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## Proponent HB 2523

House Judiciary Committee
Chairman Lance Kinzer
Feb. 15, 2012

Good afternoon, Chairman Kinzer and Committee,

I am Jeanne Gawdun, senior lobbyist for Kansans for Life, here in support of HB 2523, which **protects healthcare professionals' Rights of Conscience.**

Medical practitioners dedicated to preserving life and healing the sick have long been in the cross hairs of the imposition of legalized abortion.

HB 2523 is a narrowly tailored update to current statutes 65-443 and 65-444, enacted in 1970 to allow physicians and hospitals to defer from the provision of abortions and sterilizations.*

HB 2523 essentially

- broadens the institutions covered to any medical facility, not just hospitals,
- widens the category of morally objectionable procedures to include drugs and devices that are reasonably believed to have abortion-causing effects; and
- protects against forced referrals for such procedures, drugs and devices.

The current statutory conscience protection applies to abortion, however the abortion definition in KSA 65-6701, clearly does not apply to contraceptive drugs and devices:

> *"Abortion" means the use or prescription of any instrument,(a) medicine, drug or any other substance or device* ***to terminate the pregnancy of a woman known to be pregnant*** *with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead unborn child who died as the result of natural causes in utero, accidental trauma or a criminal assault on the pregnant woman or her unborn child, and which causes the premature termination of the pregnancy.*

Yet there are millions of contraceptive pills, patches, injections and devices (like IUDs) now in use which have what's called "post-fertilization abortifacient" effects. Beyond keeping eggs from meeting sperm, these drugs and devices also act to silently eliminate tiny human beings (zygotes) trying to implant in their mother's wombs.

Women using these drugs and devices don't even know as to when such abortion-causing actions take place in their bodies, as the actual effects vary from woman to woman, month to month, and hour to hour. But significant numbers of medical professionals who stand by the Hippocratic Oath do not want involvement in the ending of human lives, **not only through direct abortion (as defined in law) but also by indirect abortifacient** drugs and devices.

**Pharmacists** face tremendous pressure when an "abortion drug" like RU486 is chemically similar to one labeled a "contraceptive" (Ella). Kansas pharmacist, Dan Sutherland is here today to speak about that situation.

Lawsuits in this arena have been active, with mixed laws among the states, but here are two recent decisions:

- In June, an Illinois judge overturned the governor's order that pharmacists can not claim a conscience exemption for filling birth control prescriptions.
- In September, Planned Parenthood declined to appeal a ruling that upholds an Arizona law permitting conscience rights assertions for both birth control in pharmacies and "morning after" pills in the emergency room.

**Nurses** have been pressured against their conscience to assist in various aspects of abortions, most recently in a New Jersey public hospital setting where accommodation for them was made only after a lawsuit. It is important to note that the issue is not refusal to provide emergency or life-saving patient care; it is about the right to practice the healing arts without coercion to materially co-operate in abortions.

**Physicians** opposed to both abortion and abortifacient drugs have not found it easy to 'swim upstream' while navigating med school. One practicing Kansas physician, Dr. Patrick Herrick, is here today to tell of his experience of being pressured out of pursuing the obstetrics & gynecology specialty. Another Kansas physician wrote us:

> My experience substantiates that concern. This is confirmed by the fact (witnessed to in an affidavit) that the residency program director specifically pointed to religious and conscience issues in addressing another physician as to why I could not be recommended for licensure,

**The need for HB 2523 job protection and civil immunity is even greater** now that the federal administration is trampling on religious liberty with a reproductive mandate cemented into HHS rule last Friday. *(Read attachment on this situation.)*

President Obama has marginalized the religious objections of the entire nation by insisting that all abortion-acting drugs, and sterilizations must be supplied at "no cost" while having the insurance companies "launder" the money so we don't feel like we're being forced to pay for them.

The president has brazenly asserted that "the "fundamental right to healthcare"(!) trumps bedrock first amendment freedoms. He is dismissing the over 200 years of history in which accommodations were upheld for the sincerely held religious beliefs of

individuals, faith–based groups and Churches, to extricate themselves from morally objectionable activities.

Our former governor, now head of HHS, has made a fall guy of the Institute of Medicine, a political appointee group, currently packed with abortion ideologues. *(See attachments)* The IOM preventative services list reflects **a philosophy where fertility is a disease and pregnancy a pathology** and has set the stage for inevitable mandated coverage of abortion as the "treatment" when prevention fails.

So, unless the Congress takes action and the U.S. Supreme Court case invalidates Obamacare this summer, the federal government has permanently

- circumscribed religion to Houses of Worship, not education, medical centers and charity care;
- funded "women's healthcare" priorities over real disease treatments;
- forced religious groups to pay for morally objectionable services through a "pass thru" ruse;
- made it illegal to be a pro-life insurance company; and
- trashed the rights of businesses and individuals to conduct their affairs consistent with their religious principles.

The last point — that employers oppose funding abortions through company health plans -- is what motivated the Kansas insurance law passed last session.

Thus, in such an inhospitable, pro-abortion environment, valued Kansas medical personnel need to know that practicing responsibly and ethically is worth the effort and will not get them fired or sued.

Please pass HB 2523 out of committee favorably. Thank you. I stand for questions.

*Abortion by drugs comprised 26% of the approximately 8,300 abortions performed in Kansas in 2010. Female sterilization data is incomplete; Kansas tubal ligations are reported to KDHE as approximately 500 per year, but that does not include such procedures done at ambulatory surgical centers.

## The new shell game on free reproductive "preventative" care

The new policy mandates that insurance companies offer free sterilization, contraception, and abortion-causing drugs as part of their policies. According to President Obama himself:

> "*Under the rule, women will still have access to free preventive care that includes contraceptive services — no matter where they work. So that core principle remains. But if a woman's employer is a charity or a hospital that has a religious objection to providing contraceptive services as part of their health plan, the insurance company — not the hospital, not the charity — will be required to reach out and offer the woman contraceptive care free of charge, without co-pays and without hassles.*"

Got that? That's worse than before, **because under the previous evil policy if you worked for an exempt organization—say, a church—then your employer could offer you an insurance plan that did not include sterilization, contraception, and abortion drugs**.

Now there will be *no such plans*, as of Friday Feb.10, 2012. That's why abortion groups are cheering it. It's also deceptive, and here's why . . .

The idea that it will be insurance companies that pay for such services is just a shell game. Where are insurance companies going to get the money to pay for these services? They are going to pay for them with money they got from the very same churches, church-related organizations, and individuals who are otherwise paying.

That's right. That means that now the **churches *are* being asked to pay for the very same services that they were *not* paying for under the previous policy, because previously they could offer their employees insurance plans that did not include these services.**

Now the plans *will* include these services, and the churches are paying for the policies with the legal fiction that the insurance company rather than they are paying for the evil services—unless the insurance company offers the organization a lower rate on the policy, in which case the burden of paying for the abortion drugs and other services is just sloshed around through different parts of their internal spreadsheets but is ultimately still borne by those paying for the policies.

It's just a shell game. And this is why this should be of concern not just to Catholics but to our Protestant brethren and our non-Christian friends who share a concern about the cause of life. **What this means is that *we all* will be *forced* to pay for these services, but with the payment trail hidden.**

In effect President Obama is insisting that the entire American people must pay for abortion drugs, sterilizations, and contraception, **only he is having the insurance companies "launder" the money so that we don't *feel like* we're being forced to pay for them.**

So, even if you're not a Catholic, even if you don't oppose contraception, but if you do care about not funding abortion—or even if you just care about religious liberty and freedom of conscience—then you need to oppose this plan. *http://www.ncregister.com/blog/evil-obama-policy-now-even-more-evil/*

www.medscape.com

# IOM Recommends Free Health Coverage for Contraceptives

Pauline Anderson

July 20, 2011 — Birth control for women of reproductive age, gestational diabetes screening for pregnant women, and DNA testing for cervical cancer are among the preventive services that are recommended for coverage without patient copay in a new report, *Clinical Preventive Services for Women: Closing the Gap*, released July 19 by a committee of the Institute of Medicine of the National Academies. The committee recommends that these and 5 other women-specific preventive services be added to the landmark Patient Protection and Affordable Care Act (ACA) of 2010.

The ACA "holds much promise" for millions of Americans, and not just for the expansion of healthcare coverage, said Linda Rosenstock, MD, MPH, dean of the School of Public Health, University of California–Los Angeles, who chaired the committee, which was charged with finding gaps in existing coverage pertaining to women and with recommending additional preventive services.

Approved preventive services already include such things as blood pressure measurements, diabetes and cholesterol tests, immunizations, and mammography and colonoscopy screening.

The list of 8 additional preventive services necessary for women's health and well-being that the committee is recommending for inclusion under the ACA appears in the institute's new recommendations, discussed during a press briefing held yesterday.

To develop its recommendations for further coverage, the 16-member Institute of Medicine committee, which included specialists in disease prevention, women's health, adolescent health, and evidence-based guidelines, reviewed the current list of preventive services for women, examined evidence for additional services, and obtained input from stakeholders, advocacy groups, and the general public

For the purposes of the report, preventive health services were defined as measures, including medications, procedures, devices, tests, education, and counseling, that have been shown to improve women's well-being and/or decrease the likelihood or delay the onset of a targeted disease or condition.

The committees' recommendations are aimed at women and girls aged 10 to 65 years and include the following:

- Screening for gestational diabetes in pregnant women between 24 and 28 weeks' gestation and at the first prenatal visit for pregnant women at high risk for diabetes.
- Human papillomavirus DNA testing, in addition to conventional cytology testing, in women with normal cytology results every 3 years, beginning at age 30 years. "Coupling this new technology of DNA testing with conventional [Papanicolaou] smears has the opportunity to do a much better job in screening for cervical cancer," said Dr. Rosenstock during the briefing. "Doing this after 30 years of age should result in the ability to actually screen women less often, by dual testing every 3 years."
- Annual counseling on sexually transmitted infections for all sexually active women.
- Annual counseling and screening for HIV infection for sexually active women. It is often not the women themselves who undertake risky behavior, but their male partners, and women do not always know about this behavior, said Dr. Rosenstock. "It has been shown that screening these women may have important health benefits for them," she said.
- All US Food and Drug Administration–approved contraceptive methods, sterilization procedures, and patient education and counseling for women of childbearing age. Contraceptive methods would include emergency contraception such as ulipristal acetate (*ella*, Watson Pharma) tablets, but not mifepristone (sometimes referred to the "abortion pill"), according to another committee member, Alina Salganicoff, PhD, vice president

and director, Women's Health Policy, Henry J. Kaiser Family Foundation, Menlo Park, California. About half of all pregnancies in the United States are unintended, noted Dr. Rosenstock.

- Breastfeeding equipment rental costs and counseling from a trained provider for all pregnant women and new mothers, to ensure a positive breastfeeding experience.
- Screening and counseling for interpersonal and domestic violence in a culturally sensitive and supportive manner.
- An annual well-woman preventive care visit to obtain such services as preconception care and prenatal care. "We recommended this once a year, but we acknowledge that for some women in some situations, it will take more such visits," said Dr. Rosenstock.

In general, these health services met the following 2 criteria: the condition to be prevented affects a broad population and has a large potential effect on health and well-being, and the quality and strength of the evidence is supportive. Some health insurance plans already cover many of these preventive services, noted Dr. Rosenstock.

The committee did not consider costs. However, said Dr. Rosenstock, "if you're successful at prevention, that's a very cost-effective tool for avoiding conditions, or delaying their onset, and certainly for improving health."

She added that preventive services can be beneficial outside the primary care setting; for example, in schools and in the workforce.

The ACA's focus on preventive services is a profound shift from a previous system that responded primarily to acute problems, the committee members write in their report. Women stand to benefit from this shift more than men, given their longer life expectancies, reproductive and gender-specific conditions, and greater burden of chronic disease and disability

However, the committee said that it would "make the most sense" to consider a parallel approach for determining covered preventive services for men, children, and male adolescents.

Dr. Rosenstock said that the 15 of the 16 members, who represent a broad range of perspectives and backgrounds, came to a strong consensus about the evidence supporting the recommendations. One member of the committee dissented after the committee's final meeting.

The report also outlines a process for the Department of Health and Human Services to coordinate regular updates to the list of preventive screenings and services. Among other things, the committee recommends that the process for updating the preventive services for women be independent, free of conflict of interest, evidence based, and gender specific, said Dr. Rosenstock.

The secretary of the Department of Health and Human Services will now consider the recommendations and identify which ones will be followed. Committee members said they expect a prompt response, perhaps as early as August 1.

Asked to comment, Ruth Lesnewski, MD, attending physician, Beth Israel Residency program in Urban Family Practice, and medical director, East 13th Street Family Practice, New York City, said the report is "fabulous," especially as it addresses comprehensive contraction coverage.

"The contraception coverage was the piece I was waiting anxiously for, because the coverage of that is so spotty right now," Dr. Lesnewski said.

The United States has a "huge epidemic" of unintended pregnancies, with a rate that is much higher than in other developed countries, added Dr. Lesnewski, who is also a consultant at the Center for Reproductive Health Education in Family Medicine, Montefiore Medical Center, New York City. "The really poor job we're doing is not due to lack of

knowledge, it's due to lack of will, really, and this provides some direction that we need in order to get this coverage for everyone."

She especially welcomed the elimination of the copayment, pointing out that even though New York State insurance plans are required to cover contraception, to keep costs down managers make the copay equal to about 90% of the retail cost of the product. "The copay is so high that it's a serious barrier for women," said Dr. Lesnewski. "Women are neglecting their health in this important area because they can't afford it."

*Clinical Preventive Services for Women: Closing the Gap* . Released July 19, 2011.

# Medical committee behind HHS birth control mandate tied to NARAL, Planned Parenthood

by Kathleen Gilbert

Wed Sep 28 10:32 AM EST

WASHINGTON, D.C., September 28, 2011 (LifeSiteNews.com) - The medical committee behind the federal government's impending mandate that insurers cover birth control without co-pay is populated by board members of NARAL and Planned Parenthood, as well as major donors to politicians favoring legal abortion.

The pro-life organization HLI America says public records show the ideological roots of the Institute of Medicine (IOM) committee, which recommended virtually all private health insurers pay for FDA-approved contraception as essential "preventive care" under the new health care law, including drugs that can cause early abortions.

IOM, a non-governmental organization tapped by federal health officials to recommend the new guidelines, describes itself on its website as "provid[ing] unbiased and authoritative advice to decision makers."

Among the 15-member IOM Committee on Preventive Services for Women are Claire Brindis, a member of the board of directors of the NARAL Pro-Choice America Foundation; Angela Diaz, former board member of Physicians for Reproductive Choice and Health; Paula A. Johnson, Chairwoman of the Planned Parenthood League of Massachusetts and upcoming recipient of NARAL's 2011 "Champion for Choice" award; Magda G. Peck, the former board chairwoman of Planned Parenthood of Nebraska and Council Bluffs; and Alina Salganicoff, Vice President and Director of Women's Health Policy at the Kaiser Family Foundation, which strongly favors abortion and contraception on demand.

HLI America also highlights committee members' monetary contributions to pro-abortion candidates, including a $35,200 donation to Sen. Barbara Boxer (D-CA). One committee member, Linda Rosenstock, donated over $40,000 to pro-choice political candidates including Barack Obama, Hillary Clinton, Barbara Boxer, and the Democratic National Committee.

HLI America says the list is "by no means an exhaustive" exposition of the IOM committee's left-leaning political bias, but that "these eleven members—out of a total of fifteen—demonstrate a more than casual commitment to the furthering of the abortion lobby." The group also notes that records showed none of the members having donated to a candidate who opposed abortion.

The July IOM report not only favored contraception, but indicated that surgical abortion coverage would have been a viable candidate, had federal law not stood in the way.

"Despite the health and well-being benefits to some women, abortion services were considered to be outside of the project's scope, given the restrictions contained in the ACA," wrote the authors.

Less than two weeks after the report was released, HHS Secretary Kathleen Sebelius announced the implementation of "historic new guidelines that will ensure women receive preventive health services at no additional cost," including birth control, starting August 2012.

The report's ideological tack on birth control - IOM called the drug's main benefit "the ability to plan one's family and attain optimal birth spacing" - mirrored that of the Planned Parenthood Federation of America during its intensive nationwide campaign for the mandate. As the lone major force opposing Planned Parenthood's campaign, the U.S. Conference of Catholic Bishops had criticized the idea of pregnancy as a disease remedied by "preventive medicine" and said the IOM report betrayed a strong ideological bias.

Dr. Anthony Lo Sasso, the lone member of the IOM committee dissenting from the report, concurred that the findings were tainted by advocacy goals.

"Troublingly, the process tended to result in a mix of objective and subjective determinations filtered through a lens of advocacy," he wrote. "An abiding principle in the evaluation of the evidence and the recommendations put forth as a consequence should be transparency and strict objectivity, but the committee failed to demonstrate these principles in the report."

Arland Nichols, the National Director of HLI America, noted that "nearly all of the invited speakers" at the committee's three open information-gathering sessions were "known advocates of contraception and abortion on demand" - while no representative from the Catholic health care system, the largest health care provider in the United States, was sought.

"It is, perhaps, not surprising that political maneuvering and ideology have been obstacles to HHS's purported goal of securing the health of the American people; we do not expect completely disinterested policymaking in our democracy," wrote Nichols.

"What is surprising, however, is the audacity with which the committee circumvented professional research practices in order to arrive at the conclusions they held at the outset."