

WITHDRAWAL SHEET

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DOCUMENT NO. & TYPE	SUBJECT/TITLE	DATE	RESTRICTION
1. Memo	To Susan Brophy, et al, re: draft for POTUS, 2p	4/10/93	P5

RESTRICTIONS

- P1** National security classified information [(a)(1) of the PRA].
- P2** Relating to appointment to Federal office [(a)(2) of the PRA].
- P3** Release would violate a Federal statute [(a)(3) of the PRA].
- P4** Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA].
- P5** Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA].
- P6** Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA].
- PRM** Personal records misfile defined in accordance with 44 USC 2201 (3).

- B1** National security classified information [(b) (1) of the FOIA].
- B2** Release could disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA].
- B3** Release would violate a Federal statute [(b)(3) of the FOIA].
- B4** Release would disclose trade secrets or confidential commercial financial information [(b)(4) of the FOIA].
- B6** Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA].
- B7** Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA].
- B8** Release would disclose information concerning the regulation of financial institutions [(b)(9) of the FOIA].
- B9** Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA].

file: abortion

September 17, 1993

MEMORANDUM FOR THE PRESIDENT

FROM: BILL GALSTON *WKS*
SUBJECT: YOUR MEETING WITH THE WOMEN DEMOCRATIC SENATORS

Introduction

You will be meeting with the five Democratic women senators at 5:00PM on Monday afternoon to discuss the relation between abortion and key items on your legislative agenda. Two specific topics are likely to arise: our strategy to deal with forthcoming Hyde amendment struggle on the Senate floor, and the treatment of reproductive services in the health care proposal. The purpose of this memorandum is to bring you up to date concerning Hyde amendment issues. You will receive a separate briefing on health care issues.

Background

As you know, your 1994 budget proposal did not include the language of past years prohibiting federal funding for abortion in a long list of appropriations bills, of which Labor/HHS is the most important. Instead, your Administration committed itself to working with the Congress to develop a response to this problem consistent with federal and state law.

Through consultation within the Administration and with experienced Hill staff, we crafted compromise language that would (1) guarantee Medicaid funding in cases of rape, incest, or serious adverse health consequences to the mother, certified by a qualified health care professional; and (2) permit the states, at their individual option, to use federal as well as state funds to fund abortions in other circumstances. You reviewed and approved this language in late May, but you concurred in our recommendation not to propose the compromise publicly until it could be advanced effectively in the legislative process.

In the discussions leading up to the Labor/HHS vote on the House floor, we privately raised the possibility of introducing our language. We were rebuffed by both pro-life and pro-choice advocates. In particular, the pro-choice forces were convinced that they could achieve full repeal of the Hyde amendment, resulting in no restrictions whatever on Medicaid funding. They were wrong. On June 30, Rep. Hyde succeeded in bringing his

language to the House floor for a vote. After rebuffing last-minute efforts to introduce a compromise, the pro-choice forces went down to defeat by the surprisingly large margin of 255 to 178. Subsequently, some pro-choice House leaders have told us that they regret their decision to oppose all compromise.

Current Issues

The action on the Labor/HHS appropriations bill has now shifted to the Senate. Last week, with the support of Sen. Harkin (for substantive reasons) and Sen. Byrd (on procedural grounds) the Appropriations Committee reported out a "clean" bill with no abortion funding restrictions. Hyde language is certain to be proposed as an amendment when the bill reaches the Senate floor. Both Senate pro-choice forces and the Administration must now decide how to respond.

The five senators who will see you on Monday will urge a clear and unequivocal view: There should be no attempt at compromise. Instead, we should try to defeat all amendments to the committee report, and your administration should weigh in heavily to achieve this result.

There are two difficulties with this course of action. First, it is not fully consistent with the position (guaranteed floor plus state option) that you favor. Second, it is virtually certain to fail. Our vote count indicates no more than 45 votes currently in favor of full repeal of Hyde, and administration representatives who have taken the lead in lobbying this issue do not believe that there is any practical possibility of finding another 6 votes.

The women senators have two responses to this. First, they disagree with our political assessment and believe that a no-holds-barred administration effort might well produce the needed votes. Sen. Mikulski is very likely to ask you to commit to such an effort. Second, even if full repeal of Hyde is improbable, they are flatly opposed to an Administration-sponsored compromise--even if it were to succeed. They fear that any such compromise could become the blueprint for restricting the range of reproductive services included in the standard benefits health care package.

In the judgment of the Administration working group (George Stephanopoulos, Jerry Klepner, Susan Brophy, and several others) that met recently to review the situation, the position of the women senators leaves us with very few options. Without these senators' support, we could not pass our compromise and might not even be able to find anyone to champion it on the floor. To push for it in these circumstances would thus antagonize key Senate pro-choice leaders without producing any tangible gains for your position.

Accordingly, we recommend that you respond to the senators by:

- o raising the concern that their proposed strategy could lead to total defeat; as in the House, yielding identical language in the two houses of Congress, precluding the House/Senate conference from even taking up the issue, and guaranteeing another year of the Hyde amendment as the law of the land;

- o agreeing, if they insist, to oppose all abortion-related amendments to the Labor/HHS bill; and

- o agreeing, if they request, to administration lobbying against such amendments.

We recommend that you avoid committing yourself to a personal presidential lobbying effort. If pressed, you can offer the services of HHS Secretary Shalala and others, as in the case of the successful fight last month on the Treasury/Postal bill. Sen. Mikulski went out of her way to thank us for our efforts in that cause.

Sen. Mikulski may use the favorable outcome of that fight to argue that the prospects for the Labor/HHS are reasonably good. In our judgment, however, the two issues are very different. Treasury/Postal presented an easier issue: not explicit public funding (as in the case of Medicaid), but rather the right of Federal employees to use their own funds to choose health benefits plans that include reproductive service. Even so, we were only able to scrape together 51 votes, and only on a procedural motion. We would probably have lost a straight up-or-down vote on substance.

If public questions are subsequently raised, we recommend a response along the following lines:

The Administration has consistently been committed to removing the Hyde amendment and working with the Congress to forge an approach that respects both federal and state law. Especially in light of the very disappointing House vote last June, we believe that we can best move toward this objective by opposing restrictive amendments in the Senate.

8-12-03

(11)

~~Keep file copy~~

~~Send on to
Erick~~

OK: Carasco

To: Erich Vaden and Carol Rasco
From: Bill Galston
Re.: New draft of the abortion/Hyde amendment response letter

=====
Dear _____:

Thank you for your letter. I realize that the questions surrounding the abortion issue deeply concern many Americans.

I support a Freedom of Choice Act that codifies the constitutional protections of Roe v. Wade, while allowing states the flexibility they enjoyed from 1973 through 1988, and provides individuals and institutions conscientiously opposed to abortions the right not to participate in them. As I said during the campaign if such a bill reaches my desk, I will sign it into law.

For the past sixteen years, the Hyde Amendment has prohibited states from allocating federal money for abortions even in cases of rape or incest, or when the life of the mother was at stake. I believe this is wrong. In the FY 1994 budget, I did not include the restrictions on abortion funding mandated by the Hyde Amendment, and I committed my Administration to work with the Congress to develop a new approach consistent with federal and state law. I believe that the Congress will eventually ratify just such an approach. I can assure you that my administration is working hard to produce that outcome.

I realize that these are issues that divide Americans of good will, and I respect your disagreement. Let me repeat what I stated many times during my Presidential campaign: abortion should be safe, legal, and rare. Again, thank you for writing to share your concerns with me.

Sincerely,

WAG/ahl

THE WHITE HOUSE
WASHINGTON

August 5, 1993

MEMORANDUM TO CAROL RASCO

FROM: ERICH VADEN,
SENIOR WRITER, PRESIDENTIAL LETTERS

THROUGH: MARSHA SCOTT
DEPUTY ASSISTANT TO THE PRESIDENT
AND DIRECTOR OF PRESIDENTIAL CORRESPONDENCE

SUBJECT: APPROVAL OF THE ENCLOSED FORM LETTERS

As you may know, my office generates the form letters that are sent to the general public. We do extensive research on the President's positions in the process of writing them. However, as a safety measure, we send our letters to the policy experts in the White House, including members of the Domestic Policy Council, for approval. The enclosed letters contain the form language that we intend to use to answer individuals writing in on the Hyde amendment. I have been told that you are the best person to write to for approval on this issue.

I would be grateful if you would read the following letters and make any changes you think are necessary before we release them for distribution. If you have any questions, please call me at x2276.

Roz:

① Let Vaden know we will have Halston review it, he's on vacation but we can

AUG 6 RECD

fax to him & will get back as soon as

we can.

② Fax to Halston (both pgs.) as

soon as you have #.

THE WHITE HOUSE

WASHINGTON

August 5, 1993

Mr. John M. Doe
Address Line 1
Address Line 2
City, State 20001-Zip

Dear John:

Thank you for your letter. I realize that the questions surrounding the abortion issue deeply concern many Americans.

As I stated during the campaign, if Congress passes the Freedom of Choice Act, I will sign it. However, I do not support legislation that encourages or mandates abortion. The Freedom of Choice Act would simply codify into law the basic rights and protections of Roe v. Wade, while allowing the states the same flexibility with abortion legislation they enjoyed from 1973 to 1988. The Act would provide individuals and institutions with conscientious objections to refrain from participating in abortion procedures.

I believe the states should have that same latitude regarding abortion when it comes to funding. For the past sixteen years, the Hyde Amendment has prohibited states from allocating federal money for abortions even in cases of rape or incest, or when the life of the mother was at stake. I believe this is wrong. In the FY 1994 budget, I did not include the restrictions on abortion funding mandated by the Hyde Amendment. Congress is now considering the proposal.

I realize that these are issues that divide Americans of good will, and I respect your disagreement. Again, thank you for writing to share your concerns with me.

Sincerely,

(08/05/93)

orig: CHR
~~XC: HRC~~
~~RH: JWC~~

file: Abortion

Kate Michelman
President

July 28, 1993

Dear Carol,

Thought you would like to receive a copy of
NARAL's "Discussion Paper" entitled National
Health Care Reform, Women's Reproductive
Health Care, and Abortion.

I thank you in advance for taking the time to
review this material.

Warm regards,

Kate

National
Abortion Rights
Action League

1156 15th Street, N.W., 7th Floor
Washington, D.C. 20005
202-973-2000



DISCUSSION PAPER

NATIONAL HEALTH CARE REFORM, WOMEN'S REPRODUCTIVE HEALTH CARE, AND ABORTION

Reproductive health care is an essential component of primary care for women and must be included in the comprehensive benefits package that will be mandated under national health care reform. No medical rationale supports the exclusion of abortion from national health care reform. According to the Association of Reproductive Health Professionals: "Advances in reproductive medicine, including access to safe, legal abortion services, have produced unquestioned health benefits for women."¹ Anti-choice politics should not be permitted to jeopardize women's health by eliminating access to legitimate and essential reproductive health services. Moreover, excluding abortion services from the basic benefits package would prove unacceptable to Americans because it would take away services currently covered under most private health insurance policies.

Abortion is an Integral Part of Women's Health Care

Assuring adequate health coverage for all Americans -- the primary goal of this effort to reform the nation's health care system -- must mean assuring that every person will have genuine access to the basic medical services that he or she may be expected to require in the course of life. For most women, reproductive health care is the major form of health care that they receive during most years of their lives. Thus, for American women, comprehensive health care coverage cannot exist without guaranteeing coverage for reproductive health care.

Different women have differing reproductive health needs, and even the same woman has differing reproductive health needs at different stages of her life. A comprehensive national health care program must provide coverage for the whole woman throughout the many stages of life. For example, at different stages of her life, one woman might need routine gynecological exams, treatment of gynecological illnesses, various forms of contraception, and pregnancy-related treatment including pregnancy testing, prenatal care, and abortion. National health care cannot isolate one procedure for discriminatory treatment, but must assure coverage for the whole range of reproductive health care options.

Pregnancy is a health condition that requires medical attention based on a woman's individual needs, not political concerns. Care for pregnancy may involve medical services for pregnancy termination, or services to bring the pregnancy to term. Private insurance plans typically recognize abortion as integral to women's reproductive health and provide coverage for the procedure as part of pregnancy-related care.² Determining coverage for pregnancy-related medical services based upon anti-choice politics rather than on the medical needs and condition of the individual woman would severely harm women's health and well-being.

The vast majority of women require pregnancy-related medical services at some point in their lives. Most women become pregnant and more than eight out of ten will have at least one child. An estimated two-thirds of American women will have at least one unintended pregnancy in the course of their lives.³ In any single year, more than six million women become pregnant, and 3.4 million of these pregnancies are unintended.⁴ Legal abortion is one of the most commonly performed and safest surgical procedures. It entails half the risk of death involved in a tonsillectomy and one-hundredth the risk of death involved in an appendectomy.⁵ The American Medical Association recently concluded that "the risk of dying from pregnancy and childbirth has declined substantially over the past 50 years, but remains substantially greater than the risk of dying from a legal abortion."⁶ The risks of medical complications also are higher for childbirth than for abortion.⁷

All women must have the opportunity to make decisions about their reproductive health and to implement their choices through access to the full range of health services, including contraception, prenatal care and abortion.

Excluding Abortion Would Endanger Women's Health and Exacerbate the Current Shortage of Abortion Providers

National health care reform will significantly change the health care delivery system in this country and access to medical services not covered in the benefits package will be limited. The effect of exclusion would be particularly devastating for abortion services given the host of other anti-choice strategies being pursued to make abortion unavailable. Only women who could afford to purchase services outside the benefits package, and who could find a physician trained and willing to perform the procedure despite its exclusion from coverage, would have access to abortion. Some women who could not overcome these substantial obstacles would be compelled to resort to unsafe illegal abortions or forced childbearing, and others would suffer delays resulting in more risky procedures. The American Medical Association in a recent study concluded that:

If national or state funding regulations . . . deter or delay women from seeking an early termination of pregnancy . . . then more women are likely to bear unwanted children, continue a potentially health-threatening pregnancy to term, or undergo abortion procedures that would endanger their health.⁸

Forced Pregnancy and Childbearing

Some women who are denied access to abortion will be forced to carry unwanted pregnancies to term. Forced continued pregnancy subjects women to serious physical risks and burdens that range from prolonged discomfort and pain to a substantial risk of medical complications, and even death. For healthy women, the risks increase if the pregnancy was unintended and the woman is forced to carry to term against her will.⁹ Even in cases where

a pregnancy is wanted and planned, the onset or worsening of a disease or medical condition may create a need for abortion. Among the medical conditions that present increased risks to women's health during pregnancy -- sometimes to the point of threatening the woman's life -- are preeclampsia, cardiovascular disease, cancer, high blood pressure, kidney disease, immunological disorders, asthma, diabetes, and AIDS.¹⁰ For many women faced with these conditions, abortion is, at times, the only procedure that can safeguard their health.

Risky Delay

Excluding coverage would increase the health risks for women who terminate their pregnancies by imposing financial and other constraints that cause risky delays. Although a first or second trimester abortion is substantially safer than childbirth, after eight weeks the risks of death or major complications from abortion significantly increase for each week of delay.¹¹ Financial obstacles often require women to delay their abortions. Approximately half of the women who obtained abortions after 16 weeks of pregnancy were delayed by the difficulties of raising money to pay for the procedure.¹² Low-income women on average obtain their abortions two to three weeks later than middle- or upper-income women.¹³ Even women of means may be forced to delay their abortions while looking for a provider. The American Medical Association recently concluded that "as access to safer, earlier legal abortion becomes increasingly restricted, there is likely to be a small but measurable increase in mortality and morbidity among women in the United States."¹⁴

Unsafe Abortion

Any government policy that limits access to safe and legal abortion services will threaten women's health by forcing some women to resort to unsafe alternatives. Lack of insurance coverage led an estimated 2,000 women to seek illegal abortions during the first year in which federal coverage for abortion was prohibited.¹⁵ When legal abortion became widely available in the United States as a result of *Roe v. Wade*, the number of abortion-related deaths dropped sharply and non-fatal complications of abortion diminished as well.¹⁶

Between 1972 and 1974 the total number of reported abortion deaths declined from 88 to 48, and reported deaths from illegal abortions declined from 39 to 5.¹⁷ Between 1973 and 1985 there was more than a fivefold decline in the number of deaths per 100,000 abortions.¹⁸ Women who are unable to locate trained physicians willing to provide abortion services or are unable to afford the cost of purchasing services not provided in the benefits package would be forced to turn to self-induced or unsafe, illegal abortion.

The Shortage of Abortion Providers

Excluding coverage for abortion from the comprehensive benefits package mandated under the health care reform program would also exacerbate the already severe shortage of abortion providers, further isolate physicians who perform abortions, and deter medical schools from providing training in the procedure. In 83% of counties in the United States not a single physician offers abortion services; North Dakota and South Dakota have only one abortion provider each. Anti-choice extremists across the country are using violence, threats and intimidation to pressure physicians to abandon their abortion practices. The American Medical Association concluded in a recent study that "a reduction in the number and geographic availability of abortion providers, and a reduction in the number of physicians who are trained and willing to perform first- and second-trimester abortions have the potential to threaten the safety of induced abortion."¹⁹ Just such a dangerous reduction in the availability of providers can be expected if the national health care package isolates and excludes abortion from the basic benefits package.

The dramatic decline in the number of abortion-related deaths after abortion became legal and available in the United States was in part due to an increase in the number of residency programs offering training in abortion procedures and training opportunities for practicing physicians.²⁰ Since 1985, however, such training opportunities have substantially decreased. The number of obstetrics-gynecology residency programs that routinely offer training in first trimester abortions declined from 23% in 1985 to 12% in 1992; the number providing training for second trimester abortions fell from 23% to 7%.²¹ Although abortion is one of the most common surgical procedures women undergo, more than one-fourth of obstetrics and gynecology residency programs offer no abortion training.²² Anti-abortion extremists are targeting medical schools in an attempt to eliminate all abortion training.²³ Excluding abortion from the comprehensive benefits package would further stigmatize the abortion procedure and diminish abortion training opportunities in the nation's medical schools.

Conclusion

A national health care reform program that based coverage for pregnancy-related medical services on political preferences and not on the medical needs and condition of the individual pregnant woman would significantly limit women's ability to protect their health and well-being. Excluding abortion services would have the tragic effect of transforming much-needed health care reform into a dangerous and discriminatory denial of women's basic health care needs.

07/15/93

Endnotes

1. *Amici Curiae* Brief of the Association of Reproductive Health Professionals, et. al., in Support of Appellees at 12, *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989).
2. Bettijane Levine, "A Belated Debate Over Abortion Funding?," *L.A. Times*, Apr. 22, 1993, E1, E3; Rochelle Sharpe, "Abortion Coverage Looks Like Most Bitter Pill For Some in Prescription for Health-Care Reform," *Wall Street Journal*, May 11, 1993, A20; National Women's Law Center, *Reproductive Health: An Essential Part of Health Care*, June 1993, 4.
3. U.S. Bureau of the Census, "Fertility of American Women: June 1988," *Current Population Reports*, Series P-20, No. 436, 1988: 17; Jacqueline Darroch Forrest, "Unintended Pregnancy Among American Women," *Family Planning Perspectives*, vol. 19, no. 2 (Mar./Apr. 1987): 77.
4. Rachel Gold, *Abortion and Women's Health* (Washington, DC: Alan Guttmacher Institute, 1990): 11.
5. Warren M. Hern, *Abortion Practice* (Philadelphia: J.B. Lippincott Co., 1984): 23-24.
6. American Medical Association, "Induced Termination of Pregnancy Before and After *Roe v. Wade*, Trends in the Mortality and Morbidity of Women," *JAMA* vol. 268, no. 22 (Dec. 1992): 3235.
7. *Amici Curiae* Brief of the American Medical Association, et. al., in Support of Appellees at 10, *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989); Jane E. Hodgson, ed., *Abortion and Sterilization: Medical and Social Aspects* (London: Academic Press, 1981): 159.
8. American Medical Association, "Induced Termination of Pregnancy," 3238.
9. Willard Cates, Jr., "Legal Abortion: The Public Health Record," *Science*, vol., 215 (Mar. 26, 1982): 1587.
10. *Ibid.*, 659, 796, 806, 813, 816-17, 836-37, 858, 859-61.
11. Nancy Binkin, et. al., "Illegal-Abortion Deaths in the United States: Why Are They Still Occurring?," *Family Planning Perspectives*, vol. 14, no. 3 (May/June 1982): 165.
12. Aida Torres and Jacqueline Darroch Forrest, "Why Do Women Have Abortions?," *Family Planning Perspectives*, vol. 20 (July/Aug. 1988): 169.
13. Stanley K. Henshaw and Lynn S. Wallisch, "The Medicaid Cutoff and Abortion Services for the Poor," *Family Planning Perspectives*, vol. 16, no. 4 (July/Aug. 1984): 170.
14. American Medical Association, "Induced Termination of Pregnancy," 3238.
15. Willard Cates, Jr., "The Hyde Amendment in Action," *Journal of the American Medical Association*, vol. 246, no. 10 (Sept. 1981): 1111.
16. Willard Cates, Jr., and Roger W. Rochat, "Illegal Abortions in the United States: 1972-1974," *Family Planning Perspectives*, vol. 8, no. 2 (Mar./Apr. 1976): 87; Michael B. Bracken, PhD., et. al., "Hospitalization for Medical-Legal and Other Abortions in the United States 1970-1977," *American Journal of Public Health*, vol. 72, no. 1 (Jan. 1982): 30.
17. Willard Cates, "Illegal Abortions," 87.
18. American Medical Association, "Induced Termination of Pregnancy," 3232.
19. *Ibid.*, 3237.
20. *Ibid.*, 3232.
21. Helene Cooper, "Medical Schools, Students Shun Abortion Study," *Wall Street Journal*, Mar. 12, 1993, B1.
22. Philip D. Darney, et al., "Abortion Training in U.S. Obstetrics and Gynecological Residency Programs," *Family Planning Perspectives*, vol. 19, no. 4 (July/Aug. 1987): 158, 161.
23. Helene Cooper, "Medical Schools," B1.

THE WHITE HOUSE

WASHINGTON

TO: Howard Paster
George Stephanopoulos
Rahm Emanuel ¹⁾
Alexis Herman
Bernie Nussbaum
Christine Varney
Melanne Verveer

FROM: Carol H. Rasco *CHR*

SUBJ: Abortion policy

DATE: May 10, 1993

Because of the various votes that we will face in the coming months on abortion and choice issues, it is important that we come together and try to articulate a plan for the President to review. I have asked Bill Galston of my staff to convene a working group with you and/or representatives of your departments to serve as an ongoing coordinating point for this matter within the White House.

Please let Rosalyn Kelly in Domestic Policy know by the close of business Thursday, May 13 the name(s) of the person(s) in your department to be notified for a first meeting early next week.

Thank you.

cc: Bill Galston
Rosalyn Kelly

1) Joan Baggett x6257 - EOB 115

List for Choice Working Group Meeting

Legislative
Communications
Political
Public Liaison
Counsel
Cabinet
First Lady
DPC
OMB
HHS
Other

Susan Brophy ✓ 2230 (Eunice)
Ricki Seidman ✓ 2520 (Collier)
Joan Baggett ✓ 6257
Mike Lux ✓ 2920 / 7900
Steve Neuwirth ✓ 7900
Christine Varney ✓ 6280 (Laurie)
Melanne Verveer ✓ 6266 (Ann)
Carol Rasco, Bill Galston ✓
Nancy-Ann Min ✓
Jerry Klepner ✓ 690-6786 (Jill)
Mandy Grunwald ✓ 628-4235 (Jennifer)

HHS { Harriett Rabb
Jerry Klepner

THE WHITE HOUSE

WASHINGTON

May 10, 1993

MEMORANDUM FOR SUSAN BROPHY
RAHM EMANUEL
ALEXIS HERMAN
LORRAINE MILLER
BERNIE NUSSBAUM
CAROL RASCO
STEVE RICCHETTI
RIKKI SEIDMAN
GEORGE STEPHANOPOULOS
CHRISTINE VARNEY
MELANNE VERVEER

FROM: HOWARD PASTER *HP*

SUBJECT: ATTACHED DRAFT MEMORANDUM FOR THE PRESIDENT

I would welcome any comments you have on the attached draft memorandum by close of business Tuesday, May 11.

THIS FORM MARKS THE FILE LOCATION OF ITEM NUMBER 1
LISTED IN THE WITHDRAWAL SHEET AT THE FRONT OF THIS FOLDER.



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

CLOSE HOLD

May 26, 1993

pk.
*Rozj: Call Nancy-Ann
& tell her Rasco
is fine.
Let Galston
know of
my comment*

MEMORANDUM FOR CAROL RASCO

FROM: Nancy-Ann Min *NAM*
Associate Director for Health

SUBJECT: Family Planning/Abortion Q's and A's

I have attached a revised draft of Secretary Shalala's responses to the Q's and A's on family planning and abortion issues. This draft reflects comments I received from some of the members of our working group, as indicated in the margins.

I would appreciate it if everyone would give this one more careful look before we clear it for submission to the Congress.

Attachment

cc: Susan Brophy
Bill Galston
Steve Neuwirth
Melanne Vermeer
Ricki Seidman
Charlotte Hayes

Family Planning

(1) It was recently announced that Baltimore City Schools are expected to be the first in the nation to offer Norplant, a surgically implanted contraceptive, to teenage girls. The drug is expected to be offered to students at Laurence Paquin Middle and High School, and will eventually be expanded to the six high schools that have school-based health clinics on campus.

a. Do you support the distribution of Norplant to this population?

(FDA)
Norplant, a new implantable hormonal, long-term contraceptive, has been approved by the Food and Drug Administration as safe for use as a contraceptive method in the United States. Local community groups, including the Baltimore City Schools, may have a right to provide voluntary contraceptive services to sexually active individuals in compliance with any relevant Federal, State or local requirements, including informed consent requirements. However, I am not aware of any Federal restrictions on the provision of Norplant through the schools, nor would I support such restrictions at the national level.

b. Given the drug's short history, do you believe these minor girls should have to obtain parental consent before implanted with Norplant?

Norplant has been approved by the FDA as a safe, reversible family planning method. ~~These inserts can be removed~~ through a simple, outpatient procedure. ~~As with all other contraceptive services provided to adolescents through the Title X national family planning program, Norplant is available to adolescents who request such services on a confidential basis. I would, however, urge parents to become involved with their children's decisions whenever practicable.~~ As to remove the implant.

reversed

c. If you do not support parental consent before Norplant is distributed to minor girls, do you at least support parental notification before this new drug is distributed?

There are no Federal laws that require parental consent or notification for the provision of contraceptive services to minors. ~~nor would I recommend that Norplant~~ would not be singled out for such a requirement.

- d. Would you support using federal funds for this type of distribution?

Funding for the provision of Norplant is currently available through various Federal programs including Medicaid and the Title X national family planning program. Title X specifically requires that all family planning services to adolescents be provided in a confidential manner, and prohibits parental consent or notification requirements for the provision of such services. provided

- e. What if any restrictions would you place before federal funds could be used to distribute Norplant to minors?

(See above response)

Family planning

- (2) Section 1008 of the Public Health Service Act implementing the Title X Family Planning Act provides that: "None of the funds appropriated under this Title shall be used in programs where abortion is a method of family planning."
- a. How do you interpret this section of the law, which has not been altered since 1970?

The previous Administration's interpretation of this section of the statute lead to the so-called "gag rule", which has been the focus of much litigation and controversy. ~~Because we believe the rule~~ and which inappropriately restricted grantees, ~~I suspended them~~ (see insert 1 below) and proposed that the program return to the compliance standards operative prior to the issuance of the "gag rule" in 1988. The Department is currently reviewing comments received in response to the February, 1993 ~~its~~ Federal Register notice and working on the development of a new rule in accordance with the notice and comment provisions of the Administrative Procedures Act. As the Department's February, 1993 interim rule notes, the original interpretation of section 1008 (from the program's inception in 1970 up until the 1988 "gag rule") did not include a prohibition on non-directive counseling on abortion.

- b. Do you support regulations known as the "Gag Rule" which aim to separate abortion related activities from federally supported family planning activities? If not, do you support any limitations on the ability of clinics receiving federal funds to counsel and refer women for abortion in federally funded Title X clinics?

~~I support the President's efforts in which he directed~~ (see insert 2 below) ~~the Department to publish in the Federal Register --~~
 (1) a notice of proposed rulemaking (NPRM) proposing to return the program to the abortion policies and interpretations that were in effect prior to February 1988 and (2) an interim final rule suspending the "gag rule" and reinstating the pre-1988 policies pending the issuance of a final rule.

The Department has proposed that ^{the} compliance standards operative prior to 1988 be reinstated, including those set out in the Family Planning Program Guidelines which that require that in the event of an unplanned pregnancy, ~~and where the patient requests such action, that non-~~ directve counseling be provided to a client on all at her request, options relating to her pregnancy, including abortion, and to refer her for abortion, if that is the option she selects.

Insert 1: I therefore suspended the so-called "gag rule" and proposed that the program return to

Insert 2: See _____ The Department has published

Above response.

- c. Do you view the federal family planning program as preventive in nature?

Department believes that the ^{intended} Federal family planning program is ~~meant~~ to provide a broad range of acceptable and effective medically approved family planning methods and services to persons desiring such services. ~~These services must~~ ^{The Department's} be provided in a manner that does not subject ^{view is that these} individuals to coercion, deception or withholding of complete and accurate medical information about their health condition and legal options.

- d. Do you think it is important to separate abortion activities from legitimate family planning or preventive activities? How do you propose to separate abortion activities from legitimate family planning activities?

As the Department stated in the February, 1993 interim rule, we believe the 1988 "gag rule" would have required many grantees to make extensive, expensive and unnecessary alterations in their physical facilities and organizational structures. ~~We have proposed,~~ ^{that} ~~consistent with the longstanding Departmental interpretation and administration of the statute,~~ ^{we have proposed} Title X projects not be permitted to promote or encourage abortion as a method of family planning, and ~~that they~~ be required to maintain a separation (that is more than a mere exercise in bookkeeping) of their project activities from any activities that promote or encourage abortion as a method of family planning. The Department will consider this issue further ~~in response to the comment received when promulgating a new final rule/~~ in light of the comments received to its February, 1993 interim final rule.

- e. Should Title X clinics be permitted to perform abortions on the same site as the federally funded Title X clinic?

(See above response)

- f. Should personnel whose salaries are supported by federal funding be permitted to work in abortion related activities at the same site?

(See above response)

Family Planning

(3) Since its involvement in funding contraceptives and family planning, the Federal government has invested over \$2 billion to curb teenage pregnancy. Yet the rate of teenage pregnancy and sexually transmitted diseases afflicting teenagers continues to grow. Many experts feel it is time for us to admit this approach has not yielded the returns we had hoped, and to recognize that we have focused on the symptom of teen pregnancy rather than the root, which is teen sexual activity.

- a. What if anything will you direct the Department of Health and Human Services to do to curb the rate of teen sexual activity?

Adolescent pregnancy prevention is a priority within the Department in order to provide national leadership in ~~increasing~~ creating credible, reliable response to the problem. Toward this end, I have asked several experts in the Department to begin to design a strategy on teenage pregnancy in order to develop a strong adolescent pregnancy initiative.

- b. What role, should abstinence education play in this effort?

Abstinence is a legitimate public health approach to ~~delaying or~~ preventing early adolescent sexual activity ~~in order to prevent pregnancy and the transmission of~~ sexually transmitted diseases, including HIV infection. However, a broader, more comprehensive range of public health and social service approaches is needed to target these dual problems. ~~The impact of the abstinence-only message of the last decade has been minimal because it is laden with heavy moralistic tones. We need a significantly revised approach which includes among other things age-appropriate comprehensive sexuality education, comprehensive reproductive health information and services, school-based services, family life and life skills training, and on-going parenting education and family support efforts.~~

developing a

Abortion

- (1) What is your position on abortion?

~~Individuals have a right to complete and accurate medical information and unharrassed access to safe, legal medical services.~~

See insert 3 attached

- (2) Do you believe a woman should have a right to an abortion, for any or no reason, throughout the entire duration of pregnancy?

~~I support the right to privacy as articulated in the 1973 Supreme Court decision Roe v. Wade.~~

See insert 4 attached

- (3) Do you support reasonable restrictions on abortion such as parental consent for minors? What about parental notification?

~~Ideally, parents should be involved in decisions affecting the health and well-being of their children. In real life, however, such matters are not clear cut, and as with all such controversial matters, parental consent and notification requirements are a matter of continued policy debate both at the State and Federal level.~~

See insert 5 attached

- (4) What is your position on the Freedom of Choice Act?

~~This bill codifies the tenets of the Roe v. Wade decision legalizing abortion and defers to States on matters of parental involvement and public funding. The Department is reviewing this legislation, however, to date, we have no formal position.~~

See insert 6 attached

- (5) Do you support the 'Hyde' amendment which prohibits the expenditure of federal funds for abortion except in those cases where the mother's life would be endangered if the fetus was carried to term?

~~The Administration's FY 1994 budget request proposes repeal of the 'Hyde Amendment,' an annual HHS appropriations rider which has prohibited the use of any federal funds for abortions since the mid-70s. The Administration will be working with the Congress to provide for an approach that is consistent with Federal and State law.~~

include →

so-called does not

limited

Insert 3: The right of personal privacy is a fundamental liberty guaranteed and protected by our Constitution. The Government's role should be to reduce the need for abortion, not to interfere with the difficult and intensely personal decisions women must sometimes make with regard to abortion.

Insert 4: The application of the right to privacy in this content has been articulated by the Supreme Court in Roe v. Wade.

Insert 5: The Administration opposes any Federal attempt to limit access to abortion through mandatory waiting periods or parental or spousal consent requirements. The Administration supports State efforts to require some form of adult counseling or consultation for underage girls who choose to have an abortion -- as long as workable and effective bypass provisions are attached to such laws.

Insert 6: The Administration supports the Freedom of Choice Act, which codifies the tenets of Roe v. Wade.

(6) What is your position on RU-486?

~~I support the President's efforts in which~~ The President directed the Department to review the scientific basis for the import ban on RU-486 and to pursue initiatives that promote the testing, licensing, and manufacturing of RU-486 in the U.S. FDA has since lifted the ban and Roussel-Uclaf, the French manufacturer of RU-486, has agreed to license the drug to an American organization, the Population Council, to begin the process of clinical trials in the U.S.

FILED ABORTION

Orig: CHR

Xc: Galston

May 27, 1993

MEMORANDUM

To: Files
Fr: Sara
Re; Treatment of abortion

Bill → Pl.
Bring Sara up
to speed on the

From my experience with abortion as a health law issue, I can provide two basic legislative options.

work

to

date.

Thanks

CHR

1. Remain silent

Under this option, abortion would be treated like any other medical item or procedure under the new benefit plan. That is, our package would cover all medically appropriate abortions.¹

The term "medically appropriate", as we define it, is probably broader than the term "medically necessary".² That is, a medical appropriateness judgement might take in a broader view of a patient's overall health and psychosocial needs than a more narrow medical necessity standard.

Under an "appropriateness" standard, women who desire abortions for physical, psychological, or other reasons considered appropriate in the judgement of their provider,³ would be covered.

¹ Provisions such as the Hyde amendment are needed when lawmakers want to single abortions out for specific, differential treatment.

² I say "probably", because of my experience with medicaid abortion litigation in the 1970s. The first Hyde amendment was enacted because of early federal court rulings that medicaid covered elective abortions. These rulings probably were incorrect, given Medicaid's medical necessity standard. Regardless, the original Hyde amendment was enacted to limit abortions only to this that were medically necessary. However, the original language of the first "medical necessity" standard was so broad that most abortions could be justified as medically necessary. hence, the increasingly restrictive language throughout the 1970s, followed by other very restrictive language to other federal programs.

³ If we include a conscience clause, my suggestion is that we draft it to provide that any individual provider can elect not to perform the service but to also make clear that the AHP either has to find the woman another participating provider who does offer the service or else pay for the procedure on an "out-of-plan" basis. In other words, we do not want AHP corporate entities to be let off the hook simply because they enroll individual providers who refuse to honor a provision in their patients' contracts.

Absolutely elective abortions would not be covered.⁴

2. Override the medical appropriateness standard for abortions

If we want to fund purely elective abortions, we will have to draft an abortion-specific exception to the otherwise applicable "medical appropriateness" standard that applies to all other items and services under the bill. In other word, we could say something like :

"Except in the case of termination of pregnancy, which shall be at the election of the patient, no item or service shall be covered unless medically appropriate".

This language would achieve elective coverage, but would place abortion in a category not commonly found in health insurance.

It is common for private health insurance plans to contain medical appropriateness standards. To the extent that abortions are paid for, this probably is because a physician notes in the woman's record that there is some type of medical need. In other cases, abortions get paid for "under the table" as dilation and curettage because of suspected problems. In other words, someone basically misrepresents the woman's condition in order to cover her procedure.

⁴ After my experience with abortion litigation, I am still not sure from a legal viewpoint of how many absolutely elective abortions do in fact occur. I think that most women who have "elective" abortions would say they did so because they just could not handle having a child. To perform an abortion under these circumstances would be consistent with the "medical appropriateness" standard, since it would be grounded in preserving the patient's overall psychological health.

THE PRESIDENT HAS SEEN 5/21

THE WHITE HOUSE
WASHINGTON

May 20, 1993

Handwritten notes:
SLED shown
UP Handwritten
g. try to
discuss - (Hollinger memo)

MR. PRESIDENT:

file

The attached is a decision memo on abortion related issues written by Bill Galston on behalf of a Domestic Policy Council working group that includes representatives from the First Lady's Office, the Vice President's Office, Domestic Policy, Communications, Legislative, Political, Counsel's Office, Public Liaison, Cabinet Affairs, HHS and OMB.

The memo discusses various federal funding issues that are coming up -- including the Hyde Amendment and other appropriations issues -- as well as the Freedom of Choice Act.

Because the working group already includes representatives from the relevant departments and because this memo is highly sensitive, I have, for the time being, limited its circulation to Mack and the Vice President.

Carol Rasco wanted you to see this memo tonight so that she could discuss it with you tomorrow morning.

TDS
Todd Stern

cc: Vice President
Mack McLarty

COPY
from ORM

THE WHITE HOUSE

WASHINGTON

May 20, 1993

93 MAY 20 P8:52

MEMORANDUM FOR THE PRESIDENT

FROM: BILL GALSTON

SUBJ: ABORTION-RELATED ISSUES

Action-forcing Events

During the next few months, you will face a long list of decisions concerning abortion and abortion-related issues. Many of these decisions relate to federal funding, an issue that arises in at least half a dozen appropriations bills (see Tab A). Chairman Natcher has requested guidance from the White House concerning these bills by early next week. Other key decisions involve the Freedom of Choice Act, the content of the health care basic benefits package, and the Supreme Court nomination.

Many of the appropriations issues are likely to be narrowed, or eliminated altogether, when health care reform is enacted. Nonetheless, they must be addressed as freestanding issues this year in the context of the annual appropriations process.

In recent weeks, pressures to clarify our substantive positions and strategic intentions concerning abortion-related questions have been steadily intensifying. In response, the Domestic Policy Council has brought together an informal working group representing numerous departments within the White House as well as HHS and OMB. The members of this group include Ricki Seidman (Communications), Melanne Verveer (Office of the First Lady), Charlotte Hayes (Office of the Vice President), Doris Matsui (Public Liaison), Christine Varney (Cabinet Affairs), Susan Brophy (Legislative Affairs), Joan Baggett (Political Affairs), Carol Rasco (Domestic Policy Council), Steve Neuwirth (Counsel's Office), Jerry Klepner (HHS), Harriet Rabb (HHS), and Nancy-Ann Min (OMB). This memorandum--the first of a series--contains background information on key issues as well as recommendations and options for your consideration.

Political Context

Within your administration, there is a broad consensus that while we should deal with choice issues in a principled and consistent manner, we must make every reasonable effort to lower their public profile for the remainder of this year. There are two principal justifications for this view.

First, it is essential, so far as possible, to keep focused on the economic plan until it has made it through the Congress. The last thing we need is an ongoing heated controversy that divides our energies and diverts the public's attention while reinforcing their view that we're not spending enough time on the economy.

Second, it is essential to regain our balance on cultural matters. During your campaign, you reassured the American people that you identified with mainstream/heartland values, but the first four months of the administration have sown some doubts on that score. There may be worse to come. We face the possibility of a summer in which the political dialogue is largely framed by issues such as gays in the military, political correctness on campus, quotas, and reproductive services contained within a health care proposal. For this reason, while the administration should remain true to its principles, we should not go out of our way to emphasize issues that reinforce the impression that we are somehow outside the cultural mainstream.

In this connection, it is worth noting that the people now distinguish fairly sharply between choice, which they support within broad limits, and public funding, which they are much less likely to support. Even when our position on public funding is carefully framed, we are sure to encounter substantial difficulties in forging sustainable majorities in the Congress and in the court of public opinion.

An Easy Case: Federal Employee Health Benefit (FEHB) Plans

Under current law, FEHB plans (affecting federal employees and dependents) may not cover abortions unless the life of the mother is in danger. The DPC working group recommends that this restriction be eliminated. The result would be that FEHB plans would be allowed but not required to cover a wider range of abortion services. In most circumstances, federal employees would be able to choose among several plans with varying levels of coverage.



Decision on FEHB Recommendation

Accept

Reject

Discuss

A Harder Case: The Hyde Amendment

A. Substantive Issues

Your campaign made a determined effort to subsume federal funding issues under the rubric of national health care reform. You recognized, however, that they would persist as free-standing issues until the enactment of that reform. You now face the question of how to deal with the Hyde amendment.

During the campaign you opposed laws that prohibit federal funding for abortion. At the same time, you favored substantial leeway for the states to chart their own course. That is why your proposed budget simultaneously deletes the Hyde amendment and declares that "the Administration will work with the Congress to facilitate an approach that is compatible with both Federal and State law."

The difficulty is that these two bodies of law are frequently incompatible. For example, Medicaid requires states to provide all "medically necessary" services to eligible beneficiaries. Simply removing the Hyde amendment from federal legislation would almost certainly compel many states to fund abortions that they now exclude through either statutory or (as in the case of Arkansas) constitutional provisions. There is no way of fully harmonizing federal and state law as now written. The question, rather, is how they can be adjusted to reach mutual consistency.

Your DPC working group recommends that all states be required to fund Medicaid abortions in cases of rape, incest, and when the mother's life is endangered. Beyond these cases, each state should be left free to make its own determination.

The rationale is as follows: Even the Hyde amendment permitted abortions to relieve threats to mothers' lives, while rape and incest represent conditions for publicly funded abortion that enjoy substantial public support. A move to restore the original Hyde amendment would probably succeed in Congress if the alternative is simple deletion; substitute language that includes rape and incest would offer a better chance of defeating Hyde. Our proposal would establish that language as a federal baseline while not tying the hands of the states (now numbering 15) that want to go farther.

Decision on Hyde Language

*Any of just
to delete Hyde
Original Hyde*

✓

Accept

Reject

Discuss

B. Strategic Issues

There are two options for reaching this language as a legislative result. The first is to take the lead--to announce our legislative objective promptly and forthrightly, starting with Chairman Natcher, and to deploy our resources on the Hill to reach that objective during the next two months. The second is simply to restate our commitment to deleting Hyde and to working with the Congress to craft more satisfactory language. Under the second option, we would in effect be asking the Congress to make the opening bid, and we would be prepared to intervene later with our language as an alternative to reinstating Hyde.

The advantage of the first option is that it allows you to demonstrate leadership by acting clearly and decisively in a hotly contested arena. The disadvantage is that it could offend nearly everyone, at least initially. In particular, it would dismay many of your pro-choice supporters by putting you in the position of sponsoring abortion coverage that is arguably narrower than the criterion of "medical necessity" built into the Medicaid statute.

*Q&A
N/A*

An advantage of the second option is that it preserves your freedom of action to forge consensus over time. Another advantage is when you offer your substantive recommendation during the course of the Hyde debate, it might well be seen, not as selling out our pro-choice supporters, but rather as rescuing them from a straightforward reinstatement of the Hyde amendment. A disadvantage of this option is that it could be seen, and represented, as evasive and lacking in principled leadership.

The DPC working group recommends option two, with two conditions. First, we cannot say that we are working with the Congress unless we are actually doing so. To implement option two, we would have to enter substantive discussions on this matter with key congressional leaders--promptly.

Second, you would need a public articulation of your position that takes account of the undeniable difficulties and that you could sustain until the actual legislative resolution. We recommend the following as a response to questions:

"As I made clear in my budget proposal, I don't think the Hyde amendment should be reinstated. I've also stated that my administration is committed to working with the Congress to find an approach that respects both federal and state law. I'm well aware of the fact that these bodies of law aren't fully consistent, but I'm confident that we can work out a solution that both protects the principle of choice and respects the deep and legitimate differences that exist among the states as well as among individual citizens. Discussions to achieve this result are now underway."

Decision on Hyde Strategy

*What Ben Halliday
Thinks*

Option 1

Option 2

Discuss

Other Appropriations Issues

The remaining appropriation bills differ from Medicaid in that they do not raise federal-state issues. (Some, such as DC appropriations, now restrict the use of local as well as federal funds.) Otherwise, the substantive and strategic issues are very similar.

Our recommendation concerning these bills is that we declare our willingness to work with the Congress and that we adopt as our practical objective (1) the relaxation of restrictions on federal funding to include rape and incest as well as the life of the mother, and (2) where appropriate, local choice in determining the use of local funds.

Qeyun

SAUCM
MGRAMS
FROM OYUN
YONKIN

Two forthcoming bills raise special issues. We have just been informed that the Department of Defense is prepared to include a repeal of the Hyde amendment in its Authorization Bill. We will work with them to ensure, so far as possible, that the language respects the particular circumstances and sensibilities of the military.

Funding for abortion in foreign aid programs also raises a distinctive issue. As you know, the People's Republic of China has come under persistent criticism for alleged use of involuntary sterilization and forced abortion as part of a population control strategy. Your budget proposal deletes language that forbids U.S. funding for overseas programs that provide abortions as an element of voluntary family planning. But the remaining language is unequivocal in its rejection of coercive measures. Public testimony by AID officials and others should be crystal-clear on this point. And if, as some have suggested, the U.N Population Fund is sufficiently disturbed by Chinese practices to consider withdrawing from that country altogether, we should be supportive of their decision to do so.

YH

Freedom of Choice Act

As you know, the Freedom of Choice Act represents a major effort to codify the holding of Roe as interpreted prior to the Webster and Casey decisions. The Senate version of the bill has already been marked up by the full Labor and Human Resources Committee. It allows states to require parental involvement with minors' decisions and to decline to pay for the performance of abortions. It also includes a so-called "conscience clause" preventing states from imposing an obligation to perform abortions on individual doctors and institutions (such as Catholic hospitals) with principled objections to this practice. The House version of the bill, which was marked up and passed out this Wednesday, incorporates the conscience and parental involvement clauses but not the provision allowing states to decline to pay for the performance of abortions.

While these points are opposed by some advocacy groups, they are consistent with Roe and are supported by mainstream advocacy groups such as NARAL. (For additional details, see Tab B.)

During the campaign, you pledged to sign a Freedom of Choice Act along the lines of the bills reported out of the Senate and House committees. While there is a significant difference between the two versions, at this point the principal issue before us is one of timing and legislative strategy, not substance. Advocacy

groups who are longstanding supporters take the position that they refrained from bringing the bill to the floor last fall in deference to the campaign's request for delay. Now, they say, we owe it to them to intervene with the House and Senate leadership to move the bill quickly; the leadership is looking for a signal from the White House and is unlikely to move forward without one.

The counterargument runs as follows:

(1) We are already being criticized for an overly crowded agenda, and we don't need another big, controversial item that further diverts attention from the economic plan.

(2) You have already acted aggressively to further the pro-choice agenda, and you face a large number of abortion-related appropriations votes in the next few months. If you encourage a postponable abortion debate to surface during this period, it will rivet public attention on this issue and reinforce your emerging cultural disconnect with ethnic and other swing voters.

(3) We should focus our attention this summer on the unavoidable battle over the inclusion of reproductive services in the basic health benefits package.

(4) The principal reason why FOCA didn't come to the floor last year was that its backers didn't have the votes, and it's still not clear that they do. Speaker Foley has said that he will not bring the bill to the floor unless he is confident that it can pass without killer amendments. The number of close votes in the Judiciary Committee this Wednesday suggests that this is not yet the case and that more work needs to be done.

On balance, we believe that the arguments for delay are stronger than the arguments for moving forward at this time, and we so recommend. You should be aware, however, that many of your pro-choice supporters are likely to regard a decision not to proceed at this time as a deep disappointment--if not an outright betrayal. Should you choose to delay the bill significantly, they may go public with very vocal objections.

Decision on FOCA Strategy


Delay

Go Forward

Discuss

ABORTION-RELATED GENERAL PROVISIONS

<u>Appropriation Bill</u>	<u>Current Status</u>	<u>Affected Population</u>
Labor-HHS General Provisions Sec. 103	Federal funding allowed only when the life of the mother is endangered if the fetus is carried to term.	Medicaid, Indian Health Service, and PHS grantee clients
D.C. Appropriation Bill	Funding allowed only when the life of the mother is endangered if the fetus is carried to term. (Includes local tax funds).	D.C. residents who would otherwise receive non-Medicaid funding for abortions
State-Commerce-Justice General Provisions Sec. 103, 104, 105	Federal funding allowed only when the life of the mother is endangered if the fetus is carried to term. Also provides that "no funds shall be used to require any person to perform or facilitate an abortion; " but permits funds for escorting to abortion services outside the Bureau of Prisons.	INS detainees, sentenced and pre-sentenced prisoners, transitionally housed asylees, special witnesses and families protected by DOJ, and inmates
Treasury-Post Office appropriation bill, Sec. 513, 514 of Title 5	FEHB plans may not cover abortions unless the mother is endangered if the fetus is carried to term.	Federal employees and dependents
DOD-United States Code, Sec. 1093 of Title 10,	Federal funding allowed only when the life of the mother is endangered if the fetus is carried to term.	Military personnel and dependents
Foreign Aid--H.R. 5368 Foreign Operations, PL 102-391, Sec 524 and 534 (Kemp-Kasten Amendment)	No funds shall be used for : 1) abortions, 2) to lobby for abortion, or 3) involuntary sterilization as a method of family planning or as incentive to undergo sterilization.	Peace Corps workers and countries receiving U.S. foreign assistance

WASHINGTON UPDATE

Policy and Politics in Brief

THOSE WINDS OF CHANGE ARE TRICKY

BY ELIZA NEWLIN CARNEY

Just as abortion-rights groups should be relishing the fact that there is at last a President who supports their agenda, they're threatened with the loss of one of their most prized goals: a law ensuring women's right to abortion.

The so-called Freedom of Choice Act, which essentially would codify the Supreme Court's 1973 *Roe v. Wade* ruling

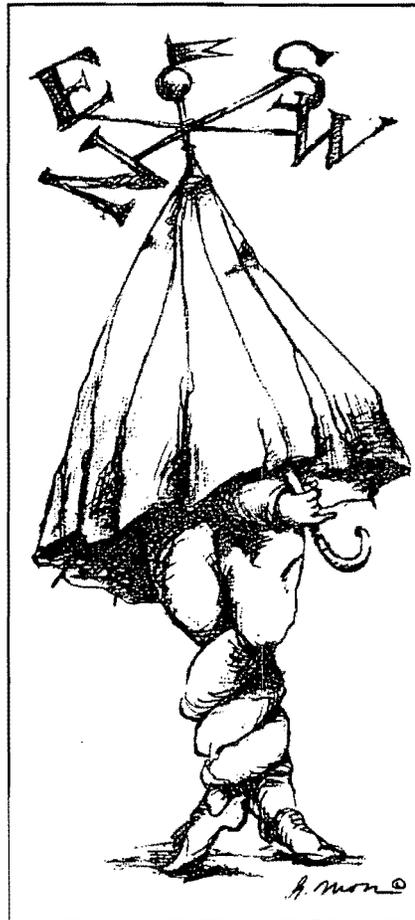
ABORTION that legalized abortion, may never reach the floor this year, House Speaker Thomas S. Foley, D-Wash., said at an April 22 press conference. Foley cited lack of support for a rule that would limit amendments likely to weaken the bill.

The uncertain fate of the bill—which is scheduled to be taken up by the House Judiciary Committee later this month—points up deep divisions in Congress over how far the government should go in restricting abortion rights. It also signals a bitter struggle ahead over pending questions such as whether Congress should allow federal spending on abortions and whether abortion services should be included in a national health care plan.

"This is a very difficult issue still," said Rep. Don Edwards, D-Calif., chairman of the Judiciary Subcommittee on Civil and Constitutional Rights and the Freedom of Choice Act's primary sponsor in the House. "The general public is in favor of choice for women, but to some extent they are ambivalent about certain limitations that the states want to put on it."

In theory, the 103rd Congress is a golden opportunity for abortion-rights advocates who've been frustrated for 12 years by an anti-abortion White House. On his second day in office, President Clinton signed five executive orders rolling back a slew of federal abortion restrictions, including the "gag rule" banning abortion counseling in government-financed clinics.

Clinton's also promised to work with Congress to repeal a law that bars medi-



caid-financed abortions for poor women; appoint a *Roe v. Wade* supporter to the Supreme Court; and include abortion financing in his national health care program. Congress and the Administration have also proposed measures to improve clinic access and safety, spurred in part by the March murder of David Gunn, a physician who performed abortions at a Pensacola (Fla.) clinic.

But instead of gaining momentum, abortion-rights advocates find themselves suddenly on the defensive, losing money, membership and support on Capitol Hill. In part, their struggle reflects the pitfalls of being on the winning side. "With the victor goes the spoils," Kathryn Colbert, vice president of the Center for Reproductive Law and Policy in New York City, said wryly.

In part, groups like the National Abortion Rights Action League (NARAL) and the Planned Parenthood Federation of America Inc. are hurt by public sentiment that the abortion battle is over.

"The greatest threat to choice is complacency," said Kate Michelman, president of NARAL, where donations from direct-mail fund raising are down a third from this time last year.

The abortion debate has also shifted ground from simple questions of legality to such thorny areas as whether taxpayers should foot the bill for abortions or whether parents must be notified before their underage daughters can obtain an abortion. Polls show that many voters who support abortion rights in general also favor some restrictions. A July CBS News-*New York Times* poll found that 56 per cent of respondents supported state laws limiting abortion's availability, and 52 per cent opposed using tax dollars to finance poor women's abortions.

On the Freedom of Choice Act, abortion-rights groups have been undermined by internal bickering. NARAL and Planned Parenthood lead a coalition that strongly backs both the House and Senate versions of the bill; the National Organization for Women (NOW), allied with several other women's and public-interest groups, opposes Senate provisions that would allow states to pass laws that require parental involvement and bar the use of state funds for abortions.

"Our position has always been that we wanted a bill that would not encourage the states to treat young women and poor women differently," said Ginny Montes, national secretary of NOW, which is joined by the American Civil Liberties Union and the Fund for the Feminist Majority in opposing the Senate bill.

But the legislation's supporters say it won't pass if language that allow states to restrict abortions is ruled out entirely. Edwards said he plans to introduce a measure clarifying that states may continue to require parental involvement, when the House Judiciary Committee marks up the bill. "All of our polls and whip checks indicate that the *Roe* provision on parental involvement must be in the bill, or we lose literally scores of votes," Edwards said.

And while abortion-rights advocates are fighting among themselves, the anti-abortion lobby is more organized than ever, presenting a unified front and flooding both chambers with mail. A well-organized postcard campaign by the Committee for a Human Life Amendment, a Washington lobby group backed by

U P D A T E

Catholic dioceses nationwide, contributed to a serious Capitol Hill mail backlog, House post office director Michael Shinay said. The campaign generated about 1.5 million postcards on the Freedom of Choice Act, he estimated.

"All the pro-life forces are united on at least three priorities: defeating the Freedom of Choice Act, preserving the Hyde Amendment [a proviso named for its sponsor, Rep. Henry J. Hyde, R-Ill., that bans medicaid financing for poor women's abortions] and preventing Clinton from imposing abortion coverage through the national health plan," said Douglas Johnson, legislative director of the National Right to Life Committee. "We're guardedly optimistic that the President may fail on all three of those fronts."

Freedom of Choice Act backers counter that Clinton's support, along with that of a new generation of women in Congress, bodes well for the measure. Many of the freshman women made abortion rights a central campaign theme, Rep. Nita M. Lowey, D-N.Y., said.

"The increase in women Members automatically brings a new perspective and urgency to the issue," said Lowey, who heads the Pro-Choice Task Force of the Congressional Women's Caucus.

But some Members of Congress admitted that sharp disagreements over strategy persist. Some bill backers want a closed rule that would allow no amendments once the bill reaches the floor. (The purpose would be to prevent anti-abortion lawmakers from weakening the bill beyond recognition.) Others say that lim-

ited amendments should be allowed. With no agreement, the legislation may die quietly.

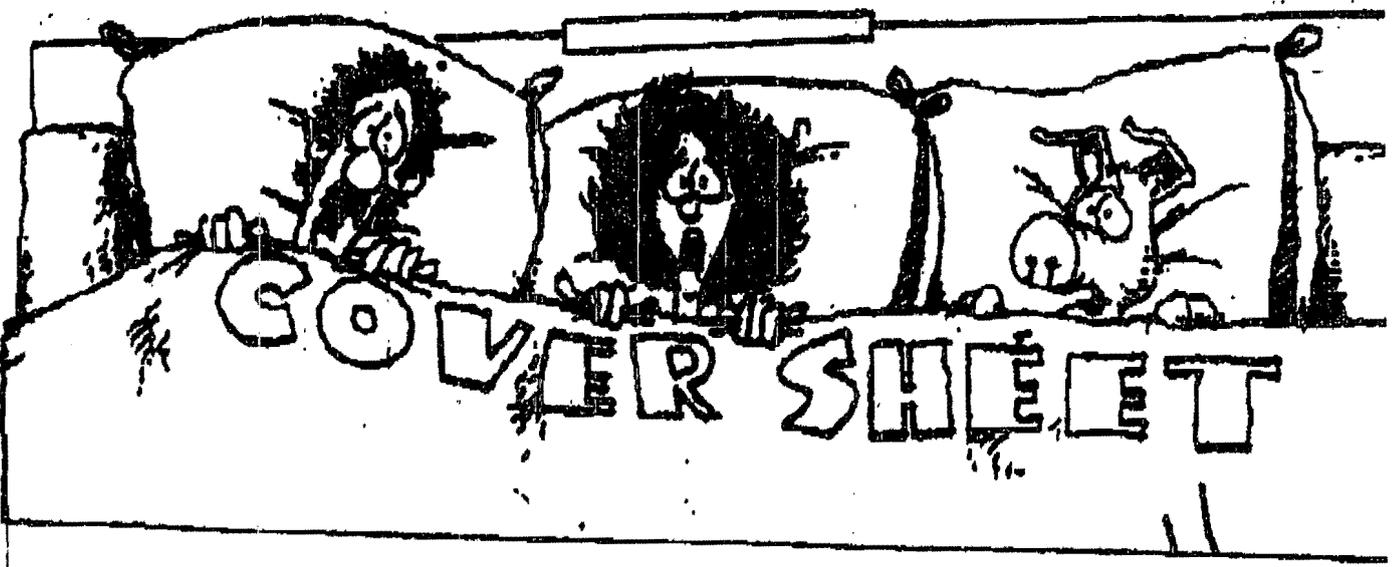
Abortion-rights advocates admit that the bill faces an uphill fight and are pushing for quick action by House and Senate leaders. Some fear that debate over the legislation and over the Hyde amendment will be heated, possibly weakening the Administration's resolve to include controversial abortion provisions in its health care package.

"In my view, we have a challenge ahead of us," said the Center for Reproductive Law and Policy's Colbert. "We need to convince legislators that these restrictions are very pernicious and that they ought not to be enacted at the state level. The problem is that, that's not a 30-second soundbite." ■

cc: Bill Galston

Free Abortion

DEC 30 REC'D



TO: Carol Raslo FOR INFORMATION CALL:

FROM: Ray Hanley

PAGES (including cover sheet): FAX



P6/(b)(6)

pr



STATE MEDICAID DIRECTORS' ASSOCIATION

December 30, 1993

Bruce Vladeck, Administrator
Health Care Financing Administration (HCFA)
H. H. Humphrey Building - Room 314G
200 Independence Avenue, S.W.
Washington, D.C. 20201-0001

Dear Bruce:

RE: Abortion Mandate

On behalf of the State Medicaid Directors' Association, I am writing to express strong objection to HCFA's decision to mandate all states extend abortion coverage to cases of rape and incest. Based on the attached Section 509 of the 1993 Appropriation Act, it seems very clear congressional intent in this area was to be permissive for states, not mandatory.

A number of states would have likely picked up the referenced expanded abortion coverage as an optional service for which the congressional appropriation language would have allowed FFP. On the other hand some states, for different reasons, would not elect to expand abortion coverage -- again in keeping with the optional nature of the appropriation language.

This situation imposes another unfunded federal mandate with apparently no notice or allowed time for comment. The unfunded mandate seems in clear violation of President Clinton's Executive Order Number 12875 dated October 23, 1993. This commitment was strongly restated as recently as November 18 by a letter from the President to Utah's Governor Mike Leavitt. I have attached a copy of this letter and would request your explanation of this apparent conflict between the President's pledge and HCFA's actions on this new mandate.

I would further question why HCFA would rush draft guidelines out on such a controversial issue within days when it takes months, or in the case of Boren -- years, to get guidelines out on many other program changes, some clearly mandates, which resulted from congressional action. States first advance notice of this mandate came from last weekend's newspapers. It was then necessary for HCFA to FAX states the mandate guidelines, normal mail delivery would have lagged behind the January 1 effective date.

I must also point out that Section 509 of the Appropriation Act makes no reference to Medicaid. This raises the question of what the language

An affiliate of the American Public Welfare Association
810 First Street, N.E., Suite 500, Washington, D.C. 20002-4205 (202) 682-0100

Letter to Bruce Vladeck
December 30, 1993
Page 2

does address. How far reaching is it to be? Does it also apply to Title X Family Planning funds? Title V MCH dollars? Educational funding? Have the federal agencies governing these programs also issued a mandate similar to HCFA's?

As we engage national debate on the President's broad health care reform plan, in which a key area is to be state flexibility, I would urge you to reconsider the decision to mandate the coverage expansion and to issue the regulation in the form of an optional benefit as it seems was congressional intent. Should the mandate decision stand, I would respectfully request in written form, along with answers to all questions I've raised, the legal rationale HCFA would cite for issuing the mandate for this expansion.

The legal authority is a crucial question as it seems clear HCFA lacks statutory authority for this mandate -- the directive is based solely on the appropriation language of a permissive rather than mandatory wording that doesn't even mention Medicaid -- there is no public law basis. At least ten states must obtain legislative authority before state matching funds may be used for abortion coverage not required to save the life of the mother. HCFA's directive clearly doesn't allow time for such action and boldly threatens loss of all federal funds unless state plans are filed within 90 days removing all barriers to the expanded abortion coverage.

Thank you for addressing these concerns promptly.

Sincerely,



Ray Hanley, Chairman
State Medicaid Directors' Association

RH/b

Attachments

cc: State Medicaid Directors
Carol Rasco, The White House
Carl Volpe, NGA
Sally Richardson, HCFA Medicaid Bureau Director

THE WHITE HOUSE
WASHINGTON

November 18, 1993

*Charlie -
This should be
circulated -
now*

The Honorable Mike Leavitt
Governor of Utah
Salt Lake City, Utah 84114

Dear Governor Leavitt:

As part of our efforts to forge a more responsible and coordinated intergovernmental relationship, it gave me great pleasure to sign Executive Order No. 12875 on October 26, 1993. This directive marks the beginning of our efforts to relieve state and local governments from the imposition of unfunded mandates, to increase the flexibility of federal programs, and to create a meaningful consultation process.

Under this executive order, federal agencies and departments are required to provide state and local governments with adequate funding to cover the cost of compliance with federal regulations. Otherwise, agencies must justify to the Office of Management and Budget the imposition of the mandate, including an account of the affected governmental entities' concerns. In addition, this order directs agencies to look favorably upon requests for waivers of federal statutory or regulatory requirements and compels them to issue timely decisions on such requests.

In conjunction with my recently issued executive order on Regulatory Planning and Review, Executive Order No. 12875 is a significant step toward building a more effective intergovernmental partnership. With your continued support for these critical efforts, we will achieve this goal.

sincerely,

Bill Clinton

Was this done? How?



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington D.C. 20201

File: Abortion

FACSIMILE

DATE DEC 28 1993

TO: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Carol Rasco
Assistant to the President
for Domestic Policy

456-2216

FROM: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Kevin Thurm
Chief of Staff

690-6133

RECIPIENT'S FAX NUMBER: () 456-2878

NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET): 4

COMMENTS:

FYI - To be released by 3:30 P.M. today.

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Tuesday, December 28, 1993

Contact: Faye Baggiano
202-690-8390

The Health Care Financing Administration today informed state Medicaid directors that a new federal law requires their programs to pay for abortions when pregnancies have resulted from rape or incest.

Previously, states were required to cover abortions only when the life of the mother would have been endangered by continuation of the pregnancy. The new policy implements a provision in the Health and Human Services Appropriations Act for fiscal year 1994, passed by Congress in October.

In the letter to the state officials, HCFA Medicaid Director Sally K. Richardson said that "as with all other mandatory medical services for which federal funding is available, states are required to cover abortions that are medically necessary.

"By definition," she said, "abortions that are necessary to save the life of the mother are medically necessary. In addition, Congress this year added abortions for pregnancies resulting from rape and incest to the category of medically necessary abortions for which funding is provided."

The directive advises states that they need to bring their rules on Medicaid abortions into conformity with the new federal law. The policy change is retroactive to Oct. 1, 1993.

Attached is a copy of the letter.

#



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

8325 Security Boulevard
Baltimore, MD 21207

December 28, 1993

Dear State Medicaid Director:

The purpose of this letter is to notify you about a recent Congressionally enacted revision to the "Hyde Amendment" which affects the Medicaid program and to tell you how this revision in the law is to be implemented.

Effective October 1, 1993, as part of P.L. 103-112, the Health and Human Services Appropriation bill, Congress passed a revision of the Hyde Amendment pertaining to Federal funding of abortions under the Medicaid program. As enacted, the provision states:

None of the funds appropriated under this Act shall be expended for any abortion except when it is made known to the Federal entity or official to which funds are appropriated under this Act that such procedure is necessary to save the life of the mother or that the pregnancy is the result of an act of rape or incest.

Thus, Federal funding (FFP) is now available for abortions performed to save the life of the mother or to terminate pregnancies resulting from rape or incest when the claim for such an abortion is paid by the State on or after October 1, 1993. Please note that it is the date that the State pays the claim and not the date of the service which determines the availability of FFP.

In order to implement this provision of the law, we are requesting that beginning with the first Quarterly Expenditure Report (HCFA-64) for fiscal year (FY) 1994 in January, States submit to the Health Care Financing Administration (HCFA) regional office (RO) a form certifying the number of abortions for which FFP is being claimed. The form should outline the number of abortions performed to save the life of the mother, the number performed for a pregnancy resulting from an act of rape, and the number performed for a pregnancy resulting from an act of incest. This certification should be submitted to the RO on a quarterly basis with the completed HCFA-64.

Current regulations at 42 CFR 441.203 and 441.206 require that before FFP can be made available, the State must obtain a signed physician's certification that, based on the professional judgment of the physician, the abortion was necessary because "the life of the mother would be endangered if the fetus were carried to term." Because the language of the current Hyde Amendment differs somewhat from its predecessors, the State must change the wording of the physician's certification to comport with the current statutory language. With regard to this portion of the Hyde Amendment, the new legislative language, "to save the life of the mother", has essentially the same meaning as the previous legislation.

Page 2 - State Medicaid Director

As with all other mandatory medical services for which Federal funding is available, States are required to cover abortions that are medically necessary. By definition, abortions that are necessary to save the life of the mother are medically necessary. In addition, Congress this year added abortions for pregnancies resulting from rape and incest to the category of medically necessary abortions for which funding is provided. Based on the language of this year's Hyde Amendment and on the history of Congressional debate about the circumstances of victims of rape and incest, we believe that this change in the text of the Hyde Amendment signifies Congressional intent that abortions of pregnancies resulting from rape or incest are medically necessary in light of both medical and psychological health factors. Therefore, abortions resulting from rape or incest should be considered to fall within the scope of services that are medically necessary.

The definition of rape and incest should be determined in accordance with each State's own law. States may impose reasonable reporting or documentation requirements on recipients or providers, as may be necessary to assure themselves that an abortion was for the purpose of terminating a pregnancy caused by an act of rape or incest. States may not impose reporting or documentation requirements that deny or impede coverage for abortions where pregnancies result from rape or incest. To insure that reporting requirements do not prevent or impede coverage for covered abortions, any such reporting requirement must be waived and the procedure considered to be reimbursable if the treating physician certifies that in his or her professional opinion, the patient was unable, for physical or psychological reasons, to comply with the requirement.

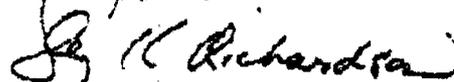
States which have State Plan language more restrictive than that provided for under the revised Hyde Amendment may qualify for Federal funding for the first quarter of FY 94 if they submit approvable State Plan language changes by December 31, 1993.

By March 31, 1994, all States must ensure that their State Plans do not contain language that precludes FFP for abortions that are performed to save the life of the mother or to terminate pregnancies resulting from rape or incest.

As you know, it is necessary for States to adhere to all conditions for Federal Medicaid funding. As part of its ongoing State assessment and audit programs, HCFA may include reviews of abortion claims, if necessary, to assure compliance with these conditions.

Please call my office if you have any questions about this matter.

Sincerely yours,



**Sally K. Richardson
Director
Medicaid Bureau**

cc: All Regional Administrators

December 28, 1993

TO: Mark Gearan/Communications

FROM: Bill Galston

SUBJ: Questions and Answers on HHS/Medicaid Funding

Question: What's going on? Why is the Administration proposing these new regulations?

Answer: Very simple. Congress passed legislation slightly relaxing the restrictions contained in the Hyde Amendment. As the responsible agency, the Department of Health and Human Services is simply moving to implement this change.

Question: Come on, isn't this a major policy shift?

Answer: No. Under Medicaid, the states have been required to fund medically necessary services unless otherwise prohibited from doing so. Now HHS is applying this settled principle to the somewhat narrower prohibition Congress adopted this year.

Question: But doesn't this contradict assurances the Administration previously gave to members of Congress?

Answer: Not at all. This issue arose a few days ago when a right-to-life group claimed that Sen. Bob Kerrey had received such assurances. But over the weekend, Sen. Kerrey rejected this claim and embraced the new HHS policy. He said, "It's in fact in keeping with what an awful lot of supporters of the Hyde amendment were actually advocating."

Question: Doesn't this jeopardize the Administration's health care bill?

Answer: Absolutely not. We're talking about a relatively small change in the implementation of the current Medicaid program. It's a different and separate issue.

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Government of Prime Minister Yitzhak Rabin at a time when it is facing criticism from the Israeli right for its efforts to establish a peace settlement with Palestinians.

Military and intelligence officials, on the other hand, have long been opposed to any leniency for Mr. Pollard. Mr. Aspin's letter, which was made available to a reporter by a Pentagon official opposed to Mr. Pollard's early release, begins by expressing concern about a compromise suggested by the Justice Department that would keep Mr. Pollard in prison for now but reduce his sentence.

The compromise, still being debated within the Administration, would make Mr. Pollard eligible for release sometime within the next seven years.

By 1995, Mr. Pollard will have been in prison for 10 years and will be eligi-

from prison because he "has continued to release classified information."

"His mail from prison is monitored, pursuant to his plea agreement," Mr. Aspin said. "Since July 1989, he has included classified information in 14 of his letters, most recently in 1992, including information classified at the Top Secret Codeword level. He clearly remembers classified information which he still has the ability to compromise."

Top Secret Codeword refers to highly restricted information from such sources as satellites and electronic eavesdropping devices.

Mr. Aspin said there were "ample indications" that Mr. Pollard might emigrate to Israel if released. "Especially, if he leaves the country, Mr. Pollard would continue to present a risk of further damage to the nation," the letter said.

Kerrey Backs New Rule Requiring States to Pay for Some Abortions

Special to The New York Times

WASHINGTON, Dec. 26 — Senator Bob Kerrey of Nebraska, countering a statement by an anti-abortion group, says he does not believe that the Clinton Administration violated assurances to Congress when the White House decided to require states to pay for some abortions for poor women.

Over the weekend, an abortion opponent, Douglas Johnson, the legislative director of National Right to Life, pointed to a letter by Senator Kerrey as proof that the Administration had gone back on its word that the states would maintain the right to keep abortion out of their Medicaid programs.

In September, Congress eased the ban on Federal financing for abortions by allowing the Government to pay for abortions for Medicaid recipients in cases of rape or incest or when the life of the pregnant woman is in danger. The Administration had sought to repeal the ban, the Hyde Amendment, named for Representative Henry J. Hyde, Republican of Illinois.

Bruce C. Vladeck, head of the Federal Health Care Financing Administration, which runs Medicare, said on

Friday that the Administration was preparing regulations that would require states to pay for such abortions, which would number about a thousand a year.

Mr. Johnson quoted Senator Kerrey in a letter to Metro Right to Life in Omaha as saying he had "received personal assurances that in the absence of the Hyde Amendment, states like Nebraska, which do not allow state funds to be used for abortions, would not be required to accept Federal funds for such procedures."

But Senator Kerrey said in a telephone interview on Sunday night that the letter concerned the amendment's repeal. "The question was asked whether states would be able to impose additional restrictions," he said. "The Administration said it would not coerce states to pay for abortions in all circumstances."

Senator Kerrey, who supported the change in the Hyde Amendment but opposed its repeal, said he favored the new policy. "It's in fact in keeping with what an awful lot of supporters of the Hyde Amendment were actually advocating," he said.

CC

THE WHITE HOUSE

WASHINGTON

TO: Mack McLarty
Phil Lader
Harold Ickes
Mark Gearan

FROM: Carol H. Rasco

SUBJ: Pennsylvania's letter on medicaid abortion coverage

DATE: January 19, 1994

I did not want to start a full discussion on this matter this morning in the 8 a.m. meeting but want you to be aware of the following:

I have reminded HHS we do NOT need to escalate this matter in the coming week prior to the return of Congress. We all know that with the convening of Congress there is very likely to be an amendment filed immediately to anything available to change the Hyde wording as passed last year. Let that be the place the changes take effect, not here.

HHS will continue to say that (a) there was no discretion in the way they gave the instruction given the amendment as it is worded and (b) when confronted now by questions regarding the fact states are issuing clear, firm statements HHS will state they will continue to work individually with states. No state is getting ready after the March 31 submission of the required state plan amendment to get cut off Medicaid totally. First of all there are about 14 appeals steps that HCFA within HHS can stretch out as long as needed, and I can assure you everyone knows how to play that game. Again, however, I will be stunned if Congress doesn't pass a remedy very quickly. Unfortunately for poor women, that remedy may set the issue of fairness back but that is another story.

Thank you.

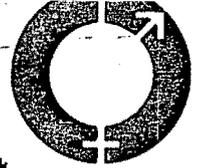


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① Key-file "Abortion"
② *Bill Galston-Syi

April 1, 1993

Mr. George Stephanopoulos
White House Communications Director
The White House
1600 Pennsylvania Avenue
Washington, DC 20500

George:

Recently, in the last couple of days in the media, there has been some controversy about the President supporting government funding of Medicaid abortions.

I have prepared a paper that I would like for you to keep and review. So many taxpayers cite the argument they don't want their tax dollars paying for abortion. This is a study and evaluation we did here in North Carolina back in 1976-77 on how much it would cost if we had not done the therapeutic abortions for these patients. There is a big difference between 1.8 million dollars and 73 million dollars. Just thought I would give you this information in case you ever needed it.

Enjoyed seeing you on March 25. Stay in touch.

I remain

Respectfully yours,

TAKEY CRIST, M.D., F.A.C.O.G., F.A.C.S.
Director
Crist Clinic for Women

TC:jg

To: Carol R.
Nancy Minh
Fr: George S.
FYI

**THE COST EFFECTIVENESS OF
ELECTIVE THERAPEUTIC ABORTION
COST SAVINGS AS DEMONSTRATED IN
NORTH CAROLINA DURING FY 76-77**

TAKEY CRIST
200 Memorial Drive
Jacksonville, NC 28546

It has been argued by the anti-abortionists that taxpayers should not pay for elective therapeutic abortion, that it is too expensive, and it is a waste of taxpayers funds.

Taxpayers also pay for wars of which they may be opposed, taxpayers also paid for Jeremiah Denton's Chastity Bill which was probably one of the most unscientific studies ever funded by the government.

Critics who say that paying for federally financed abortions would put the taxpayers into the "grisly business" of abortion are using the same scare tactics that were used back in 1976 and 1977 by Henry Hyde who has been financed and paid off by the Catholic church for years.

There is no evidence that abortions would increase late in pregnancy.

Elective abortions performed during FY 76-77 were funded through Title XIX and Title XX in the state of North Carolina. The number of abortions performed and paid for by Title XIX money was 1,536, the number of abortions performed by Title XX was 2,608 for a total of 4,144 therapeutic abortions. The majority of the abortions (82 percent) were done in the first trimester. This totalled 3,399, second trimester abortions totalled 745, the average cost of Title XIX and Title XX therapeutic abortions was \$442.32 for a total cost of \$1,832,977.12. A summary of that information is enclosed.

What would have been the cost to the taxpayers if these women had not been allowed to terminate a pregnancy? Assuming that all the pregnancies were carried to term, the cost of normal labor and delivery in FY 76-77 would have been \$5,062,500.

However, that is not the end of the financial story. These patients would also be entitled to income maintenance payment, medical services (Medicaid), and food stamps for a total of \$818.28, and the projected first year cost would be \$3,682,260, but one must remember these payments continue until the child reaches the age of eighteen. The total cost would be \$66,280,680.

It should also be pointed out that the above figures do not take into account the cost of prenatal care, labor and delivery, nor do they include agency administrative cost to support income maintenance and Social Service programs, the cost of medical care required as a result of illegal or self-induced abortions, or the cost of human suffering in the form of increased family stress and the neglect and abuse of unwanted children.

The cost of normal labor and delivery is included in illustrative figure and the average monthly payment per AFDC recipients is also included.

The total cost for the therapeutic abortions paid for through Title XIX and Title XX money for FY 76-77 in North Carolina was \$1,832,977.12. The total cost if these therapeutic abortions would not have been allowed would have exceeded \$73,000,000.

With this factual financial data, I am sure that there are a lot of taxpayers that would rather have their tax dollars pay for a therapeutic abortion rather than pay for the support of unwanted children.

TAKEY CRIST
200 Memorial Drive
Jacksonville, NC 28546

TABLE 2

ELECTIVE ABORTIONS PERFORMED DURING FY 76-77
FUNDED THROUGH TITLES XIX AND XX

TAKEY CRIST
200 Memorial Drive
Jacksonville, NC 28546

	Number of Abortions Performed	Estimated Number First Trimester Abortions*	Estimated Number Second Trimester Abortions*	Average Cost Per Abortion	Total Cost
Title XIX	1,536	1,260	276	\$645.24**	\$ 991,088.64
Title XX	2,608	2,139	469	\$322.81**	\$ 841,888.48
Totals	4,144	3,399	745	(Average XIX & XX) \$442.32	\$1,832,977.12

*Based on North Carolina Reported Abortions 1976 - Public Health Statistics Branch,
North Carolina Division of Health Services

**Although the reason for the difference in the average Title XX cost and the average Title XIX cost cannot be documented, it is thought to be directly related to the fact that county departments of social services authorized Title XX abortion procedures individually and made efforts to refer clients to certified abortion clinics or out patient hospital clinics when at all possible rather than to private physicians who would be forced to admit them to a hospital to perform the procedure. In many cases it was necessary for the client to travel across county lines to an abortion clinic, but travel costs were much less than hospital costs. Medicaid recipients (Title XIX) were free to purchase all allowable medical services with Medicaid labels and were not required to have further authorization from the county DSS to seek abortion services. Medicaid recipients more than likely went to their family physician who admitted them to a local hospital in order to perform the abortion. Hospital admission usually doubles the cost of abortion services and probably accounts for the significantly higher Title XIX average abortion cost:

PREGNANCY CARRIED TO TERM
 COST OF NORMAL LABOR AND DELIVERY*

Average Hospital Costs Per Day

Ancillary Charges	\$ 100.00
Room and Board	+ 60.00
Total	\$ 160.00

Average Days of Hospitalization (5)	x 5
Average Hospitalization Total Cost	\$ 800.00
Average Physician Charge	+325.00
Average Labor and Delivery Total Cost	\$1,125.00

(Projected Labor and Delivery Cost For 4,500 Cases \$5,062,500)

*North Carolina Medicaid Statistics - May 1977

AVERAGE MONTHLY PAYMENT PER AFDC RECIPIENT*

Average Income Maintenance Payment	\$ 15.36
Average Medical Services (Medicaid)	26.59
Average Food Stamps	<u>26.24</u>
Monthly Total	\$ 68.19
	<u>x 12</u>
Annual Total	\$818.28**

(Projected First Year Cost For 4,500 Infants \$3,682,260)

*North Carolina Department of Human Resources Statistical Journal
Division of Social Services January - March 1977

**These figures do not take into account the cost of prenatal care, labor and delivery (average \$1,125.00), nor do they include agency administrative costs to support income maintenance and social services programs, the cost of medical care required as a result of illegal or self-induced abortions or the cost of human suffering in the form of increased family stress and the neglect or abuse of unwanted children.