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The Senate Health Care Reform Bill: Funding Abortions at Community Health Centers

Confusion has arisen over the question of federal abortion funding in the Senate health care reform bill (H.R. 3590). In particular: As currently written, does the legislation require large-scale funding of abortion at federally regulated Community Health Centers (CHCs)?

Unfortunately, the answer is yes. Understanding why requires some knowledge of current federal law and past judicial history on abortion.

Everyone agrees on these basic facts: Sec. 10503 of the bill *authorizes* a new “CHC Fund” to expand funding for the CHC program (which was established by Section 330 of the Public Health Service Act). More unusually, the Senate bill also directly *appropriates* its own new funds for these services, instead of leaving that task to the annual Labor/HHS appropriations bill that generally funds programs at the Department of Health and Human Services. For Fiscal Years 2011 to 2015, the bill appropriates \$7 billion for services (to be increased to \$11 billion under the President’s new proposal), \$1.5 billion for construction and renovation of CHCs, and \$1.5 billion for the National Health Service Corps.

To understand why this creates a massive problem of federal abortion funding, one must understand some facts:

Fact #1: A long and consistent series of federal court rulings since *Roe v. Wade* requires that broad statutory mandates for provision of health services must be construed to include mandated provision of abortions, unless the statute specifies otherwise.

Having decided in 1973 to establish a constitutional right to abortion to serve women’s “health,” the courts decided that legislative references to health services or “medically necessary” services (the term of art used in the Medicaid statute) encompass abortion. In the abortion context, the Supreme Court has said that “health” must be defined very broadly to include “all factors - physical, emotional, psychological, familial, and the woman's age - relevant to the wellbeing of the patient.” *Doe v. Bolton*, 410 U.S. 179, 192 (1973). In short, if a physician decides that a woman should be able to have an abortion for her “wellbeing,” a government program requiring provision of health services must provide such abortions.

Hence, in the years before the Hyde amendment was first enacted by Congress in 1976, Medicaid was required to pay for about 300,000 abortions a year. No regulatory or administrative leeway was allowed on this point. The Medicaid statute said that grantees must provide “medically necessary” services provided by physicians, and the federal courts held that this category (or other broad categories for requiring health services) includes elective abortions, even though the statute never says the word “abortion.” As one court has

observed: “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).

Even after the Hyde amendment to the Labor/HHS appropriations act was enacted in 1976, barring funds appropriated in this act from being used for most abortions, a legal battle ensued for years. Not until 1980 did the U.S. Supreme Court rule that the *statutory* language of the Hyde amendment trumps the underlying statute’s presumptive mandate for abortion, and is constitutionally valid. *Harris v. McRae*, 448 U.S. 297 (1980).

Some had even argued that the abortion mandate remained in place *after* the Hyde amendment was enacted – that while the amendment withheld federal funds from certain abortions, the underlying statute still required them to be provided, using state matching funds if necessary. The Supreme Court rejected this argument. 448 U.S. at 309-10.

However, federal courts still insist that the mandate remains in place for any abortion for which funding is *not* barred by a provision like the Hyde amendment. When the Hyde amendment ceased to prohibit use of federal Medicaid funds for abortions in cases of rape and incest in 1993, federal courts throughout the country ruled that states participating in the program were now required by the underlying Medicaid statute to provide and help pay for rape/incest abortions – even if that meant overriding state constitutions that allow state funding of abortion only in cases of danger to the life of the mother. See *Engler*, 73 F.3d at 638, and cases cited therein.

Fact #2: In line with this legal precedent, the Community Health Centers program would be required to provide abortions now if not for the Hyde amendment.

The statute establishing the CHC program has the same kind of broad mandate for providing health services that Medicaid does. In some ways it presents an even more clear-cut case. The statute *defines* a “health center” in the program as an entity that provides, at a minimum, “required primary health services” to certain low-income populations. 42 USC § 254b (a)(1)(A). “Required primary health services” are defined to include “health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians” (and by other medical professionals where appropriate), as well as “voluntary family planning services.” 42 USC §254b (b)(1)(A). Thus, to be considered as eligible centers at all, centers in the program must provide the same broad categories of services that triggered the abortion mandate in Medicaid, and some that are even more specific (e.g., gynecology services).

This statutory mandate will trump any lesser authority, such as the preferences of the centers themselves or of an HHS Secretary or other executive-branch official. These officials must obey the laws passed by Congress as interpreted by the federal courts.

Fact #3: The new funding appropriated for community health centers by the Senate health care bill is not covered by the Hyde amendment.

This should be clear from the wording of the Hyde amendment itself: “None of the funds appropriated *in this Act*” may be used for most abortions (referring to the annual Labor/HHS appropriations act). The Senate bill’s new funds are not appropriated in the Labor/HHS appropriations act, so Hyde does not cover them.

A similar situation came to light in 1979, when members of Congress asked why the Indian Health Service (IHS) was continuing to provide abortions despite enactment of the Hyde amendment. The agency replied that it had no choice but to do so: The authorizing legislation for the IHS created a broad mandate for services to conserve the “health” of Indians, and the Interior appropriations bill funding these services contained no abortion limitation like the Hyde amendment to the Labor/HHS bill. Therefore “we would have no basis for refusing to pay for abortions” (Letter from Director of the Indian Health Service to Cong. Henry Hyde, July 30, 1979). Not until 1988 did Congress finally revise the authorizing legislation for the IHS to require that program to conform to the annual Hyde amendment.

The problem here is exactly parallel. The new billions of dollars appropriated here for services at CHCs simply are not covered by the Hyde amendment or other similar provisions, which only govern the use of funds appropriated by the legislation that they amend.

It follows that these funds are also not restricted by any regulations implementing the Hyde amendment. On this point some have cited thirty-year-old regulations stating that elective abortions are not funded in programs receiving “Federal financial assistance” at the Department of Health and Human Services (42 CFR §§ 50.301 through 50.306). But for their statutory basis the regulations cite only the appropriations bills valid at that time and the previous year, which contained the Hyde amendment (Public Laws 95-205 and 96-86). These laws expired three decades ago; but even a citation to the Hyde amendment in the current Labor/HHS appropriations bill would not help. Hyde governs only funds appropriated in the Act that it amends; and a regulation implementing Hyde can only have that same limited scope. If such a regulation *were* found to be relevant to the new funds provided by the Senate health care bill, the regulation would almost certainly be challenged as contrary to the *statutory* mandate to provide abortions in the CHC authorizing legislation (see Fact #1 above). A regulation cannot trump a statute passed by Congress.

Fact #4: The Senate health care bill itself contains no relevant provision to prevent the direct use of federal funds for elective abortions.

To be sure, the House-passed bill does include language to ensure that “no funds authorized or appropriated by this Act (or an amendment made by this Act)” may be used to pay for most abortions. And the Nelson/Hatch/Casey amendment offered in the Senate had exactly

this same language. But the Senate chose not to take up the House-passed bill, and it chose to table the Nelson amendment, 54 to 45.

The abortion funding language in the Senate bill relates *solely* to the use of tax credits and other federal funds to help pay for abortion coverage in qualified health plans. Section 1303 of the bill does reference the abortions ineligible for funding under the Hyde amendment in any given year, and those which are eligible. But this reference to eligible and ineligible abortions is used only to say the following: “If a qualified health plan provides coverage of services described in paragraph (1)(B)(i) [i.e., abortions ineligible for federal funds under the Hyde amendment that year], the issuer of the plan shall not use any amount attributable to any of the following for purposes of paying for such services...” (Sec. 1303 (b)(2)). This is followed by specific references solely to the tax credits and cost-sharing reductions used to subsidize qualified health plans.

Thus the legislation contains no general ban on using the funds it appropriates for elective abortions. One other section of the Senate bill, establishing a program of school-based clinics for minors, does exclude abortions from the scope of services at those clinics (Sec. 4101 (b)). But all other sections of the bill that appropriate funds, including Section 10503 on CHCs, remain unrestricted in their use of these funds for elective abortions.

Conclusion: In line with longstanding federal jurisprudence, the authorizing legislation for Community Health Centers creates a presumptive mandate for funding abortions without meaningful limit. Currently such funding is prevented only by the fact that funds under the Labor/HHS appropriations act are governed by the Hyde amendment. By appropriating new funds not covered by Hyde, and by failing to include any relevant abortion limitation of its own, the Senate health care bill as presently worded would disburse billions of dollars in federal funding that no one could prevent from being used for elective abortions.

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