

Testimony of Douglas Johnson
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Before the Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
on the *Protect Life Act of 2011*
February 9, 2011

SUMMARY

- Beginning with Medicaid, federal statutes authorizing funding of general health services and health coverage have been construed to authorize coverage of abortions essentially without restriction, except when Congress has explicitly prohibited such subsidies.
- The Patient Protection and Affordable Care Act (PPACA, Public Law 111-148) contains multiple provisions that provide authorizations for subsidies for abortion, both implicit and explicit, and also multiple provisions which may be used as bases for abortion-expanding administrative actions. The law lacks effective, bill-wide protective language such as the House of Representatives attached to its version of health care restructuring legislation on November 7, 2009 (the Stupak-Pitts Amendment).
- The first major component of the PPACA to be implemented, the Pre-Existing Condition Insurance Plan (PCIP) program, a 100% federally funded program, provided a graphic demonstration of the problem: The Department of Health and Human Services initially approved plans from multiple states that explicitly covered elective abortions. After NRLC blew the whistle on this development and a public outcry ensued, DHHS announced a discretionary decision that the PCIP plans would not cover elective abortions – but stakeholders on all sides of the issue acknowledged that coverage of abortions was not impeded by any provision of the PPACA, nor even addressed in Executive Order 13535.
- Executive Order 13535 is a hollow political construct – or, as described by the president of the Planned Parenthood Federation of America, “a symbolic gesture.”
- There are, by conservative estimate, more than one million Americans who were born alive and are with us today, who would have been aborted if the Hyde Amendment had not been in place. The Guttmacher Institute has termed this a “tragic result,” but NRLC regards it a major pro-life success story. The Hyde Amendment is the most successful domestic “abortion reduction” policy ever enacted by Congress.

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Chairman Pitts, distinguished members of the subcommittee, I am Douglas Johnson, federal legislative director for the National Right to Life Committee (NRLC), a position that I have held since 1981.

NRLC is a federation of state right-to-life organizations nationwide. Since its inception, NRLC's organizational mission has been to defend the right to life of innocent human beings, where that right is threatened or denied by such practices as abortion, infanticide, and euthanasia.

Consistent with that mission, NRLC is opposed to government funding of abortion and government subsidies for health insurance plans that cover abortion. NRLC supports the Protect Life Act, as well as the more comprehensive, government-wide approach incorporated in the No Taxpayer Funding for Abortion Act (H.R. 3).

The Protect Life Act would correct the new abortion-expanding provisions that became law in March, 2010, as part of the so-called Patient Protection and Affordable Care Act ("PPACA," Public Law 111-148). That law contains multiple provisions that authorize subsidies for abortion, as well as provisions that could be employed for abortion-expanding administrative mandates. Some of these objectionable provisions are entirely untouched by any limitation on abortion, whether contained in the PPACA itself or elsewhere, while others are subject only to limitations that are temporary, contingent, and/or riddled with loopholes.

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The PPACA also created multiple new streams of federal funding that are “self-appropriated” – that is to say, they will flow outside the regular funding pipeline of future DHHS appropriations bills¹ and therefore would be entirely untouched by the Hyde Amendment² (which controls only funds appropriated through the regular annual Health and Human Services appropriations bill), even if one assumed that the Hyde Amendment would be renewed for each successive fiscal year in perpetuity, which would be a reckless assumption.

BACKGROUND

Federal funding of abortion became an issue soon after the U.S. Supreme Court, in its 1973 ruling in *Roe v. Wade*, invalidated the laws protecting unborn children from abortion in all 50 states. The federal Medicaid statutes had been enacted years before that ruling, and the statutes made no reference to abortion, which was not surprising, since criminal laws generally prohibited the practice. Yet by 1976, the federal Medicaid program was paying for about 300,000 elective abortions annually,³ and the number was escalating rapidly.⁴ If a woman or girl was Medicaid-eligible and wanted an abortion, then abortion was deemed to be “medically necessary” and federally reimbursable.⁵ It should be emphasized that “medically necessary” is, in this context, a term of art – it conveys nothing other than that the woman was pregnant and sought an abortion from a licensed practitioner.⁶

That is why it was necessary for Congressman Henry J. Hyde (R-Ill.) to offer,

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beginning in 1976, his limitation amendment to the annual Health and Human Services appropriations bill, to prohibit the use of funds that flow through that annual appropriations bill from being used for abortions.

Unfortunately, the pattern that we saw established under Medicaid was generally replicated in other federally funded and federally administered health programs: Where general health services have been authorized by statute for any particular population, elective abortions ended up being funded, unless and until Congress acted to explicitly prohibit it. In diverse federal health programs, federal funds were used to subsidize abortions, not because Congress had explicitly mandated or explicitly authorized subsidies for abortions, but because administrators and the federal courts interpreted any type of general language authorizing health coverage as implicitly authorizing and mandating abortion coverage. Moreover, administrators and courts accepted the premise that if a woman or girl was pregnant and sought an abortion, then that abortion was, by definition, “medically necessary” or otherwise a legal entitlement.

Many other examples could be given to illustrate this principle, but I will cite just one more here: In 1979, Congressman Hyde wrote to the Indian Health Service to inquire as to why that agency was paying for elective abortions. He received this response:

You ask where the Indian Health Service is specifically permitted in authorizing legislation to pay for abortions. Neither abortion nor any other medical procedure or health service, nor the payment for such is specifically provided in authorizing legislation. The authorizing legislation for IHS is the Snyder Act (25 U.S.C. 13) which permits the expenditure of appropriated funds for the ‘benefit, care, and assistance of the Indians throughout the United States’ for a number of purposes

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including the ‘relief of distress and conservation of health.’ . . . All current requirements having been met, and procedures followed, we would have no basis for refusing to pay for abortions.⁷

Given this pattern, beginning in the late 1970s, there were many battles over whether to exclude abortion from one or another specific program. Over time, restrictions were applied to nearly all of them – in a piecemeal, patchwork fashion. Many of these protections were achieved, at least initially, through limitation amendments to various appropriations bills, and to this day, that is what many of them remain. They are called “limitation amendments” because they limit the expenditure of funds for a specific purpose – in this case, abortion – but this is a disfavored form of legislation. For one thing, there are procedural constraints, especially in the House of Representatives, which at times pose difficulties in offering detailed language that is contoured to a particular program. More importantly, these limitation amendments expire with the term of each appropriations bill, which is never more than one year. Unless each limitation is renewed by Congress and the President at least annually, it will lapse, and the program in question will revert to the default position of subsidizing abortion without restriction.

Some of these pro-life policies have indeed been lost for varying periods because of their transient nature. I will give you one quite current example. In 2009, President Obama proposed, in the White House budget recommendations, removal of a longstanding ban on the use of appropriated funds to pay for elective abortion in the District of Columbia – which is, of course, a federal enclave, placed under the exclusive

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legislative authority of Congress by Article I of the Constitution. An appropriations bill incorporating this recommendation passed the House over our objections, was then wrapped into a huge omnibus funding bill, and enacted into law.⁸ So today, because of the action of the 111th Congress and the Obama White House, congressionally appropriated funds may be used for abortion for any reason, at any point in pregnancy,⁹ right here in the Nation's Capital.

It is our position, therefore, that when Congress creates or reauthorizes a health or health insurance program, it should write the appropriate abortion policy language into the law itself. That is what was done, for example, when Congress created the State Children's Health Insurance Program (SCHIP) in 1997. It was generally recognized that this proposed program would end up funding abortions for children under age 18 without limitation if there was no explicit restriction, so such a restriction was written into the base statute. During more recent Congresses there were debates over various issues on bills to reauthorize SCHIP, but there was no fight over abortion policy, because that issue had been addressed explicitly when the program was created.

This is the approach that we advocated during the 111th Congress with respect to health care restructuring. NRLC did not take a position on many of the structural issues that dominated much of the debate, such as whether or not there should be a "public option" insurance plan. But we strongly advocated that all programs created or modified by the health care bill should be governed by explicit, permanent language to apply the

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principles of the Hyde Amendment to the new programs. By “the principles of the Hyde Amendment,” I mean no federal funding of abortion, and no federal subsidies for health plans that include coverage of abortion, with very limited exceptions.

I wish here to underscore what some people have tried hard to obscure: The language of the Hyde Amendment, as it has long been applied to appropriations within the Health and Human Services appropriations purview, prohibits *not only* direct federal funding of abortion procedures, but *also* provides, “None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended *for health benefits coverage that includes coverage of abortion. . . .*”

The term ‘health benefits coverage’ means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.”¹⁰ [italics added for emphasis]

Nevertheless, during the 111th Congress, some critics of the Stupak-Pitts Amendment claimed that it would go far beyond the principles of the Hyde Amendment – that the amendment, as Congresswoman Nita Lowey (D-NY) said on the House floor on November 7, 2009, “puts new restrictions on women’s access to abortion coverage in the private health insurance market even when they would pay premiums with their own money.” This claim was rated flatly “false” by PolitiFact.com, which wrote, “In fact, women on the exchange who pay the premiums with their own money will be able to get abortion coverage. So we find her statement False.”¹¹

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Phraseology similar to the Hyde Amendment language is found in the abortion-related provisions that govern other federal health insurance programs – for example, the laws that currently govern SCHIP and the Federal Employees Health Benefits (FEHB) Program.¹²

I would add that, when a federal program pays for abortion or subsidizes health plans that cover abortion, that constitutes federal funding of abortion – no matter what deceptive labels or gimmicks might be employed to conceal the reality. The claim, made by advocates of PPACA and its precursor bills during the 111th Congress, that a federal agency can send checks to abortionists to pay for abortions, but without employing public funds, amounts to a political hoax. The federal government collects monies through various mechanisms, but once collected, they become public funds -- federal funds. When government agencies use such funds to pay for abortions, that is federal funding of abortion.¹³

Beyond the question of abortion subsidies, during the 111th Congress, we also strongly advocated that health care legislation must contain robust protections for health care providers who do not wish to collaborate in providing abortions. Finally, we advocated strong language to prevent any of the multitude of administrative authorities created by the health care legislation from being used to *mandate* expansions of abortion “services.”

The bill that initially passed the House of Representatives on November 7, 2009,

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H.R. 3962 (111th Congress), fulfilled all those goals, Mr. Chairman. This was not true of the bill when it emerged months earlier from the Energy and Commerce Committee, however. The committee-reported H.R. 3962 contained some conscience protection language and some anti-mandate language, but it also contained explicit and permanent authorizations for federal government subsidies of abortion, both through a huge new premium-subsidy (tax credit) program and through a proposed “public option.”¹⁴

Fortunately, however, the corrective amendment that you offered on the House floor, in concert with Congressman Bart Stupak (D-Mi.), was adopted, 240-194. Your amendment to H.R. 3962 replaced those abortion-authorizing provisions with permanent language to prohibit *any component* of the bill from being used to subsidize abortion or health coverage of abortion, with exceptions for life of the mother, rape, and incest. (The key operative phrase in the amendment was, “No funds authorized or appropriated by this Act (or an amendment made by this Act)”)

Unfortunately, the bill that came back from the Senate, the PPACA, contained vastly different abortion-related provisions – provisions directly at odds with the principles of the Hyde Amendment. I would place the blame for that, in the first instance, on the shoulders of President Obama, who lamented the House’s action in adopting the Stupak-Pitts Amendment, and whose subordinates worked actively to block such language in the U.S. Senate – although the blame is fairly shared with the Democratic leadership in both houses.

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We recognized from the outset, of course, that the President entered the fight over health-care restructuring with a long history of hostility to limitations on abortion of any kind, and consistent opposition to any limitations on government funding of abortion.

On July 17, 2007, then-Senator Obama appeared before the annual conference of the Planned Parenthood Action Fund. Speaking of his plans for “health care reform,” Obama said, “In my mind, reproductive care is essential care. It is basic care, and so it is at the center and at the heart of the plan that I propose.” He stated that, “What we’re doing is to say that we’re going to set up a public plan that all persons and all women can access if they don’t have health insurance. It’ll be a plan that will provide all essential services, including reproductive services.” Under his plan, he explained, people could choose to keep their existing private health care plans, but “insurers are going to have to abide by the same rules in terms of providing comprehensive care, including reproductive care . . . that’s going to be absolutely vital.”¹⁵

The original bills introduced in the House and Senate by Democratic leaders in 2009 contained provisions that would have fulfilled every abortion-expanding component of Senator Obama’s pledge. However, the president ultimately did not obtain, in the PPACA, *every* pro-abortion component that he had mentioned as his goals. For example, he did not get an explicit mandate that private insurers must cover abortions in every health plan.¹⁶ [See PPACA §1303(b)(1)(A), 42 U.S.C. 18023] Nevertheless, the PPACA as enacted contains multiple components under which federal subsidies for

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abortion are authorized, implicitly and even explicitly, and that predictably will result in such funding in the future -- unless the law itself is repealed, or unless the law is amended by enactment of the legislation that is the subject of this hearing, the Protect Life Act, or by enactment of a uniform, government-wide policy, as embodied in the No Taxpayer Funding for Abortion Act (H.R. 3, 112th Congress).

ABORTION-EXPANDING COMPONENTS OF PPACA

We offer here only the briefest summary of what we see as the objectionable components of the PPACA with respect to abortion subsidies. However, I submit with this testimony an affidavit that I executed, dated October 28, 2010, that explains four of the major components of the bill that authorize subsidies for elective abortion.¹⁷ It is presented in the form of an affidavit because it is an adaption of an earlier and very similar affidavit that was requested as part of an administrative proceeding before a state regulatory body. This affidavit addresses only abortion subsidy issues. It does not address other serious abortion-related deficiencies of the PPACA, those being inadequate protections against abortion-expanding administrative mandates and gravely deficient conscience protection language, but the Protect Life Act would address those two concerns as well.

The affidavit focuses primarily on our objections to authorization for abortion coverage under the Pre-Existing Condition Insurance Plan program (affidavit paragraphs 37-49), federal subsidies for private health plans that cover elective abortions (paragraphs

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50-54), authorization for abortion funding through Community Health Centers (paragraphs 55-57), and authorization for inclusion of abortion coverage in health plans administered by the federal Office of Personnel Management (paragraph 65). We note that this is not an exhaustive list – there are other components that also lack satisfactory abortion language, including those dealing with the Indian Health Service. In the affidavit, we cite many documents from sources outside our organization, which are also accessible on our website.

There is nothing in the PPACA that remotely resembles the Stupak-Pitts Amendment. There are certain apparent abortion limitations, but for the most part they are cosmetic. Instead of the bill-wide language that would have permanently applied the Hyde Amendment principles to the new programs, we find a hodge-podge of artful exercises in misdirection, bookkeeping gimmicks, loopholes, ultra-narrow provisions that were designed to be ineffective, and/or provisions that are rigged to expire.¹⁸

I would exempt from that negative characterization the provision [PPACA §1303(a)(1) 42 U.S.C. 18023] that allows individual states to pass legislation to keep abortion out of the health plans that participate in the exchanges in those states. We encourage state legislatures to avail themselves of this option. But, even where a state does this, it does not address the other fundamental problems with the PPACA – and 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.

EXECUTIVE ORDER 13535

The PPACA was unable to achieve House passage for a period of more than two months, in early 2010, in substantial part because a small group of House Democrats, most often identified with Congressman Stupak, refused to support the Senate-passed bill precisely because of the array of abortion-expanding components that I have described. Regrettably, a number of the members of this group, after efforts to obtain a vote on remedial language were unsuccessful,¹⁹ abandoned their resistance and voted for the bill, proclaiming that the abortion problems were corrected by Executive Order 13535 ((75 Fed. Reg. 15599 (2010)), which was signed by President Obama on March 24, 2010.

Executive Order 13535 has the hallmarks of a primarily political document. It was carefully crafted to provide as much as possible in the way of political “optics,” by which I mean rhetorical political “cover” for certain members of Congress, while at the same time containing as little as possible in “force of law” provisions that would offend the pro-abortion advocacy groups with which President Obama has long been allied.

The assessments of the Order made by some prominent advocates on the pro-abortion side of the debate are, I believe, consistent with our judgment. For example, Cecile Richards, the president of the Planned Parenthood Federation of America (PPFA), the nation’s largest abortion provider, said that the Order amounted to “a symbolic gesture” (*USA Today*, March 25, 2010).

The language of Section 1 of the Order is purely discursive and rhetorical; it

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contains no binding directives from the chief executive to his subordinates whatsoever.

The two operative sections of the Executive Order (Sections 2 and 3) are focused on only two of the components of the massive law, and do not truly correct the abortion-related problems even with respect to those two components, for reasons described in detail in the affidavit referenced earlier. Still less does the Order establish any PPACA-wide or government-wide barrier to federal subsidies for abortion, as some have claimed.

The fourth and final section of the Order reiterates that the Order must be construed consistently with applicable laws and does not affect pre-existing agency authorities – which underscores why it is the language of the law that really matters here, and why enactment of remedial legislation is essential.

THE FIRST DEMONSTRATION

The first major component of the PPACA to be implemented, the Pre-Existing Condition Insurance Plan (PCIP) program, a 100% federally funded program, provided a graphic demonstration of the problem: The Department of Health and Human Services approved plans from multiple states that would have covered elective abortions. NRLC documented this and blew the whistle in July, 2010, which produced a public outcry, after which DHHS announced a discretionary decision that the PCIP plans would not cover elective abortions. Commentators on all sides of the issue were in agreement about one thing: Coverage of elective abortions within this new, 100% federally funded program was *not* impeded by any provision of the PPACA, and was not even addressed in

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Executive Order 13535.

On the same day that DHHS issued its decision to exclude abortion from this program – July 29, 2010 – the head of the White House Office of Health Reform, Nancy-Ann DeParle, issued a statement on the White House blog explaining that the discretionary decision to exclude abortion from the PCIP “is not a precedent for other programs or policies [under the PPACA] given the unique, temporary nature of the program . . .” Laura Murphy, director of the Washington Legislative Office of the American Civil Liberties Union, said, “The White House has decided to voluntarily impose the ban for all women in the newly-created high risk insurance pools. . . . What is disappointing is that there is nothing in the law that requires the Obama Administration to impose this broad and highly restrictive abortion ban.” (“ACLU steps into healthcare reform fray over abortion,” *The Hill*, July 17, 2010.)

PUBLIC OPINION

Mr. Chairman, we are confident that the great majority of Americans are in agreement with the policy goals embodied in your legislation, and in the No Taxpayer Funding for Abortion Act. I will cite just a few of the many polls that demonstrate this. According to a Quinnipiac University poll from January 2010, 67% of Americans are opposed to allowing public funds to pay for abortion through health care. This included 68% of women (and 65% of men), and 47% of Democrats.²⁰ A 2010 Zogby/O’Leary poll found that 76% of Americans said that federal funds should never pay for abortion or

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should pay only to save the life of the mother.²¹ A September 2009 International Communications Research poll asked, “If the choice were up to you, would you want your own insurance policy to include abortion,” to which 68% of respondents answered “no” and only 24% answered “yes.”²²

THE HYDE AMENDMENT AND “ABORTION REDUCTION”

Mr. Chairman, during his quest for the Democratic presidential nomination, then-Senator Obama and his campaign went to great lengths to emphasize his unblemished record of opposition to limitations on abortion, including opposition to parental notification laws²³ and bans on partial-birth abortion,²⁴ and including his support for repeal of the Hyde Amendment.²⁵ He even advocated elimination of the very modest federal support available for crisis pregnancy centers.²⁶ After securing the nomination, however, he adopted a rhetorical line of advocating government policies to reduce the number of abortions. For example, at the August 17, 2008 Saddleback Forum, Senator Obama said, “So, for me, the goal right now should be -- and this is where I think we can find common ground . . . how do we reduce the number of abortions?”

So let us talk about “abortion reduction.” There is abundant empirical evidence that where government funding for abortion is not available under Medicaid or the state equivalent program, *at least* one-fourth of the Medicaid-eligible women carry their babies to term, who would otherwise procure federally funded abortions. Some pro-abortion advocacy groups have claimed that the abortion-reduction effect is substantially greater –

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one-in-three, or even 50 percent. For example, a 2010 NARAL factsheet contains this statement:

A study by the Guttmacher Institute shows that Medicaid-eligible women in states that exclude abortion coverage have abortion rates of about half of those of women in states that fund abortion care. This suggests that the Hyde amendment forces about half the women who would otherwise choose abortion to carry unintended pregnancies to term and bear children against their wishes.²⁷

But even if we stick with a conservative 25 percent abortion-reduction figure, it means that well over one million Americans are walking around alive today because of the Hyde Amendment.²⁸

Many of the voices raised against the Protect Life Act and the No Taxpayer Funding for Abortion Act think that those million-plus individuals, who now number among your collective constituents, should not have been born. Indeed, over the years, some critics of the Hyde Amendment policy have quite explicitly argued for federal funding of abortion as a cost-saving expedient.²⁹

Whatever their motivations, if these groups and their congressional allies had succeeded in their efforts to block the Hyde Amendment, these million-plus children *would not* have been born. Their birth was, according to a 2007 Guttmacher Institute monograph, a “tragic result” of the Hyde Amendment:

Perhaps the most tragic result of the funding restrictions, however, is that a significant number of women who would have had an abortion had it been paid for by Medicaid instead end up continuing their pregnancy.³⁰

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Mr. Chairman, anyone who thinks that the million-plus Americans that walk among us today because of the Hyde Amendment, constitute a “tragic result,” should vote against your bill. Those who believe otherwise, we respectfully submit, should vote for the Protect Life Act, and for the No Taxpayer Funding for Abortion Act as well.

We believe that the Hyde Amendment has proven itself to be the greatest domestic abortion-reduction law ever enacted by Congress. If the principles of the Hyde Amendment are applied to the PPACA, or to whatever legislation may ultimately replace PPACA, then the lifesaving effects that we have already seen will be multiplied, and this a goal that our organization regards as the furthest thing from a tragedy.

Thank you.

END NOTES

1. “Most of the funding for the big-ticket items that the GOP objects to . . . will be shielded from appropriators’ knives because it was mandated in the law and will happen automatically.” “Health Law Funding Is No Easy Target,” *CQ Today*, January 10, 2011, page 1. See also Congressional Research Service memoranda of August 28, 2009, and August 31, 2009, at <http://www.nrlc.org/AHC/CRStrustfundmemo.pdf> and <http://www.nrlc.org/AHC/CRSpUBLICoptionmemo.pdf>, respectively.
2. NRLC memorandum, “Why the Hyde Amendment will not prevent government funding of abortion under H.R. 3200, the House Democratic leadership health care bill,” September 3, 2009.
<http://www.nrlc.org/AHC/NRLCmemoHydeAmendmentWillNotApply.html>
3. Statement of the Department of Health, Education and Welfare, “Effects of Sec. 209, Labor-HEW Appropriations Bill, H.R. 14232,” June 25, 1976.
4. The 1980 *CQ Almanac* reported, “With the Supreme Court reaffirming its decision [in *Harris v. McRae*, June 30, 1980] in September, HHS ordered an end to all Medicaid abortions except those allowed by the Hyde Amendment. The department, which once paid for some 300,000 abortions a year and had estimated the number would grow to 470,000 in 1980 . . .” In 1993, the Congressional Budget Office, evaluating a proposed bill to remove limits on abortion coverage from Medicaid and all other then-existing federal health programs, estimated that the result would be that “the federal government would probably fund between 325,000 to 675,000 abortions each year.” Letter from Robert D. Reischauer, director, Congressional Budget Office, to the Honorable Vic Fazio, July 19, 1993.
5. As the Sixth Circuit Court of Appeals explained it: “Because abortion fits within many of the mandatory care categories, including ‘family planning,’ ‘outpatient services,’ ‘inpatient services,’ and ‘physicians’ services,’ Medicaid covered medically necessary abortions between 1973 and 1976.” [*Planned Parenthood Affiliates of Michigan v. Engler*, 73 F.3d 634, 636 (6th Cir. 1996)]
6. It has long been understood and acknowledged by knowledgeable analysts on both sides of abortion policy disputes that “medically necessary abortion,” in the context of federal programs, really means any abortion requested by a program-eligible woman. For example: In 1978, Senator Edward Brooke (R-Ma.), a leading opponent of the Hyde Amendment, explained, “Through the use of language such as ‘medically necessary,’ the Senate would leave it to the woman and her doctor to decide whether to terminate a pregnancy, and that is what the Supreme Court of these United States has said is the law

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of the land.” In 1993, William Hamilton, vice president of the Planned Parenthood Federation of America, told Knight-Ridder Newspapers that “medically necessary” abortions include “anything a doctor and a woman construe to be in her best interest, whether prenatal care or abortion” (*Philadelphia Inquirer*, Sept. 8, 1993). The National Abortion and Reproductive Rights Action League (NARAL) defined “medically necessary” as “a term which generally includes the broadest range of situations for which a state will fund abortion” (*Who Decides? A Reproductive Rights Issues Manual*, 1990). A senior Clinton Administration health official told Congress, “When we're talking about medically necessary or appropriate [abortion] services we are also talking about all legal services.” (Judith Feder, principal deputy assistant secretary for planning and evaluation, Department of Health and Human Services, Jan. 26, 1994.)

7. Letter from Emery A. Johnson, M.D., Assistant Surgeon General, Director, Indian Health Service, to the Honorable Henry J. Hyde, July 30, 1979.

<http://www.nrlc.org/AHC/INSlettertoHyde1979.pdf>

8. Public Law No. 111-117, Consolidated Appropriations Act, 2010, Division C, Title VIII, General Provisions – District of Columbia.

9. The city council, a political entity that operates entirely under delegated congressional authority, apparently removed any trace of a limitation on abortion, at any point in pregnancy, in 2004.

10. The full text of the current version of the Hyde Amendment (spelled out in Pub. L. No. 111-117, Consolidated Appropriations Act, 2010, Division D, Title V, General Provisions) reads as follows:

SEC. 507. (a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion. (b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion. (c) The term “health benefits coverage” means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement. SEC. 508.

(a) The limitations established in the preceding section shall not apply to an abortion – (1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. (b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity,

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or private person of State, local, or private funds (other than a State's or locality's contribution of Medicaid matching funds). (c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds). (d)(1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions. (2) In this subsection, the term "health care entity" includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

11. PolitiFact.com, "Lowey says Stupak amendment restricts abortion coverage even for those who pay for their own plan" [rated "false"], November 9, 2009, <http://www.politifact.com/truth-o-meter/statements/2009/nov/09/nita-lowey/lowey-says-stupak-amendment-restricts-abortion-cov/>

12. The statute governing the State Children's Health Insurance Program (SCHIP) states that federal funds may not be used "to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion." [42 U.S.C. §1397ee(c)(7)] The appropriations law governing the Federal Employees Health Benefits (FEHB) program, which helps subsidize health premiums for all members of Congress and about eight million others, prevents the use of these subsidies for abortions "or the administrative expenses in connection with any health plan under the ... program which provides any benefits or coverage for abortions" [Public Law No. 111-117, Consolidated Appropriations Act, 2010, Division C, Title VI, General Provisions – This Act.] These laws contain exceptions similar to the Hyde Amendment.

13. See also NRLC memorandum, "Rebutting the 'private funds' myth," September 7, 2009, <http://www.nrlc.org/AHC/NRLCmemoFederalFundsnotPrivateFunds.html>, and Congressional Research Service, memorandum to Hon. Christopher H. Smith (R-NJ), "Questions Related to H.R. 3200, the America's Affordable Health Choices Act of 2009," October 9, 2009, <http://www.nrlc.org/AHC/CRSpublicoptionfederalfunds.pdf>.

14. "As for the House bill as it stands now, it's a matter of fact that it would allow both a 'public plan' and newly subsidized private plans to cover all abortions." FactCheck.org, "Abortion: Which Side Is Fabricating?," August 21, 2009. <http://www.factcheck.org/2009/08/abortion-which-side-is-fabricating/>

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15. See PolitiFact.com, “Boehner says abortion access was always a key goal for Obama health plan,” September 11, 2009, and “Planned Parenthood says Obama promised to ‘put reproductive health care at the center’ of health reform,” November 10, 2009 [both statements rated "True"], at, respectively, <http://politifact.com/truth-o-meter/statements/2009/sep/11/john-boehner/boehner-says-abortion-access-was-always-key-goal-o/> and <http://www.politifact.com/truth-o-meter/statements/2009/nov/10/planned-parenthood/planned-parenthood-says-obama-promised-put-reprodu/>.

16. Nevertheless, the PPACA grants administrative authorities to entities within the Executive Branch that might be employed to advance towards such a goal. See NRLC letter in opposition to the Mikulski Amendment, November 30, 2009, <http://www.nrlc.org/AHC/MikulskiAmendLetter.pdf>

17. The affidavit is posted on the NRLC website at: <http://www.nrlc.org/AHC/DvSBA/GenericAffidavitOfDouglasJohnsonNRLC.pdf>
The primary documents cited in the affidavit are posted at: <http://www.nrlc.org/AHC/DvSBA/Index.html>

18. Similar assessments were issued by other knowledgeable analysts, including “Legal Analysis of the Provisions of The Patient Protection and Affordable Care Act and Corresponding Executive Order Regarding Abortion Funding and Conscience Protection,” issued by the Office of General Counsel of the U.S. Conference of Catholic Bishops (USCCB) on March 25, 2010.

19. In what turned out to be a final effort to amend the Senate-passed bill, Rep. Stupak and ten others introduced H. Con. Res. 254 on March 19, 2010, an “enrollment correction” resolution, which if enacted would have amended the PPACA to prevent any component of the bill from subsidizing elective abortion; the language of this resolution was very similar to the anti-subsidy provisions of the Protect Life Act. However, Speaker Nancy Pelosi (D-Ca.) refused to allow a vote on this corrective measure. <http://www.nrlc.org/AHC/DvSBA/HConRes254MoreEvidence.html>

20. Quinnipiac University, conducted January 5-11, 2010, 1767 registered voters nationwide, margin of error: +/- 2.3 %. www.quinnipiac.edu/x1295.xml?ReleaseID=1413

21. Zogby/O’Leary, January 19-21, 2010, *The O’Leary Report*, August/September 2010, Volume 5, Issue 4, http://www.olearyreport.com/media/pdf/OLR_Vol5Issue4_AugustSeptember2010Final.pdf

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22. International Communications Research, September 16-20, 2009, 1043 adults, margin of error: +/-3.0%.

23. See, for example, "Wash. Post's Solomon ignored Planned Parenthood support for Obama's abortion votes," Media Matters for America, December 14, 2007, <http://mediamatters.org/research/200712140004>.

24. As a state senator in Illinois, Obama was also directly responsible for killing legislation to extend legal protection to all infants born alive during abortions, which he saw as an infringement on abortion rights. See "Barack Obama's Actions and Shifting Claims on the Protection of Born-Alive Aborted Infants -- and What They Tell Us About His Thinking on Abortion," by Douglas Johnson and Susan T. Muskett, J.D., NRLC White Paper, August 28, 2008, <http://www.nrlc.org/ObamaBAIPA/WhitePaperAugust282008.html>.

25. See, for example, "Sen. Barack Obama's RH Issues Questionnaire," December 21, 2007, in which the Obama campaign provided this official written response: "Obama does not support the Hyde amendment. He believes that the federal government should not use its dollars to intrude on a poor woman's decision whether to carry to term or to terminate her pregnancy and selectively withhold benefits because she seeks to exercise her right of reproductive choice in a manner the government disfavors." <http://www.rhrealitycheck.org/blog/2007/12/21/sen-barack-obamas-reproductive-health-questionnaire>.

26. "[Question:] Does Sen. Obama support continuing federal funding for crisis pregnancy centers? Why or why not? [Obama campaign answer:] No." *Ibid.*

27. "Discriminatory Restrictions on Abortion Funding Threaten Women's Health," NARAL Pro-Choice America Foundation factsheet, January 1, 2010, citing Rachel K. Jones et al., *Patterns in the Socioeconomic Characteristics of Women Obtaining Abortions in 2000-2001, Persp. on. Sexual & Reprod. Health* 34 (2002).

28. That the Hyde Amendment has resulted in at least one million births is recognized (and lamented) in materials produced by various pro-abortion advocacy groups. "Because of the Hyde Amendment, more than a million women have been denied the ability to make their own decisions about bringing a child into the world in the context of their own circumstances and those of their families." From "Whose Choice? How the Hyde Amendment Harms Poor Women," Center for Reproductive Rights, 2010, page 4, <http://reproductiverights.org/en/feature/whose-choice-download-report>. Some pro-abortion sources cite higher figures, e.g., "millions."

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29. For example, during a House floor debate on June 27, 1979, Congresswoman Geraldine Ferraro (D-NY) argued, “The cost of putting an unwanted child through the system far outweighs the cost of these [abortion] procedures.” Such reasoning was challenged by, among others, the Rev. Jesse Jackson, who during the early congressional debates over the Hyde Amendment wrote: “An open letter to Congress. As a matter of conscience I must oppose the use of federal funds for a policy of killing infants. The money would much better be expended to meet human needs. I am therefore urging that the Hyde Amendment be supported in the interest of a more humane policy and some new directions on issues of caring for the most precious resource we have – our children. Rev. Jesse L. Jackson, National President, Operation PUSH.” [The original Western Union telegram, dated September 6, 1977, is preserved in NRLC archives.]

30. Here is the quote in context, from *The Heart of the Matter: Public Funding Of Abortion for Poor Women in the United States*, by Heather D. Boonstra, *Guttmacher Policy Review*, Volume 10, Number 1, Winter 2007:

Perhaps the most tragic result of the funding restrictions, however, is that a significant number of women who would have had an abortion had it been paid for by Medicaid instead end up continuing their pregnancy. . . . Studies published over the course of two decades looking at a number of states concluded that 18–35% of women who would have had an abortion continued their pregnancies after Medicaid funding was cut off. According to Stanley Henshaw, a Guttmacher Institute senior fellow and one of the nation’s preeminent abortion researchers, the best such study, which was published in the *Journal of Health Economics* in 1999, examined abortion and birthrates in North Carolina, where the legislature created a special fund to pay for abortions for poor women. In several instances between 1978 and 1993, the fund was exhausted before the end of the fiscal year, so financial support was unavailable to women whose pregnancies occurred after that point. The researchers concluded that about one-third of women who would have had an abortion if support were available carried their pregnancies to term when the abortion fund was unavailable.