



Secretariat of Pro-Life Activities

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Abortion Funding in the New Health Care Reform Act

Congress and the public agree that the federal government should not fund elective abortions. For over three decades this policy has been reflected in the Hyde amendment to the Labor/HHS appropriations bill and many similar laws. In key respects the newly enacted "Patient Protection and Affordable Care Act" (henceforth "the Act") does not follow this longstanding policy:

- **Federal funds in the Act can be used for elective abortions.** For example, the Act authorizes *and appropriates* \$7 billion over five years (increased to \$9.5 billion by the Health Care and Education Reconciliation Act of 2010) for services at Community Health Centers. These funds are not covered by the Hyde amendment (as they are not appropriated through the Labor/HHS appropriations bill governed by that amendment), or by the Act's own abortion limitation in Sec. 1303 (as that provision relates only to tax credits or cost-sharing reductions for qualified health plans, and does not govern all funds in the bill). So the funds can be used directly for elective abortions.
- **The Act uses federal funds to subsidize health plans that cover abortions.** Sec. 1303 limits only the direct use of a federal tax credit specifically to fund abortion coverage; it tries to segregate funds *within* health plans, to keep federal funds distinct from funds directly used for abortions. But the credits are still used to pay overall premiums for health plans covering elective abortions. This violates the policy of current federal laws on abortion funding, including the Hyde amendment, which forbid use of federal funds for any part of a health benefits package that covers elective abortions. By subsidizing plans that cover abortion, the federal government will expand abortion coverage and make abortions more accessible.
- **The Act uses federal power to force Americans to pay for other people's abortions even if they are morally opposed.** The Act mandates that insurance companies deciding to cover elective abortions in a health plan "*shall... collect from each enrollee* in the plan (without regard to the enrollee's age, sex, or family status) a separate payment" for such abortions. While the Act says that one plan in each exchange will not cover elective abortions, every other plan may cover them -- and everyone purchasing those plans, because they best meet his or her family's needs, will be required by federal law to fund abortions. No accommodation is permitted for people morally opposed to abortion. This creates a more overt threat to conscience than insurers engage in now, because in many plans receiving federal subsidies everyone will have to make separate payments solely and specifically for other people's abortions. Saying that this payment is not a "tax dollar" is no help if it is required by government.
- **The solution is to follow current law.** The Stupak/Pitts provision in the House-passed health bill (also offered but rejected in the Senate as the Nelson/Hatch/Casey amendment) would have solved these problems by following longstanding current laws such as the Hyde amendment: No funds authorized or appropriated in the entire bill may be used for elective abortions or health plans that cover them. People would not be forced to pay for other people's abortions, and those who want abortion coverage could buy it separately without using federal funds. Legislation to maintain this longstanding federal precedent is still needed, to ensure that health care reform will truly expand life-affirming health care and not abortion.

(For more in-depth analysis of the Act on these issues, and of President Obama's executive order issued after its enactment, see www.usccb.org/healthcare/03-25-10Memo-re-Executive-Order-Final.pdf.)

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“(1) the extent to which self-insured group health plans can offer less costly coverage and, if so, whether lower costs are due to more efficient plan administration and lower overhead or to the denial of claims and the offering very limited benefit packages;

“(2) claim denial rates, plan benefit fluctuations (to evaluate the extent that plans scale back health benefits during economic downturns), and the impact of the limited recourse options on consumers; and

“(3) any potential conflict of interest as it relates to the health care needs of self-insured enrollees and self-insured employer’s financial contribution or profit margin, and the impact of such conflict on administration of the health plan.

“(c) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a report concerning the results of the study conducted under subsection (a).”

SEC. 10104. AMENDMENTS TO SUBTITLE D.

42 USC 18021.

(a) Section 1301(a) of this Act is amended by striking paragraph (2) and inserting the following:

“(2) INCLUSION OF CO-OP PLANS AND MULTI-STATE QUALIFIED HEALTH PLANS.—Any reference in this title to a qualified health plan shall be deemed to include a qualified health plan offered through the CO-OP program under section 1322, and a multi-State plan under section 1334, unless specifically provided for otherwise.

Criteria.

“(3) TREATMENT OF QUALIFIED DIRECT PRIMARY CARE MEDICAL HOME PLANS.—The Secretary of Health and Human Services shall permit a qualified health plan to provide coverage through a qualified direct primary care medical home plan that meets criteria established by the Secretary, so long as the qualified health plan meets all requirements that are otherwise applicable and the services covered by the medical home plan are coordinated with the entity offering the qualified health plan.

“(4) VARIATION BASED ON RATING AREA.—A qualified health plan, including a multi-State qualified health plan, may as appropriate vary premiums by rating area (as defined in section 2701(a)(2) of the Public Health Service Act).”

42 USC 18022.

(b) Section 1302 of this Act is amended—

(1) in subsection (d)(2)(B), by striking “may issue” and inserting “shall issue”; and

(2) by adding at the end the following:

“(g) PAYMENTS TO FEDERALLY-QUALIFIED HEALTH CENTERS.—If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1905(1)(2)(B) of the Social Security Act (42 U.S.C. 1396d(1)(2)(B))) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of such Act (42 U.S.C. 1396a(bb)) for such item or service.”

(c) Section 1303 of this Act is amended to read as follows:

42 USC 18023.

“SEC. 1303. SPECIAL RULES.

“(a) STATE OPT-OUT OF ABORTION COVERAGE.—

“(1) IN GENERAL.—A State may elect to prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law to provide for such prohibition.

“(2) TERMINATION OF OPT OUT.—A State may repeal a law described in paragraph (1) and provide for the offering of such services through the Exchange.

“(b) SPECIAL RULES RELATING TO COVERAGE OF ABORTION SERVICES.—

“(1) VOLUNTARY CHOICE OF COVERAGE OF ABORTION SERVICES.—

“(A) IN GENERAL.—Notwithstanding any other provision of this title (or any amendment made by this title)—

“(i) nothing in this title (or any amendment made by this title), shall be construed to require a qualified health plan to provide coverage of services described in subparagraph (B)(i) or (B)(ii) as part of its essential health benefits for any plan year; and

“(ii) subject to subsection (a), the issuer of a qualified health plan shall determine whether or not the plan provides coverage of services described in subparagraph (B)(i) or (B)(ii) as part of such benefits for the plan year.

“(B) ABORTION SERVICES.—

“(i) ABORTIONS FOR WHICH PUBLIC FUNDING IS PROHIBITED.—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

“(ii) ABORTIONS FOR WHICH PUBLIC FUNDING IS ALLOWED.—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

“(2) PROHIBITION ON THE USE OF FEDERAL FUNDS.—

“(A) IN GENERAL.—If a qualified health plan provides coverage of services described in paragraph (1)(B)(i), the issuer of the plan shall not use any amount attributable to any of the following for purposes of paying for such services:

“(i) The credit under section 36B of the Internal Revenue Code of 1986 (and the amount (if any) of the advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act).

“(ii) Any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act (and the amount (if any) of the advance payment of the reduction under section 1412 of the Patient Protection and Affordable Care Act).

“(B) ESTABLISHMENT OF ALLOCATION ACCOUNTS.—In the case of a plan to which subparagraph (A) applies, the issuer of the plan shall—

“(i) collect from each enrollee in the plan (without regard to the enrollee’s age, sex, or family status) a separate payment for each of the following:

“(I) an amount equal to the portion of the premium to be paid directly by the enrollee for coverage under the plan of services other than services described in paragraph (1)(B)(i) (after reduction for credits and cost-sharing reductions described in subparagraph (A)); and

“(II) an amount equal to the actuarial value of the coverage of services described in paragraph (1)(B)(i), and

“(ii) shall deposit all such separate payments into separate allocation accounts as provided in subparagraph (C).

In the case of an enrollee whose premium for coverage under the plan is paid through employee payroll deposit, the separate payments required under this subparagraph shall each be paid by a separate deposit.

“(C) SEGREGATION OF FUNDS.—

“(i) IN GENERAL.—The issuer of a plan to which subparagraph (A) applies shall establish allocation accounts described in clause (ii) for enrollees receiving amounts described in subparagraph (A).

“(ii) ALLOCATION ACCOUNTS.—The issuer of a plan to which subparagraph (A) applies shall deposit—

“(I) all payments described in subparagraph (B)(i)(I) into a separate account that consists solely of such payments and that is used exclusively to pay for services other than services described in paragraph (1)(B)(i); and

“(II) all payments described in subparagraph (B)(i)(II) into a separate account that consists solely of such payments and that is used exclusively to pay for services described in paragraph (1)(B)(i).

“(D) ACTUARIAL VALUE.—

“(i) IN GENERAL.—The issuer of a qualified health plan shall estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under the qualified health plan of the services described in paragraph (1)(B)(i).

“(ii) CONSIDERATIONS.—In making such estimate, the issuer—

“(I) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care;

“(II) shall estimate such costs as if such coverage were included for the entire population covered; and

“(III) may not estimate such a cost at less than \$1 per enrollee, per month.

“(E) ENSURING COMPLIANCE WITH SEGREGATION REQUIREMENTS.—