Washington Insider

In the last quarter of 2009, discussions of bioethics in Washington, D.C., focused almost entirely on Congress's lengthy and (at this point) stalled effort to reform our ailing health care system. Even the long-debated issue of human embryonic stem cell research fell almost completely from public view, albeit with one development in December as the government approved its first "new" embryonic stem cell lines eligible for federally funded research.

New Human Embryonic Stem Cell Lines

On December 3, the National Institutes of Health certified thirteen new embryonic stem cell lines, created using private funds, as being eligible for federally funded research under the guidelines the NIH issued in July 2009, with more approvals planned in the weeks to come. While hailed by some as an expansion of the cell lines available for such research, this was more accurately seen as a substitution: Under the earlier Bush administration policy, twenty-one such lines were eligible, and it seems most if not all of these will be ineligible under the new procedural rules established by the NIH.

The news was greeted by scientists favoring destructive human embryo research as a step forward for science—though, as usual, none cited any specific evidence that the new cell lines are needed for advances that cannot be pursued in other ways. Dr. George Daley of Children's Hospital in Boston, who developed eleven of the thirteen new lines, indicated that the new federal grants would be especially welcome because, in the words of the *New York Times*, "private financing had been drying up" for this avenue of research.[1] The *Times* apparently did not inquire further into why investors are leaving the field if it is so promising and now has new government support behind it.

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[1]Nicholas Wade, "New Stem Cell Lines Open to Research," *New York Times*, December 3, 2009, A27, http://www.nytimes.com/2009/12/03/science/03stem.html.

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The fact that adult stem cells and reprogrammed adult cells, known as "induced pluripotent stem (iPS) cells," are far closer to producing help for patients has dawned even on the California Institute for Regenerative Medicine, established by a $3 billion state bond issue in 2004 specifically to pursue human embryonic stem cell advances. When the institute disbursed almost $230 million for fourteen new projects in October 2009, only four projects involved human embryonic stem cells. Spokespersons say this "new direction" away from embryonic cells is made necessary by the need to show progress toward treatments before the institute's ten-year commitment expires in 2014.[2]

The Obama administration's political commitment to use of human embryonic stem cells continues to make acknowledgment of these realities unlikely at the federal level. At the same time, there has been no action in Congress throughout 2009 either to write the NIH guidelines into permanent law or to expand them, as some members had proposed when the guidelines were issued.

Issues of Life and Conscience in Health Care Reform: A Comparison of House and Senate Bills

By the end of 2009, both chambers of Congress had approved health care reform bills. As of this writing these bills had not been reconciled or merged into a final product. The House of Representatives approved its Affordable Health Care for America Act (H.R. 3962) on November 7 by a vote of 220 to 215. The Senate approved its version, the Patient Protection and Affordable Care Act (Senate substitute for H.R. 3590) on December 24 by a vote of 60 to 39, garnering the exact number of votes needed to avert a filibuster that could block the legislation. (Henceforth these will be referred to simply as the "House bill" and "Senate bill.")

The January 19 election of a Republican in Massachusetts to fill the late Edward Kennedy's Senate seat, depriving the Democrats of the 60 votes needed to advance their agenda in that chamber, led many to conclude that health care reform would stall unless it could take on a more bipartisan character in 2010. At this writing, the ultimate fate of the legislation cannot be predicted. However, a detailed analysis of the bills passed by House and Senate can provide a snapshot of the kinds of moral issues raised in any attempt to overhaul the health care system.

The Catholic bishops' conference wrote numerous letters to Congress in 2009 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 have said, is "a public good, moral imperative and urgent national priority."[3] The bishops have repeatedly cited three specific moral criteria for

[2]Karen Kaplan, "Grant Money Could Speed Stem Cell Cures," *Los Angeles Times*, January 10, 2010, http://articles.latimes.com/2010/jan/10/science/la-sci-stem-cells10-2010jan10.

[3]U.S. Conference of Catholic Bishops (USCCB), Letter of December 22, 2009, to U.S. Senate, http://www.usccb.org/healthcare/letter-to-senate-20091222.pdf. For the Conference's letters and other materials on health care reform, see http://www.usccb.org/healthcare/.

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 House and Senate bills deal with the third criterion, respect for life and conscience.

On these issues the bishops' conference has said that health care reform legislation must maintain the "status quo" on federal abortion policy—that is, current long-standing 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.[4]

This status quo principle does not mean that the legislation should seek to maintain all unjust situations in the private sector which occur because of the absence of corrective law. For example, when insurance companies and private employers choose the 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 marker, not a seller's market"[5]—that is, to take power away from insurance companies and give it to the individual. The proposed bills transform 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 legislation 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

Long-standing 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 elective 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

[4] See John Paul II, *Evangelium vitae* (March 25, 1995), nn. 72–73.

[5] See remarks of Sen. Christopher Dodd (D-CT) in *Congressional Record* 155 (November 30, 2009): S11994.

Program), and in a permanent provision of the Children's Health Insurance Program first enacted in 1997, among other laws.[6]

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, both House and Senate bills would provide income-based federal subsidies or credits to make health coverage affordable for millions of Americans who cannot currently obtain such coverage through an employer. Both bills also provide for insurance "exchanges," organized by state or region, where health plan issuers can compete for new customers (including some who lack employer-based insurance but do not qualify for a subsidy).

Of the two bills, only the House bill conforms to current law on abortion funding. An amendment offered by Rep. Bart Stupak (D-MI), approved 240 to 194 immediately before the House vote to pass the overall health care reform bill in November, states 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 are 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 may purchase broader or elective abortion coverage only as "separate supplemental coverage" paid for entirely with non-federal funds.[7] Health plan issuers may 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 may also sell health plans that include elective abortions to non-subsidized purchasers on the exchange, as long as they offer the identical plan without such abortions to subsidized purchasers (House bill, sec. 265).

In the Senate, an amendment offered by Senator Ben Nelson (D-NE) that was very similar to the Stupak amendment was tabled (set aside) on December 8 by a vote of 45 to 54.

The final Senate bill 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.[8] While the Hyde amendment has for many years allowed abortion funding only for cases of life endangerment

[6] See USCCB Secretariat of Pro-Life Activities, "Current Policy on Federal Abortion Funding: What Is the Status Quo?" October 23, 2009, http://www.usccb.org/prolife/issues/healthcare/abortion_funding_102309.pdf.

[7] Throughout this analysis, the phrase "elective abortions" will be used to refer to abortions that have long been ineligible for federal funding in major health programs (all abortions except in cases of rape, incest, or danger to the life of the mother). The term is used here as shorthand for a long-standing federal policy, not to express a medical or moral judgment.

[8] The Senate bill explicitly recognizes this particular premium credit as a form of federal funding that is subject to the Hyde amendment's restrictions on funding abortions

and rape or incest, a reference to this annual rider is potentially far less secure than the House bill's 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. Last-minute negotiations between Senate leadership and Senator Nelson led to a "segregation of funds" policy requiring 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 (Senate bill, sec. 1303). This new federal requirement for a separate "abortion surcharge" paid by all enrollees in these plans clearly violates the status quo.

Thus under the Senate bill, 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—estimated at "not 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 House bill, by contrast, follows other federal health programs in treating the exclusion of elective abortion coverage as the norm, so that issuers and purchasers who favor abortion coverage must take the initiative of contracting for it with separate funds.

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. In the health care reform debate this has been argued in terms of a "public option," a government-run health plan offered nationwide to compete with privately offered plans in the exchanges.

The House bill's public option, the "community health insurance option," may not cover abortions except in cases of rape, incest, or danger to the mother's life. Unlike non-federal plans, the government-run plan may not sell supplemental coverage for abortion or offer a health plan covering abortions to non-subsidized purchasers on the exchange. In this way it conforms to other government-run health programs such as the Federal Employees Health Benefits Program (FEHBP).

The Senate bill does not have a public option as such. But it 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

(Senate bill, sec. 1303 (b)(2)(A)(i)). The deficiency is that the bill 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 other federal health programs do.

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 (Senate bill, 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 both the House bill and the current FEHBP program, which exclude elective abortions from *all* plans that OPM contracts for or that use federal subsidies.

Moreover, even the Senate bill'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 restrictions 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, 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 (Senate bill, sec. 10503). This seems to create a new and expansive funding stream for health care services, without any restraint on use of the funds for elective abortions.[9]

There is one clear exception to this general concern. Both House and Senate bills authorize a new program for promoting "school-based" health clinics, which will (among other things) dispense contraceptive drugs and devices to minors.[10] However, both bills state that federal funds for this program may not be used to "provide abortions" (House bill, sec. 2511 (a), creating new 42 USC 399Z-1 (c)(2); Senate bill, sec. 4101 (b), creating new 42 USC 399Z-1 (f)(1)(B)). Both bills also state, in their definition of a "school-based health clinic," that such a clinic does not "perform abortion services" (House bill, new 42 USC 399Z-1 (l)(3)(E); Senate bill, new 42 USC 399Z-1 (f)(1)(B)). This seems to prevent clinics receiving federal funds from providing abortions even with other funds. It is not clear that either bill prevents these clinics from providing abortion referrals, with or without federal funds.

Abortion Mandates and the Conscience Rights of Enrollees

Both bills forbid the federal government to use this Act to mandate any abortions as part of the "essential benefits" offered by qualified health plans; the decision whether to provide abortion coverage as part of such essential benefits is to be made by the issuer of the health plan (House bill, sec. 222 (e); Senate bill, sec. 1303 (b)(1)).

[9] This column's statements about the Senate bill (the Senate substitute for H.R. 3590) are true of the final legislation signed by President Obama on March 23, 2010. A budget reconciliation bill signed a week later increased the funding for community health centers from $7 billion to $9.5 billion.

[10] The distinct concern about new programs in this legislation promoting contraceptive services, particularly to minors, is discussed separately below.

The form such coverage may take and how it can be funded differs in the two bills as seen above.

However, the House anti-mandate provision states that federal officials do not require any qualified health plan to include abortion services on any basis. The parallel Senate provision is more narrow, stating that abortion may not be required as part of such a plan's "essential health benefits." Thus plans may be required to include elective abortions by mandates arising from other provisions. For example, the Senate bill 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" (Senate bill, 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 difference between the two bills arises from the Senate bill'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 will be readily available or that it will meet the particular health needs of that individual and his or her family in other ways. In the House bill, by contrast, the decision to purchase elective abortion coverage is an individual option, and premiums for abortion are paid only by those who choose this option. Americans who object to abortion have a full range of health plans to choose from without compromising their conscience.

Conscience Rights for Health Care Providers on Abortion

Both bills provide 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" (House bill, sec. 304 (d); Senate bill, sec. 1303 (b)(4)). This forbids discrimination by a health plan itself against pro-life health care providers within the plan.

The House bill also protects health care entities (including HMOs and health insurance 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. Such governmental entities also may not require any health plan created or regulated by the Act to practice such discrimination (House bill, sec. 259). This important protection is modeled closely on the Weldon amendment on conscience rights that has been part of the annual Labor/HHS appropriations bills since 2004, applying its principles to the new funding and new health plans authorized by the health care reform legislation. The Senate bill lacks a provision of this kind.

As with the anti-mandate provisions protecting health plans mentioned above, these conscience clauses for providers may be in tension with the bills' other provisions. For example, both bills have 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')" (House bill, sec. 1908; Senate bill, 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 legislation's conscience protections, such as sec. 259 of the House bill, by deeming some abortions to be "emergency services."

Respect for Other State and Federal Laws

The bills contain identical language on non-preemption of state laws and noninterference with other federal laws relating to abortion (House bill, sec. 258; Senate bill, sec. 1303 (c)). This language has some deficiencies and potential loopholes. For example, the provision says this new law 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). But it does not mention state conscience laws or state laws that actually restrict or prohibit abortion (e.g., current laws against partial-birth and late-term abortions).

Another clause in this provision states that the health care reform legislation 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. 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 (House bill, sec. 258 (b)(1); Senate bill, sec. 1303 (c)(2)). 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, neither bill includes general protection for conscience rights beyond the context of abortion (and, in the case of the Senate bill, assisted suicide).

Both bills include 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 in the Senate bill is one example. Both bills also create broad definitions for what constitutes an "essential health benefit," with later details to be specified by a federal official. The House bill, for example, requires coverage of the "professional services of physicians and other health professionals" and of "prescription drugs" (House bill, sec. 222 (b)) and creates the post of "Health Choices Commissioner" to define more specific requirements (sec. 241). The Senate bill requires coverage of "ambulatory patient services" and "prescription drugs," and authorizes the Secretary of Health and Human Services to make more specific requirements, instructing the Secretary to ensure that the scope of such benefits "is equal to the scope of benefits provided under a typical employer plan" (Senate bill, 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, these bills do contain some provisions respecting religious freedom, but these are of no help to Catholics or others who may have moral objections to specific procedures. Both bills provide 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 (House bill, sec. 501 (a), creating sec. 59B (c)(5) of the Internal Revenue Code of 1986; Senate bill, sec. 1501 (b), creating sec. 5000A (d)(2)(a) of the Internal Revenue Code of 1986). The House bill's lengthy section on Indian Health Services includes a program for suicide prevention and other mental health care for Indian youth, which allows Indian tribes and tribal organizations to use and promote "the traditional health care practices of the Indian Tribes of the youth to be served" in carrying out the purposes of the provision (House bill, sec. 3101 (a), creating sec. 708 (d)(2) of the Indian Health Care Improvement Act). And the Senate bill's 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" (Senate bill, 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.

These bills' 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.[11] 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, these bills will expand coverage for contraceptive services as part of broader categories of services. In this respect they do 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 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.[12]

Both House and Senate bills take the former position, through two new programs aimed at school-age children and youth. First, both bills create a new program for promoting "school-based" health clinics that, among other things, can provide contraceptives to minors (House bill, sec. 2511 (a); Senate bill, sec. 4101 (b)). As noted above, these clinics are barred from providing abortions. Second, both bills create 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.

The House bill creates a "Healthy Teen Initiative to Prevent Teen Pregnancy," providing grants to states for "evidence-based education programs" shown to serve any of the following goals: delaying initiation of sex, decreasing number of partners,

[11]For texts and citations, see USCCB Secretariat for Pro-Life Activities, "Current Federal Laws Protecting Conscience Rights," August 2008, http://www.usccb.org/prolife/issues/abortion/crmay08.pdf.

[12]For an overview of some of this evidence, see USCCB Secretariat on Pro-Life Activities, "Fact Sheet: Greater Access to Contraception Does Not Reduce Abortions," July 17, 2009, http://www.usccb.org/prolife/issues/contraception/contrafactsheet.pdf.

reducing teen pregnancy, or reducing sexually transmitted diseases (House bill, sec. 2526, creating sec. 317U of the Public Health Service Act). It seems states may fund programs serving one, some, or all of these goals; however, the states must choose from a federal "registry of programs" that the Secretary of Health and Human Services certifies as "evidence-based," "medically and scientifically accurate," and "age-appropriate" in the information presented. It is difficult to say how many programs dedicated to abstinence may find their way onto this registry. States may also retain any laws they have on "parental involvement and decision-making in children's education." This section authorizes $50 million a year over five years for this program.

The Senate bill also creates a new grant program for states, to fund "personal responsibility education" (Senate bill, sec. 2953, creating new sec. 513 of the Social Security Act). States will be allotted funds based on their applications reporting their pregnancy and birth rates among youth and their plans for reducing these. Only the Senate bill refers to a goal of "reducing pregnancy rates *and birth rates*" among youth (new sec. 513 (a)(1)(C)(II), emphasis added). 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 (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 Senate bill 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 (sec. 2594). Thus, instead of allowing dedicated abstinence programs to be eligible for funding under the new program as in the House, the Senate bill allows 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, both bills allow states to expand Medicaid eligibility for family planning services (House bill, sec. 1714; Senate bill, 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" (House bill, sec. 1714 (a)(3); Senate bill, 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.[13] 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.

[13] Teddy Davis, "Contraceptive Measure Dropped From Stimulus," *ABC News*, January 27, 2009, http://blogs.abcnews.com/thenote/2009/01/contraceptive-m.html.

End-of-Life Issues and Assisted Suicide

Early reports that the House bill 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 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 merit scrutiny.[14]

The House bill has two provisions promoting wider discussion and use of advance directives. One of these requires entities such as insurance companies that offer qualified health benefit plans to disseminate information on "end-of-life planning," including advance directives, to individuals seeking to enroll in their plans (House bill, sec. 240). This section states that the decision whether to sign a directive must be completely voluntary, and that information provided "shall not presume the withdrawal of treatment" but must include information on options to "maintain all or most medical interventions." The provision states twice that this effort must not "promote suicide, assisted suicide, euthanasia, or mercy killing" (secs. 240 (a)(3), 240 (b)(3)).

These last terms are not defined. Therefore a concern has been raised as to how this requirement would be implemented in states whose laws define the provision of lethal drugs to terminally ill patients by physicians as not constituting "assisted suicide" (which remains illegal).[15]

This House provision provides a confusing answer to this question. In addition to the disclaimers noted above, the provision states that the "advanced directives and other planning tools" may not include options for assisted suicide, euthanasia, or mercy killing, "regardless of legality" (sec. 240 (d)(1)). On the other hand, the general mandate is to provide such documents "according to the laws of the State in which the individual resides" (sec. 240 (a)(2)(A)). Moreover, the section's final clause

[14] For an attempt at a balanced overview of the controversy, see Richard M. Doerflinger, "Health Care Reform and a Dispute about Dying," syndicated column, USCCB Life Issues Forum, August 21, 2009, http://www.usccb.org/prolife/publicat/lifeissues/082109.shtml.

[15] Physician-assisted suicide for terminally ill patients has been legal in Oregon since 1994. Physicians there may prescribe a deliberately lethal dose of medication for patients who are expected to live less than six months and who follow certain consent procedures. In 2008, Washington approved a similar law by public referendum. Both laws state that the practice they allow will not constitute an assisted suicide for legal purposes. And in December 2009 the Montana Supreme Court ruled that the state's law against assisting a suicide does not forbid physicians to provide deliberately lethal drugs to such patients.

states that nothing in this provision may be construed to "preempt or otherwise have any effect on State laws regarding advance care planning, palliative care, or end-of-life decision making," and the earlier clause (excluding assisted suicide) is said to be "subject" to this one (sec. 240 (d)(3)). Unfortunately, one way to read this set of seemingly conflicting provisions would be to say that assisted suicide may not be promoted—unless it is a settled matter in the state's law that what it allows is not to be considered assisted suicide. This provision cries out for clearer drafting.

The second House provision allows for federal reimbursement for "voluntary advance care planning consultations" between physicians and Medicare patients (sec. 1233). Such consultations (and any signing of an advance directive) must be optional for the patient, and ordinarily will not be reimbursed if conducted more often than once every five years. Finally, nothing in the provision can "encourage the promotion of suicide or assisted suicide" (sec. 1233 (b)(3)). This section, as well, does not define "assisted suicide," and does not address the ambiguity discussed above regarding states which may exclude some lethal prescriptions from the legal meaning of the term.

The Senate bill includes neither of these provisions. 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" (Senate bill, 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)).

The Senate provision's objective definition and disclaimers are 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 since 2004 prevented government discrimination against health care providers that decline involvement in abortion; that amendment, applied to its original context of abortion, is included in the House health care reform bill (sec. 259) but not the Senate bill. So in the area of conscience rights, the House bill is clearly better on abortion but the Senate bill is better on assisted suicide. This Senate conscience provision 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 also raised in both bills 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 bills create a new Title XXXII of the Public Health Service Act for this program (House bill,

sec. 2581 (a); Senate bill, 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 (creating new sec. 3205 (c)(1)(B) of the Public Health Service Act). Both bills also provide that the beneficiary can ask to be assigned an "advice and assistance counselor" who, among other things, will provide information on these same topics (creating new sec. 3205 of the Public Health Service Act). These provisions speak broadly of documents and instructions "recognized under State law," without the clarifications on assisted suicide that these bills elsewhere seek 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 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 Senate health care reform bill is very deficient compared to the House version. This overview should not conclude without noting that the Senate bill includes helpful provisions on life-affirming support for "pregnant and parenting teens and women," and on adoption assistance, that are not found in the House bill. These provisions were included in the 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 (Senate bill, 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 retaining in any final legislation. 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.[16] Legislation using federal funds and federal authority to provide elective abortion coverage to millions of people who do not have

[16] 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 Rachel K. Jones, Jacqueline E. Darroch, and Stanley K. Henshaw, "Patterns in the Socioeconomic Characteristics of Women Obtaining Abortions in 2000–2001," *Perspectives on Sexual and Reproductive Health* 34.5 (September/October 2002): 231, http://www.guttmacher.org/pubs/journals/3422602.pdf.

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.

A final bill should include the House's policy on federal funding and conscience rights regarding abortion, the Senate's provisions on support for pregnant women, and 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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