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**Testimony of Richard M. Doerflinger
on behalf of the
U.S. Conference of Catholic Bishops
before the
Subcommittee on the Constitution
House Judiciary Committee
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Hearing on H.R. 3, No Taxpayer Funding for Abortion Act

I am Richard M. Doerflinger, Associate Director of the Secretariat of Pro-Life Activities at the United States Conference of Catholic Bishops (USCCB). I want to thank this Subcommittee for allowing us to present our views in support of H.R. 3, the No Taxpayer Funding for Abortion Act.

A Permanent Ban on Abortion Funding: Long Overdue

H.R. 3 will write into permanent law a policy on which there has been strong popular and congressional agreement for over 35 years: The federal government should not use tax dollars to support or promote elective abortion.¹

Since 1976 this principle has been embodied in the Hyde amendment to annual appropriations bills funding the Department of Health and Human Services (HHS), and in numerous similar provisions governing a wide range of domestic and foreign programs. It has consistently had the support of the American people. For example, reflecting a long history of public support for the Hyde amendment, a November 2009 CNN survey found that Americans oppose “using public funds for abortions when the woman cannot afford it” by a margin of 61 to 37%.² In December 2009 a Quinnipiac University poll found 72% opposition to “allowing abortions to be paid for by public funds under a health care reform bill.” In a survey conducted for my organization by International Communications Research at about the same time, 67% (including 60% of those supporting health care reform legislation) opposed “measures that would require people to pay for abortion coverage with their federal taxes.” That survey also asked: “If the choice were up to you, would you want your own insurance policy to include abortion?” Only 24% said yes; 68% of U.S.

¹ In this testimony the phrase “elective abortion” refers to abortions that have long been ineligible for federal funding; in recent years this has included abortions except for cases of rape, incest, or danger to the life of the mother. The term is used here as shorthand for a longstanding federal policy, not as expressing a medical or moral judgment.

² This poll even found a majority against companies including abortion in private insurance plans involving no government money, 51% to 45%. See CNN/Opinion Research Corporation Poll of November 13-15, 2009, at <http://i2.cdn.turner.com/cnn/2010/images/03/09/top17.pdf>.

adults, and 69% of women, said **no**. Also saying **no** were 82% of those currently uninsured, presumably the primary target audience for health care reform.³

Even public officials who take a “pro-choice” stand on abortion have supported bans on public funding as a “middle ground” on this contentious issue – sometimes observing that it is not “pro-choice” to force others to fund a procedure to which they have fundamental objections. And even courts insisting on a constitutional “right” to abortion have said that this alleged right “implies **no limitation** on the authority of a State to make a value judgment favoring childbirth over abortion, and to implement that judgment by the allocation of public funds.”⁴ As the U.S. Supreme Court said in 1980:

By subsidizing the medical expenses of indigent women who carry their pregnancies to term while not subsidizing the comparable expenses of women who undergo abortions (except those whose lives are threatened), Congress has established incentives that make childbirth a more attractive alternative than abortion for persons eligible for Medicaid. These incentives bear a direct relationship to **the legitimate congressional interest in protecting potential life**. Nor is it irrational that Congress has authorized federal reimbursement for medically necessary services generally, but not for certain medically necessary abortions. **Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life.**⁵

So secure is this legal and political consensus, in fact, that some have *assumed* it is already fully implemented at all levels of our federal government. For example, some wrongly argued during the recent debate on health care reform that there was no need for restrictions on abortion funding in the legislation, because this matter had already been settled by the Hyde amendment. However, the Hyde amendment itself is only a rider to the annual Labor/HHS appropriations bill, and thus governs only funds appropriated under that particular Act.

The fact is that Congress’s *policy* has been remarkably consistent for decades, but the implementation of that policy in *practice* has been piecemeal, confusing and sometimes sadly inadequate. Federal funds are prevented now from funding abortion by riders to a number of annual appropriations bills, as well as by provisions incorporated into specific authorizing legislation for programs such as the Department of Defense, Children’s Health Insurance Program, Title X family

³ These and other recent polls are summarized in National Right to Life Committee, “Public opinion on ‘health care reform’ and abortion,” January 6, 2010, at www.nrlc.org/ahc/AHCPollsSummary.pdf. For more on the ICR survey see USCCB News Release, “New Survey: Most Americans Want Health Care Reform, Oppose Abortion Coverage, Support Conscience Protection Laws,” September 22, 2009, at www.usccb.org/comm/archives/2009/09-186.shtml.

⁴ *Maier v. Roe*, 432 U.S. 464, 474 (1977) (emphasis added).

⁵ *Harris v. McRae*, 448 U.S. 297, 325 (1980) (footnotes omitted, emphasis added). The Court’s only error here was its use of the incoherent and undefined term “potential life.” The unborn child is actually (not just potentially) human and alive, unless he or she is made actually (not just potentially) dead by abortion. Note that this court decision upheld the original Hyde amendment of Fiscal Year 1977, which allowed federal abortion funding only in cases of danger to the life of the mother; that policy was also in effect from 1981 to 1993.

planning, and foreign assistance.

On occasion a gap or loophole has been discovered that does not seem to be addressed by this patchwork of provisions, highlighting the need for a permanent and consistent policy to be applied across the federal government:

- In 1979, Congressman Hyde learned that elective abortions were being funded for American Indians and Alaska Natives through the Indian Health Service (IHS). In response to his inquiries, IHS Director Emery Johnson, M.D., replied that while funding abortions was not specifically authorized by any law, the authorizing legislation for the IHS did permit expenditure of appropriated funds for the “relief of distress and conservation of health” of Indians. “All current requirements having been met, and procedures followed,” he wrote, “we would have no basis for refusing to pay for abortions” (Letter to Rep. Henry Hyde, July 30, 1979). He added that IHS services were funded through a separate Department of the Interior appropriations bill, which had no provision like the Hyde amendment. The Reagan Administration later attempted to place an administrative restraint on this practice in 1982; Congress finally enacted legislative language as part of the IHS reauthorization bill in 1988, but even this language only references whatever policy the Hyde amendment places on HHS funds in a given year.
- In 1997, it was discovered that some states were using federal Medicaid funds not to reimburse directly for particular services, but to help pay premiums for overall benefits packages or capitation fees for health maintenance organizations (HMOs). Since the Hyde amendment only prohibited expending federal funds for abortion itself, some thought states might be free to subsidize elective abortions by using federal funds to help purchase overall health plans that cover abortion. A second sentence had to be added to the Hyde amendment, to forbid using federal funds for “health benefits coverage that includes coverage of abortion.” This same policy of denying federal funds to health plans that cover abortion was also incorporated into the State Children’s Health Insurance Program (SCHIP) and the Federal Employees Health Benefits Program (FEHBP), creating a consistent federal policy: Wherever federal and nonfederal funds are combined to purchase a health benefits package, that package may not cover elective abortions. That policy was consistently applied until 2010, when it was contradicted by the final version of the Patient Protection and Affordable Care Act (PPACA).
- In 1998, Congress became aware that Medicare was subsidizing abortions for non-elderly enrollees who were eligible for Medicare due to disability. Because federal funds appropriated through the Labor/HHS appropriations bill are combined with other funds such as premium payments and co-pays in the Medicare trust fund, which then reimburses for medical services, some federal officials thought they could fund these abortions while claiming this was not a use of federally appropriated funds. After congressional inquiries,

HHS Secretary Donna Shalala reversed this interpretation and said that Medicare would follow the Hyde criteria (Letter to Senate Assistant Majority Leader Don Nickles, June 22, 1998). This policy, that a trust fund receiving federal funds may not be used to help fund abortions (or to help fund a health plan that covers abortions), was incorporated into the Hyde amendment for Fiscal Year 1999 and has remained in effect ever since.

- The absence of a government-wide law against federal funding of abortion led most recently to the passage of major health care reform legislation that contains at least *four* different policies on this issue. Section 1303 of PPACA, on health plans in state exchanges, complies with the first sentence of Hyde (against direct and traceable funding of abortion procedures themselves) but violates Hyde's second sentence (against funding health plans that cover abortions). Section 1101, on state high-risk insurance pools, appropriates its own new funds outside the bounds of the Hyde amendment, and allows those funds to be used for abortions or not, depending on a changeable decision by the Secretary of Health and Human Services. Section 10503, on community health centers, omits any reference to Hyde, and allows its new funding to be governed by underlying mandates in the authorizing legislation for these centers – mandates that in other health programs have been interpreted by federal courts to *require* federal funding of abortion when not corrected by Hyde language. Finally, Section 4101, on school-based clinics, explicitly excludes abortion funding. All except the last of these disparate policies are incompatible with the Hyde amendment and similar longstanding federal policies; each of them is incompatible with all the others.⁶

Obviously the current patchwork of almost a dozen legislative provisions, most of which must be reapproved each fiscal year, has not always adequately served the will of Congress or the American people in preventing all forms of federal subsidy for abortion. However, at least until last year, Congress has always acted to address the immediate problem once it has understood that problem and had an opportunity to address it. It should do no less today. In fact, it should finally put a stop to this ungainly mechanism and simply apply the principle of the Hyde amendment across the federal government once and for all.

If a bill like H.R. 3 had been enacted before the health care reform debate began, that debate would not have been about abortion funding. A major obstacle to support by Catholics and other pro-life Americans would have been removed, and the final legislation would not have been so badly compromised by provisions that place unborn human lives at grave risk.

The USCCB also supports the Protect Life Act, H.R. 358, to address these and other abortion-related problems in the health care reform law itself. The benefit of H.R. 3, however, is

⁶ For more about this and other problems in the final version of PPACA see www.usccb.org/healthcare. The United States Conference of Catholic Bishops has declined advocating for or against repeal of PPACA in this Congress, focusing instead on advocating changes to address its key priorities of universal access to affordable care, respect for life and conscience, and fairness to immigrants. See USCCB letter to House of Representatives of January 18, 2011, at www.usccb.org/sdwp/Letter-hc-repeal112th-final.pdf.

that it would prevent problems and confusions on abortion funding in future legislation. Federal health bills could be debated in terms of their ability to promote the goal of universal health care, instead of being mired in debates about one lethal procedure that most Americans know is not truly “health care” at all. Annual funding bills could be discussed in terms of how their budget priorities best serve the common good, instead of being endangered because some want to use them to reverse or weaken longstanding federal policy on abortion funding. This is a result that everyone in Congress should welcome.

Ensuring the Civil Rights of Health Care Providers

H.R. 3 would also codify the Hyde/Weldon amendment that has been part of the annual Labor/HHS appropriations bills since 2004. Hyde/Weldon ensures that federal agencies, and state and local governments receiving federal funds, do not discriminate against health care providers because they do not perform, provide or otherwise participate in abortions. It is long overdue for this policy, as well, to receive a more secure legislative status. In this regard the USCCB supports the Abortion Non-Discrimination Act (H.R. 361) as a free-standing bill to address this need; but it is very appropriate to address the problem in H.R. 3, as the Hyde/Weldon amendment has been an added subsection of the Hyde amendment itself for seven years.

As with the Hyde amendment’s ban on abortion funding, the policy of the Hyde/Weldon amendment is both clear and widely supported. Hospitals, doctors and nurses should not be forced to stop providing much-needed legitimate health care because they will not participate in destroying a developing human life. In the ICR survey cited earlier, 63% of U.S. adults favored keeping in place federal laws that “protect doctors and nurses from being forced to perform or refer for abortions against their will.” In an April 2009 survey by The Polling Company, Inc., 87% of American adults believed it is important (and 65% saw it as very important) to “make sure that healthcare professionals in America are not forced to participate in procedures and practices to which they have moral objections.”⁷

Yet on this issue as well, the policy has been clear but the mechanism for achieving it has suffered from drawbacks and loopholes:

- The Hyde/Weldon amendment is only a Labor/HHS appropriations rider requiring renewal each year, giving no assurance to young doctors, nurses and students in the healing professions that if they enter these professions their fundamental rights will be respected.
- This nondiscrimination policy only covers government entities receiving funds from the Labor/HHS appropriations bill, omitting many health programs. For example, the billions of dollars newly appropriated each year under PPACA are not covered.⁸

⁷ On the April 2009 survey see www.freedom2care.org/docLib/200905011_Pollingsummaryhandout.pdf.

⁸ The health care reform bill approved by the House of Representatives in November 2009 contained its own

- Because this rider was crafted as a “limitation on funds” provision to avoid points of order, the only apparent remedy for stopping discrimination is to withhold all funds under the Labor/HHS Appropriations Act: no funds under the Act may be provided to a government entity that discriminates. This remedy is so sweeping that many see the threat of imposing it as unconvincing. Some state officials, for example, have implied that they may freely ignore the rights that Catholic health care providers should enjoy under the amendment, because no one will deny an entire state all its Medicaid and other health funds under the Labor/HHS bill.
- The amendment fails to state any mechanism by which a complaint may even be raised, whether in court or by appeal to HHS. The Bush administration had issued regulations to designate the HHS Office for Civil Rights to investigate complaints; but the Obama administration has proposed rescinding these regulations, and recently told a federal court that it will soon take final action on this proposal.⁹ Moreover, the amendment does not provide for a private right of action allowing providers whose rights are being violated to file suit to vindicate their rights. Recently a federal appellate court ruled that a similar conscience law, commonly known as the Church amendment, does not allow such a suit to be heard in court because the law did not explicitly provide for one – and so a nurse who was forced under threat of dismissal to take part in a grisly late-term abortion at Mount Sinai Hospital in New York in 2009 has found herself without recourse, her complaint to HHS also having received no visible action thus far.¹⁰

H.R. 3 addresses these serious problems, by writing this essential civil rights protection into permanent law; allowing for measured and reasonable remedies to ensure compliance with the law; providing for a private right of action; and also designating the HHS Office for Civil Rights to hear complaints, an avenue that under H.R. 3 will be available separately and in parallel with the right to file suit in federal court.

The need for stronger protection in this area is clear. The American College of Obstetricians and Gynecologists, which supports “abortion rights,” has issued and recently reaffirmed an ethics committee opinion that calls on pro-life physicians to refer for abortions in a wide array of circumstances, to perform abortions themselves when referral is not possible, and even to locate

Hyde/Weldon provision, but this was not accepted by the Senate. The final PPACA legislation includes a weaker provision, barring only discrimination by qualified health plans against pro-life health care providers (Sec. 1303 (b)(4)); discrimination by governmental entities is not addressed.

⁹ See Federal Defendants’ Response to November 3, 2010 Show Cause Order, *State of Connecticut v. United States of America*, No. 3:09-cv-54-VLB (D. Conn. Dec. 1, 2010).

¹⁰ See *Cenzon-DeCarlo v. Mount Sinai Hospital*, 626 F.3d 695 (2d Cir. 2010).

themselves near abortion practitioners to maximize access to abortion.¹¹ The American Civil Liberties Union has launched a campaign urging the federal government to force Catholic hospitals to violate their moral and religious convictions by providing “emergency” abortions (by which the ACLU means all abortions to serve women’s life or “health,” defined by federal courts to encompass social “wellbeing”).¹² And many institutions apparently remain oblivious even to health care professionals’ clearly established statutory rights, as when a medical center affiliated with the State University of New York at Stony Brook recently suspended eight nurses for stating that they would not assist in abortions.¹³

Some of the recent threats are overt efforts to suppress or eliminate health care that is guided by Catholic moral principles. This in itself is an obvious threat to access to life-affirming health care. Catholic hospitals care for 1 in 6 patients in the United States each year, and provide the full continuum of health care through more than 2,000 sponsors, systems, facilities, and related organizations, employing 725,000 individuals. Catholic and other religiously affiliated health care facilities provide higher quality and more effective care, including care for women, than any others.¹⁴ If Congress wants to expand rather than eliminate access to life-saving health care, particularly for the poor and underserved, it should be concerned about any effort to attack the rights of these providers and undermine their continued ability to serve the common good.

Answering questions about H.R. 3

A number of questions have been raised about H.R. 3, sometimes in the form of charges by

¹¹ ACOG Committee Opinion No. 385, “The Limits of Conscientious Refusal in Reproductive Medicine” (Nov. 2007, Reaffirmed 2010), at www.acog.org/from_home/publications/ethics/co385.pdf. The reference to “limits” here is misleading, as the opinion makes it clear that anything like a right to refuse participation in morally abhorrent procedures simply vanishes in the face of the overriding mandate to maximize abortions.

¹² The ACLU’s July 2010 and December 2010 letters, urging HHS to suppress health care based on Catholic teaching, are available at www.aclu.org/reproductive-freedom/aclu-sends-second-letter-asking-government-investigate-potential-denials-emerge. The ACLU’s claim that current federal laws already require all hospitals to provide abortions in some cases has been ably rebutted by the Becket Fund in its letter to HHS of August 19, available at www.becketfund.org/index.php/article/1355.html. Among other things, the ACLU claims that the federal Emergency Medical Treatment and Active Labor Act (EMTALA) creates a mandate for “emergency” abortions – yet EMTALA explicitly calls on emergency health care personnel to respond to any condition that places a pregnant woman or “her unborn child” in jeopardy, requiring them to stabilize the medical condition of both mother and child. 42 USC §1395dd(e).

¹³ See “LI hospital issues abortion apology to nurses,” *New York Post*, April 28, 2010, at www.nypost.com/p/news/local/li_hospital_issues_abortion_apology_LbmfSompPhRIjakeEbUtlzN?CMP=OTC-rss&FEEDNAME.

¹⁴ A recent study of 255 health systems found: “Catholic and other church-owned systems are significantly more likely to provide higher quality performance and efficiency to the communities served than investor-owned systems. Catholic health systems are also significantly more likely to provide higher quality performance to the communities served than secular not-for-profit health systems.” David Foster, Ph.D., M.P.H., *Research Brief: Differences in Health System Quality Performance by Ownership* (Thomson Reuters, August 9, 2010), at www.100tophospitals.com/assets/100TOPSystemOwnership.pdf.

groups committed to government support for abortion. These groups have abandoned their earlier slogan of “choice” and instead are committed to “access” – which means maximizing abortions, and using the coercive power of government to enlist the unwilling aid of taxpayers and health care providers who disagree with them. Answers are offered here for some of these questions.

Does H.R. 3 eliminate private coverage for abortion?

No, in fact Section 305 of the bill explicitly allows such coverage as long as it does not use federal subsidies. Those who want abortion coverage can use nonfederal money to purchase a plan that includes it; or they can receive a federal subsidy to purchase a plan that does not include it, then buy abortion coverage separately with nonfederal funds.

Critics claim that such separate abortion riders will not be offered or will be difficult to obtain. The experience in states that have generally prohibited abortion coverage except by optional rider rebuts this claim. Supplemental abortion coverage is available in these states – in some plans offered by large insurers, choosing this coverage requires a simple check-off. The problem is that almost no woman chooses abortion coverage, which is to be expected in light of the surveys showing that most women oppose it. Abortion coverage is included in so many plans now because it is imposed on women and men by employers and insurance companies without their consent and generally without their knowledge. (In the ICR poll cited earlier, 68% of those who had insurance simply *did not know* whether their plan covered abortion, though that same percentage would reject it if asked.)

What this legislation does is place abortion coverage more in the arena of *individual choice* for women – an outcome opposed by groups that once claimed to be “pro-choice” and “pro-woman.” They prefer a status quo in which insurance companies or employers choose abortion coverage and impose it on others chiefly because it is cheaper for them than reimbursing for live birth.¹⁵

A more limited and subtle argument has been advanced by Prof. Sara Rosenbaum and colleagues at George Washington University.¹⁶ They point out that the policy outlined here – denial of federal subsidies for health plans that include elective abortions – already affects many millions of people under Medicaid, the Federal Employees’ Health Benefits Program, SCHIP and so on. By

¹⁵ John Nugent, CEO of Planned Parenthood of Maryland, says of abortion coverage that “the insurance companies think they should be offering it” because it’s “cheaper to terminate an unwanted pregnancy rather than taking it to term.” David Whelan, “Obamacare: Why Private Insurers Like Paying for Abortion,” *Forbes* Blog, at <http://blogs.forbes.com/sciencebiz/2010/01/07/obamacare-why-private-insurers-like-paying-for-abortion/>.

¹⁶ Sara Rosenbaum *et al.*, “Analysis of the Implications of the Stupak/Pitts Amendment for Coverage of Medically Indicated Abortions,” The George Washington University Medical Center, November 16, 2009, at www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_FED314C4-5056-9D20-3DBE77EF6ABF0FED.pdf.

extending this policy to millions more (*e.g.*, to lower-income people who purchase their coverage on state exchanges), the new legislation when combined with existing laws may produce a “tipping point” where coverage without abortion becomes the usual norm for health insurance; coverage that includes abortion will be permitted but rare.

My response to this is that I hope it is correct. As the Supreme Court noted approvingly three decades ago, the purpose of a federal funding ban is to use the government’s funding power to encourage childbirth over abortion. Abortion coverage, and therefore abortion, may become more rare, a result favored by all but the most committed advocates for abortion.

Does Section 303 of H.R. 3 create an unprecedented policy of denying “tax benefits” to abortion?

No, that issue was settled by PPACA. Members of Congress discussed whether the premium tax credits that help make health coverage affordable on state exchanges constitute federal funding, and decided in the affirmative. The provision forbidding direct use of these credits for abortion is even titled “Prohibition on the Use of Federal Funds” (Sec. 1303 (b)(2)).¹⁷

The PPACA debate drew attention to the issue of how our tax system treats abortion, and uncovered some remarkable facts. For example, the individual tax deduction for medical expenses can be directly used to help reduce the cost of an abortion performed for *any* reason (not just abortion coverage but payments for abortions themselves).¹⁸ This seems a very explicit and direct statement that the government wants to help pay for your elective abortions. Now that this loophole allowing tax support for abortion has been discovered, H.R. 3 is addressing it.

Does Section 308 of H.R. 3 depart from precedent by saying that federal law does not compel states to fund any abortions?

No, on this point as well it simply follows the policy of PPACA. It specifically states that the new federal “essential health benefits” mandate may not require inclusion even of abortions that are eligible for funding under the Hyde amendment (Sec. 1303 (b)(1)(A)(i)). Two distinct provisions of the final law also explicitly allow states to exclude abortion coverage in all circumstances (Secs. 1303 (c)(1) and 1303 (a)(1)). The first two provisions mentioned here were first offered in subcommittee by Rep. Henry Waxman (D-CA) and Lois Capps (D-CA) in summer 2009; the third was developed by Senate Democrats and added to the Senate bill in a Manager’s Amendment by Senate Majority Leader Harry Reid (D-NV). This policy of not *forcing* states to

¹⁷ This provision still violates the policy of the Hyde amendment by allowing use of these credits to purchase overall health plans that cover abortion. But it did establish the idea that abortions not eligible for funding under Hyde should also be ineligible for tax credits.

¹⁸ “You can include in medical expenses the amount you pay for a legal abortion.” Internal Revenue Service, Publication 502, *Medical and Dental Expenses (Including the Health Coverage Tax Credit)*, Dec. 9, 2008, page 5.

provide or fund any abortion coverage has become a point of consensus across partisan and ideological lines.¹⁹

Does H.R. 3's conscience clause place women's lives at risk?

Of course not. It simply continues the longstanding and consistent policy of federal law, beginning with the Church amendment of 1973, to allow health care providers to decline involvement in abortion in all circumstances.²⁰ That 38-year-long policy has not been responsible for any woman's death – on the contrary, as noted above, hospitals that perform no abortions provide the finest high-quality health care in the country. During this period abortion itself has caused the deaths of (at least) hundreds of women, chiefly women who were perfectly healthy until they placed themselves in the hands of an abortion provider. If Congress should be concerned about health care providers who endanger women's lives – and in this regard Dr. Gosnell, the infamous Philadelphia physician now facing eight murder indictments, is the tip of the iceberg -- it needs to start with the abortion industry itself.²¹

Conclusion

H.R. 3 is a well-crafted and reasonable measure to maintain longstanding and widely supported policies against active government promotion of abortion. It consistently applies to all branches of the federal government the principle that government can encourage childbirth over abortion through its funding power, and that it should not coerce anyone's involvement in abortion. It merits prompt and overwhelming support by this Congress.

¹⁹ At times when the Hyde amendment had a rape/incest exception prior to 1981, it also explicitly allowed states to decide whether to fund abortions eligible for federal funding. When the federal rape/incest exception was restored in 1993, unfortunately, that "state discretion" clause was omitted. This led to a constitutional crisis in states like Arkansas and Colorado whose constitutions barred state funding of abortion except in cases of danger to the life of the mother; those states were told they must ignore their own constitutions or be ejected from the Medicaid program, and at one point faced the prospect that their constitutional provision would be nullified entirely to allow unlimited abortion funding. That crisis should not be repeated now.

²⁰ For a compendium of many of these laws see USCCB Secretariat of Pro-Life Activities, "Current Federal Laws Protecting Conscience Rights," at www.usccb.org/prolife/issues/abortion/crmay08.pdf.

²¹ See Melinda Henneberger, "Kermit Gosnell's Pro-Choice Enablers (Is This What an Industry That Self-Regulates Looks Like?)," *Politics Daily*, January 23, 2011, at www.politicsdaily.com/2011/01/23/kermit-gosnells-pro-choice-enablers-how-clinics-become-death-t/.