ANTI-LIFE PROVISIONS OF THE

2010 HEALTH CARE REFORM LAW

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Part I: Using Premium Tax Credits and Shared Expense Refunds for Abortions

The Patient Protection and Affordable Care Act (PPACA), Pub.L. 111-148, enacted on March 23, 2010, substantially expands funding of abortions by federal tax dollars. Federal tax dollars, of course, are your dollars, conscripted to serve the federal government's purposes. This article provides the nuts and bolts of one of the several ways this will happen if the law is not changed or repealed.

Unless a State opts out by forbidding abortion coverage, Qualified Health Plans plans that are sold through the new Exchanges may include abortion coverage. PPACA § 1303(a). (The "§" sign means "section.") Qualified Health Plans will be offered within each state by private insurers, § 1301, and also by "Consumer Operated and Oriented Programs," § 1322. Multi-state plans will be offered by the Federal Office of Personnel Management, § 1334. All of these will follow the rules described below. §§ 1301(a)(2) & 10104(a).

Missouri has exercised its opt-out right, so that none of the new Qualified Health Plans will offer abortion coverage here. Rev. Stat. Mo. § 376.805. However, federal tax dollars collected from Missouri taxpayers will still subsidize abortions in states that do not opt out.

In those states, PPACA describes two different payment and accounting systems for abortion premiums, one for funding abortions of the types that the Department of Health & Human Services can pay for under the federal Hyde Amendment (hereinafter, "HHS abortions"); another for coverage of abortions that HHS cannot pay for under Hyde ("non-HHS abortions"). Currently, HHS abortions include those when the baby is conceived as a result of rape or incest, and those performed if a physical disorder, physical injury, or physical illness as certified by a physician would place a woman in danger of death. Consolidated Appropriations Act of 2012, Pub.L. 112-74, §§ 506-507, 125 Stat. 1111-12. Additionally, the federal government's regulations provide that "morning after" pills (Preven, Plan B) are not abortifacients. Abortion is apparently presumed to consist of ending a pregnancy, regardless of the status of human life involved, so the the regulations allow HHS funds to pay for drugs that prevent implantation. 42 CFR 441.207.

It is appropriate to make three points about HHS abortions here. First, some physicians will certify that any pregnancy puts a woman in danger of death. The author of the standard textbook on abortion procedures, Dr. Warren Hern of Colorado, said in connection with a proposed exception for partial birth abortions, "I will certify that any pregnancy is a threat to a woman's life . . . ." (The Record, Bergen County, N.J., May 14, 1997) (emphasis supplied).

Second, preventing the implantation of a developing human being is an abortion, whatever the federal regulations say. Science clearly demonstrates that when ordinary means of reproduction are used (i.e., other than cloning), a separate human being comes into existence at conception. "The development of a human begins with fertilization, a process by which the spermatozoon from the male and the oocyte from the female unite to give rise to a new organism, the zygote." T. Sadley, Langman's Medical Embryology 3 (1995).

The time of fertilization represents the starting point in the life history, or ontogeny, of the individual." B. Carlson, Patten's Foundations of Embryology 3 (1996). By the time a newly-conceived human being is ready for implantation, almost a full week has elapsed after conception. The human being consists not of one or two cells, but approximately 150 cells (NIH Stem Cell Information: Glossary, "Blastocyst"), and he or she is already beginning a self-directed process of cell differentiation and growth that requires a vast increase in nutrients that implantation will allow him or her to receive. Wikipedia has a decent description of this process in its article, "Human embryogenesis." In short, there is no such thing as "implantation of a fertilized egg"; the little human being has already moved far beyond that stage when he or she is ready to implant.

Finally, the Hyde Amendment is attached to appropriations bills, so it has to be passed every year to limit the reach of Medicaid and other governmental health programs. If it ever fails to pass, then the federal government will pay for all abortions that are sought by recipients of federal health assistance. The numbers of HHS abortions, then, are always in danger of a vast increase, depending on the makeup of Congress in any particular session.

Now we return to the two systems of payment for abortion in states that have not opted out of abortion coverage altogether. PPACA sets up a system in which payments for non-HHS abortions come from segregated accounts that the insurance companies must maintain. PPACA §§ 1303(b)(2)(B) & 10104(c). The separate premiums that are charged for those abortions are deposited into the segregated account. HHS abortions are not paid for out of these segregated accounts; only non-HHS abortions are paid from them. HHS abortions are paid from the regular bank accounts of insurers.

Beginning in the year 2014, PPACA creates two major subsidies for health care insurance, and the funds that pay the subsidies come from federal tax money. First are tax credits for health insurance premiums that are provided to taxpayers who earn up to 400% of the federal poverty level (currently, that limit is approximately $92,000). New Internal Revenue Code (IRC) § 36B, enacted by PPACA §§ 1401 & 10105, and Reconciliation Act (Pub. L. 111-152), §§ 1001(a) & 1004. Second are refunds of cost-sharing payments (e.g., co-payments and deductibles) for individuals. PPACA § 1402; Reconciliation Act § 1001(b). These subsidies must go into the insurers' regular accounts and cannot be deposited into the non-HHS-abortion segregated accounts. §§ 1303(b)(2)(A) & 10104(c).

The end result? The premium subsidies and the cost-sharing refunds go into the accounts that pay for HHS abortions. Therefore, these federal tax dollars will pay for HHS abortions covered under Qualified Health Plans in states that have not opted out of abortion coverage. §§ 1303(b)(2)(A) & (C) and 10104(c).

Substantial growth in abortions may be expected from the expanded availability of abortion coverage. The United State Conference of Catholic Bishops (USCCB) reports that the abortion rate for low-income women in states that provide their own funding for Medicaid abortions is more than double the abortion rate for low-income women in other states. USCCB Secretariat of Pro-Life Activities, "Issues of Life and Conscience in Health Care Reform: An Analysis of the 'Patient Protection and Affordable Care Act' of 2010," p. 11, n.16 (May 24, 2010). The same may be expected for individuals who now obtain coverage for abortions under the provisions of PPACA.

In states that opt out of abortion coverage, their citizens' federal tax dollars are still going to pay for HHS abortions in all the states that do not opt out. If these provisions of PPACA are still in effect after 2013, Missouri taxpayers are going to pay for HHS abortions in Illinois, California, New York, and other states that do not opt out of abortion coverage in Qualified Health Plans.
Future articles will describe more ways that PPACA uses federal tax dollars to subsidize abortions.