . will have an industry-wide effect, eliminating coverage of medically indicated abortions over time for all women, not only those whose coverage is derived through a health-insurance exchange.”³⁹

H.R. 358 would forsake the fundamental promises of healthcare reform. It would deny women the protection of insurance coverage for abortion despite stringent restrictions that already assure that federal funding is segregated from payments for coverage, and would threaten or eliminate coverage that women already have for abortion in the private insurance marketplace.

Conclusion: Congress Should Reject these Harmful Bills.

The Center for Reproductive Rights urges Congress to reject this dangerous and extreme legislation.

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 Harm’s 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 Harm’s 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 Harm’s 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 See I.R.C. § 45R.

⁹ See I.R.C. § 36B.

¹⁰ LESTER SALAMON, *THE TOOLS OF GOVERNMENT* 28 (2002).

¹¹ *Ibid.*

¹² *Zelman v. Simmons-Harris*, 536 U.S. 639, 649 (2002) (citations omitted) (emphasis added).

¹³ *Id.*

¹⁴ *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).

¹⁵ *Id.* at 399.

¹⁶ 474 U.S. 481, 487 (1986)

¹⁷ 509 U.S. 1 (1993).

¹⁸ *Id.* at 10 (emphasis added).

¹⁹ *Zelman v. Simmons-Harris*, 536 U.S. 639, 649 (2002).

²⁰ 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").

²¹ Center for Reproductive Rights, *Whose Choice? How the Hyde Amendment Harms Poor Women* 28-29 (2010), available at <http://reproductiverights.org/en/feature/whose-choice-how-the-hyde-amendment-harms-poor-women>.

²² Statement of DJ Feldman on Harmful Impact of Abortion Coverage Restrictions, Nov. 16, 2009 at <http://reproductiverights.org/en/feature/no-abortion-ban-statement-by-dj>.

²³ See Church Amendment, 42 U.S.C. § 300a-7 (2006); Coats Amendment, 42 U.S.C. § 238n (2006); Weldon Amendment, Pub. L. No. 111-8, § 508(d)(1), 123 Stat. 524, 803 (2009).

²⁴ Patient Protection and Affordable Care Act, Pub L. No. 111-148, § 1303(b)(4), 124 Stat. 119, 168-171 (codified at 42 U.S.C.A. § 18023 (West 2010)) (hereinafter "PPACA").

²⁵ Guttmacher Institute, *Facts on Induced Abortion in the United States* (Jan. 2011), at http://www.guttmacher.org/pubs/fb_induced_abortion.html.

²⁶ Protect Life Act, 112th Cong. § 2(a)(7) (2011).

²⁷ International Covenant on Civil and Political Rights, Art. 18, *opened for signature* December 19, 1966, 999 U.N.T.S. 85 (entered into force March 23, 1976), *ratified by the United States*.

²⁸ See, e.g., *Janaway v. Salford Health Authority*, 2 All E.R. 1079 (H.L. 1988) (conscience objection clause in UK abortion law only applies to participation in treatment); Regulations for the Implementation of the Act dated June 13 1995 no. 50 concerning Termination of Pregnancy, with Amendments in the Act dated 16 June 1978 no. 66 cf. § 12 of the Act, laid down by Royal Decree, 1 December 1978, § 20 (Nor.) (Regulations implementing Norway's abortion law expressly provide that the right to refuse to assist in an abortion belongs only to the personnel who perform or assist the actual procedure).

²⁹ See, e.g., Code de la Sante Publique, arts. L2212-8 and R4127-18 (Fr.) (2001) (France's Public Health code places a legal obligation on providers to immediately communicate their refusal to perform an abortion).

³⁰ 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>.

³¹ See Center for Reproductive Rights, *Ex-Ob-Gyn Chief in Arizona Receives Million-Dollar Settlement in Discrimination Case*, at <http://reproductiverights.org/en/press-room/ex-ob-gyn-chief-in-arizona-receives-million-dollar-settlement-in-discrimination-case>.

³² Ian Fisher, *Casualty of the Abortion Debate; A Doctor, Aiming at Conciliation, Instead Loses a Post*, N.Y. Times, Mar. 24, 1998.

³³ Protect Life Act, 112th Congress, § 2(a)(4), *available at* http://republicans.energycommerce.house.gov/Media/file/PDFs/pitts_01a_xml.pdf (hereinafter “Protect Life Act”).

³⁴ Protect Life Act, 112th Congress, § 2(a)(4).

³⁵ Guttmacher Institute, *Memo on Private Insurance Coverage of Abortion* (Jan. 19, 2011), *at* <http://www.guttmacher.org/media/inthenews/2011/01/19/index.html>.

³⁶ *See*, Sara Rosenbaum et. al., *An Analysis of the Implications of the Stupak/Pitts Amendment for Coverage of Medically Indicated Abortions*, at 25 (Nov. 16, 2009), *at* http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_FED314C4-5056-9D20-3DBE77EF6ABF0FED.pdf.

³⁷ *See, e.g.*, Kaiser Foundation, “How the House Abortion Restrictions Would Work,” Nov. 10, 2009, *available at* <http://www.kaiserhealthnews.org/Stories/2009/November/10/abortion-explainer.aspx> (last visited Nov. 11, 2009); Peter Slevin, *Insurers report on use of abortion riders*, Washington Post, Mar. 14, 2010.

³⁸ PPACA § 1312(f)(2)(B)(i).

³⁹ Sara Rosenbaum et. al., *An Analysis of the Implications of the Stupak/Pitts Amendment for Coverage of Medically Indicated Abortions* (Nov. 16, 2009), *available at* http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_FED314C4-5056-9D20-3DBE77EF6ABF0FED.pdf.