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December 22, 2009

RE: Cloture vote on Reid health care bill (H.R. 3590)

Dear Senator:

The National Right to Life Committee (NRLC), the federation of right-to-life organizations in all 50 states, strongly opposes the “Patient Protection and Affordable Care Act” (H.R. 3590), as amended, and opposes cloture on the legislation. NRLC intends to include the roll call on cloture in its scorecard of key right-to-life roll calls of the 111th Congress.

Regarding abortion policy, the bill language is light years removed from the Stupak-Pitts Amendment that was approved by the House of Representatives on November 7 by a bipartisan vote of 240-194. We view a vote for cloture on the Senate bill as a vote to advance legislation to allow the federal government to subsidize private insurance plans that cover abortion on demand, to oversee multi-state plans that cover elective abortions, and to empower federal officials to mandate that private health plans cover abortions even if they do not accept subsidized enrollees. In addition, as explained below, we object to certain other provisions of the bill that would place substantial restrictions on the ability of Americans to spend their own money to obtain lifesaving medical care.

The abortion-related language violates the principles of the Hyde Amendment by requiring the federal government to pay premiums for private health plans that will cover any or all abortions. The federal subsidies would be subject to a convoluted bookkeeping requirement, different in detail but similar in kind to the Capps-Waxman accounting scheme that the House of Representatives rejected when it adopted the Stupak-Pitts Amendment on November 7. The Senate bill now requires that all enrollees in an abortion-covering plan make a separate payment into an account that will pay for abortions, but the bill also contains language [Section 1303 (b)(3)(A) and (b)(3)(B)] that is apparently intended to prevent or discourage any insurer from explaining what this surcharge is to be used for. Moreover, there is nothing in the language to suggest that payment of the abortion charge is optional for any enrollee.

The so-called “firewall” between federal funds and private funds is merely a bookkeeping gimmick, inconsistent with the long-established principles that govern existing federal health programs, such as the Hyde Amendment. Moreover, the “firewall” is made of rice paper – it exists only so long as the annual appropriations bill for the Department of Health and Human Services continues to contain the Hyde Amendment. At any future date when the congressional appropriators and/or the President decide to block renewal of the Hyde Amendment, the bookkeeping requirements would automatically evaporate, and insurers could pay for elective abortions with the federal subsidies without even bookkeeping requirements. This is in stark contrast with the House-passed Stupak-Pitts Amendment, which would permanently prohibit the

federal subsidies from paying any part of the premium of a plan that covers elective abortions (while explicitly affirming that insurers may sell, and persons may buy, through the Exchanges, plans that cover any or all abortions, as long as federal subsidies are not used to purchase such plans).

The Senate bill, as amended, also establishes a new program under which the federal government (the Office of Personnel Management, OPM) would administer a program of “multi-state” health plans offered by private insurers. The provision requires that the OPM director “shall ensure that . . . there is at least one such plan that does not provide coverage of” abortions beyond the types of abortions that are funded under the federal Medicaid program in any given year, which is described as “assured availability of varied coverage.” This seems to envision a system under which the OPM director would administer multi-state plans that cover elective abortions, and perhaps even possess authority to require such plans to cover elective abortions, as long as the director also ensured that there was one plan that did not cover abortions (except types of abortions also funded by the federal Medicaid program). This would be a sharp break from the policy that has long governed the Federal Employees Health Benefits program, which is also administered by OPM, under which private plans are completely prohibited from covering elective abortions if they wish to participate in the program.

The legislation provides [in Section 1303(a)(1)] that 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.” This provision is defective in several important respects. First, it apparently would apply only to laws enacted in the future. Other new language in the bill [Section 1303 (b)(1)(A)(ii)] might be construed to conflict with some existing state laws. It is unclear how the state opt-out clause would be interpreted in light of other provisions in the bill, including the authority granted to the OPM director to set rules for the new federal program of multi-state plans. Moreover, even if a state enacts an opt-out law, the residents of that state cannot opt out of paying the federal taxes that will subsidize the premiums for abortion-covering plans in the other states that have not enacted opt-out laws.

The House-passed health bill contains language to prevent federal Executive Branch officials from requiring private health plans to cover abortions, but the Senate bill contains provisions that could be employed to support federal pro-abortion mandates. For example, the Senate on December 3 adopted an amendment (the Mikulski Amendment) that could be employed by the Department of Health and Human Services to require private health plans to cover all abortions, simply by defining them as “preventive care.” The bill contains language to prevent the Secretary of Health and Human Services from defining elective abortion as an “essential benefit,” but it does not remove the entirely separate authority granted by the Mikulski Amendment to mandate that all plans cover abortion as a “preventive” service. As NRLC noted in our November 30 letter to the Senate opposing the Mikulski Amendment, a number of pro-abortion authorities have already begun to classify abortion as a “preventive” service.

It should also be noted that the “conscience” protection provision for health care providers (sometimes referred to as “the Weldon language”), which was included in the House-passed health bill (H.R. 3962, Section 259), is not included in the Senate bill.

The manager's amendment added to H.R. 3590 the entire text of the Indian Health reauthorization bill (S. 1790). This language is objectionable because it does not contain an amendment (the Vitter Amendment) that was adopted by the Senate on February 26, 2008, by a vote of 52-42, during the Senate's most recent consideration of Indian health reauthorization legislation. The Vitter Amendment would permanently prohibit coverage of elective abortions in federally funded Indian health programs.

H.R. 3590 also contains highly objectionable provisions on other issues of concern to the right-to-life community. Since its inception, the pro-life movement has been as concerned with protecting the lives of older people and people with disabilities from euthanasia, including the involuntary denial of treatment, food, and fluids necessary to prevent death, as it has been dedicated to protecting unborn children from abortion. In its final form, the Senate health care restructuring bill contains provisions that threaten these lives, including significant limits on Americans' right to spend their own money to save their own lives. (Documentation of and further details concerning the points made below are available at www.nrlc.org/HealthCareRationing/ReidSubstitute.html.)

The "Independent Payment Advisory Board," as a result of the manager's amendment, not only dictates cuts in Medicare but also is directed to make recommendations to "slow the growth" in PRIVATE (non-federal) "health expenditures . . . that the Secretary [of Health and Human Services] or other Federal agencies can implement administratively." Section 10320(a)(5), adding Section 1899A (o)(1)(A) of the Social Security Act, p. 188. To the extent these are effective, they will limit the ability of private citizens to spend their own money to protect their own lives, by obtaining health care or health insurance that is not rationed.

Section 1003 empowers the Commissioners of the state Health Insurance Exchanges to exclude from the exchange plans offered by health insurance issuers whom they consider to have "excessive or unjustified premium increases." This essentially grants to state bureaucrats the discretion to impose price controls on insurance premiums. While no one wants to pay more for anything, including health care, being prohibited from paying what may be needed to obtain unrationed health insurance amounts to government-imposed health care rationing.

Under current law, Medicare recipients have the legal option, if they choose, of adding their own money on top of the government contribution in order to obtain "private fee-for-service" Medicare Advantage plans that can use the additional premiums to ensure access by paying providers higher rates and to avoid "managed care" limitations on treatments and tests. Presently, the Medicare statute prevents the government from second-guessing or imposing limits on the premiums for private fee-for-service plans, allowing beneficiaries to balance cost, benefit, and affordability in making their own decisions whether to purchase such plans. Section 3209 amends that provision so as to empower the federal government to exclude from competing in Medicare Advantage those plans whose bids it does not like. The consequence is to give the Centers for Medicare and Medicaid Services (CMS) the discretion to deny older Americans the choice of plans whose premiums CMS deems too high. This amounts to the imposition of price controls, thus limiting what older Americans are permitted to spend for health insurance. Again, being prohibited from paying what may be needed to obtain unrationed health insurance amounts to government-imposed health care rationing.

Provisions in the bill could be used to establish standards that would result in the denial of lifesaving medical care based upon degree of disability, age, or "quality of life." Section 3014, as altered by the manager's amendment, empowers the Secretary of Health and Human Services to impose "efficiency measures," in addition to the "quality measures" already provided for under the Reid Substitute, on health care providers. Much of the professional literature advocates the use of "quality of life" standards that devalue the lives of older people and people with disabilities in such measures. While there are anti-discrimination limits on the use of comparative effectiveness research to justify denial of treatment based on quality of life criteria under Section 6301(c) of the Reid Substitute, the quality and efficiency measures are not made subject to these critically important anti-discrimination protections.

Thank you for your consideration of NRLC's objections to cloture on H.R. 3590.

Sincerely,



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Executive Director



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