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DOCUMENT NO.	FORM	SUBJECT/TITLE	PAGES	DATE	RESTRICTION(S)
001	Memorandum	UNFPA - To: POTUS - From: Jay Lefkowitz	5	06/19/2002	P5;
002	Memorandum	Mexico City Policy - To: POTUS - From: Jay Lefkowitz	4	02/10/2003	P5;
003	Memorandum	Mexico City Policy - To: POTUS - From: Jay Lefkowitz	3	08/22/2003	P5;
004	Memorandum	Enrolled Bill S. 686 - To: POTUS - From: Joshua Bolten	3	03/20/2005	P5;
005	Memorandum	Bioethics Agenda - To: POTUS - From: Yuval Levin	5	05/12/2005	P5;
006	Memorandum	Memo to the President Regarding Pro-Life Policies - To: POTUS - From: Karl Zinsmeister	3	05/02/2007	P5;
007	Talking Points	Press Points	1	N.D.	P5;
008	Memorandum	Proposed Regulatory Changes to HHS's Title X Family Planning Program - To: POTUS - From: Karl Zinsmeister	3	02/05/2008	P5;

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This document was prepared on Wednesday, October 24, 2012



Pro-Life Legacy

A Timeline (2001–2008)

Domestic Policy Council

THE WHITE HOUSE

WASHINGTON

October 21, 2008

INFORMATION

MEMORANDUM FOR THE PRESIDENT

THROUGH: Karl Zinsmeister

FROM: Anna Abram

SUBJECT: **Pro-Life Legacy (2001-2008)**

The Bush Administration has a strong record of upholding pro-life policies guided by President Bush's recognition that every human life has inherent value at every stage and his belief that all children should be welcomed into life and protected in law.

Promoting a Culture of Life

One of his first actions as President was to restore the Mexico City Policy on January 22, 2001. From the time President Reagan announced the Mexico City Policy (MCP) in 1984 until it was revoked by President Clinton in January 1993, the U.S. Administration for International Development (USAID) was prohibited from giving grants for family planning activities to any foreign nongovernmental organization (NGO) that performs abortion or actively promotes abortion as a method of family planning. On August 29, 2003, President Bush issued a memo directing the Secretary of State to extend the MCP requirements applicable to USAID family planning assistance to all family planning assistance funded through the Foreign Assistance Act. This memorandum also clarified that MCP restrictions do not apply to multilateral organizations that are associations of governments and do not apply to foreign assistance furnished through the President's Emergency Plan for AIDS Relief (PEPFAR).

Consistent with President Bush's efforts to build a culture of life, in 2002, the Centers for Medicare and Medicaid Services proposed and finalized a rule to allow States the option to provide vital healthcare services to promote healthy pregnancies for women and their unborn children who would otherwise be ineligible for coverage under the State Children's Health Insurance Program (SCHIP). Under this regulation, States are also able to provide eligibility for unborn children of low-income immigrants, which results in access to important prenatal care.

The Bush Administration has also witnessed and supported landmark legislative pro-life victories. On August 5, 2002, President Bush signed the Born Alive Infants Protection Act, which ensures that every infant born alive—including an infant who survives an abortion procedure—is considered a person under federal law. In April 2005, HHS issued guidance related to the Born Alive Infants Protection Act, instructing hospitals, states, and state survey and certification agencies that infants born alive at any stage of development- including after

abortion procedures- are protected by the Emergency Medical Treatment and Labor Act and provisions of the Child Abuse Prevention and Treatment Act.

To help provide compassionate support to pregnant or parenting youth, in October 2003, President Bush signed the Runaway, Homeless, and Missing Children Protection Act, which explicitly authorized the use of funds for maternity group homes as part of the transitional living program.

On November 5, 2003, President Bush signed the Partial-Birth Abortion Ban Act, which banned the abhorrent procedure commonly known as partial-birth abortion. When the U.S. District Court for the Northern District of California ruled against the Partial-Birth Abortion law, the Administration issued a strong statement that "partial birth abortion is an abhorrent procedure that must be ended once and for all," and that "the Administration will take every necessary step to defend this law in the courts." This strong defense culminated in the Supreme Court's decision upholding the Partial-Birth Abortion Ban in April 2007.

On April 1, 2004, the President signed the Unborn Victims of Violence Act, another significant pro-life legislative win. This legislation, also referred to as the "Laci and Conner's Law," provides that, under Federal law, any person who causes death or injury to a child in the womb shall be charged with a separate offense, in addition to any charges related to the mother.

In March 2005, as the nation watched the events surrounding Theresa (Terri) Schiavo unfold, the President reiterated the importance of building a culture of life in which all Americans are welcomed, valued, and protected. He especially emphasized that those at the mercy of others and in cases like Terri Schiavo, there should be a presumption in favor of life. A Florida state court ordered that Mrs. Schiavo's feeding tube be removed on March 18, 2005 in response to a lawsuit filed by her husband. In the days following this development, Congress swiftly passed legislation, which President Bush signed on March 21, 2005, providing a federal district court with the jurisdiction to render judgment on a suit on behalf of Mrs. Schiavo for the alleged violation of any of her federal rights. Despite numerous legal attempts by Mrs. Schiavo's parents to petition on her behalf in federal court as a result of this legislation, all such claims on her behalf were unsuccessful. Upon Mrs. Schiavo's passing on March 31, 2005, the President urged those who honor her to continue to work to build a culture of life.

Faced with a hostile new leadership under the 110th Congress and an expectation that they would likely attempt to undo many of the pro-life advances secured during the Bush Administration, President Bush made clear in a May 3, 2007 letter to Congress that he would defend all existing pro-life protections. His letter clearly warned that any legislation weakening current federal policies and laws on abortion, encouraging the destruction of human life at any stage, or reversing existing pro-life policies via appropriations riders would be vetoed.

In response to concerns that many healthcare providers routinely face discrimination based upon their refusal to participate in abortion procedures in direct opposition to their personal convictions, on August 21, 2008, Secretary Leavitt issued a proposed regulation to help protect healthcare providers' right of conscience. Over the past three decades, Congress has enacted laws to safeguard healthcare providers' conscience rights so that they are not forced to perform

or refer for abortions. On December 18, 2008, Secretary Leavitt issued the final regulation, which codifies key statutory provisions that prohibit entities receiving federal financial assistance from discriminating against healthcare providers who refuse to participate in an activity to which they object based on their religious beliefs or moral convictions, such as refusing to perform or refer for abortions.

Promoting Adoption

Throughout the Bush presidency, he has encouraged and helped facilitate adoption as a compassionate alternative to abortion. In his first budget submission in February 2001, President Bush called for increasing and making the adoption tax credit permanent, and also called for reauthorizing and increasing funding for the Promoting Safe and Stable Families program, a program which helps place children with adoptive families. In June 2001, he signed the Economic Growth and Tax Relief Reconciliation Act, which increased and permanently extended the adoption tax credit. In January 2002, he signed the Promoting Safe and Stable Families Amendments of 2001, which included the funding increase you proposed. Later that year, in July 2002, President Bush also announced the first federal adoption website, www.AdoptUSKids.org, and unveiled a new public service announcement to promote adoption to help every child find a loving home.

In December 2003, President Bush signed the Adoption Promotion Act of 2003, which reauthorized and expanded the adoption incentive payments program. This bill specifically amended the formula by which Adoption Incentive funds are allocated to states so that states that place more children ages 9 and older from foster care into adoptive families receive more money, an idea the Bush Administration promoted to address the problem of older children aging out of the foster care programs. In November 2007, President Bush signed the instrument of ratification for the Convention on Protection of Children and Cooperation in Respect of Inter-country Adoption, which established procedures to be followed in inter-country adoptions and mandated safeguards to protect the best interests of the children. President Bush has also helped to promote adoption awareness by issuing a proclamation in honor of National Adoption Month each year of his Presidency.

Finally, throughout his Administration, President Bush has recognized every National Sanctity of Human Life day through proclamations and annually addressed the March for Life participants. Through each of these venues, he has consistently promoted and supported programs that offer compassionate alternatives to abortion, such as adoption, crisis pregnancy centers, and maternity group homes. Under his steadfast leadership, these consistent efforts, along with the enactment of landmark pro-life legislation and key Administrative actions, have all helped to build a culture of life.

PRO-LIFE (2001-2008)

(TAB)

January 22, 2001 (1)

The President issues a memorandum instructing the Administrator of United States Agency for International Development (USAID) to restore the Mexico City Policy. The Mexico City policy was announced by President Reagan in 1984 and requires that foreign nongovernmental organizations (NGOs) agree as a condition of their receipt of federal funds not to perform or actively promote abortion as a method of family planning. This policy had been in effect until it was rescinded by President Clinton on January 22, 1993. In his memorandum, the President made clear his conviction that taxpayer funds should not be used to pay for abortions or advocate or actively promote abortion either domestically or abroad.

Press Statement: Restoration of the Mexico City Policy (2)

February 28, 2001 (3)

The President submits his first budget to Congress. To encourage more adoptions, the President's FY2002 Budget calls for making the adoption tax credit permanent and increasing it from $5,000 to $7,500. The section of the Budget discussing strengthening families also underscores the President's support for the Promoting Safe and Stable Families program, an HHS program which helps place children with adoptive families. Specifically, to strengthen States' ability to promote child safety, permanency, and well-being, the President proposed to reauthorize the Promoting Safe and Stable Families program at $505 million in FY 2002, a $200 million increase over the FY 2001 level.

March 27, 2001 (4)

A memo is delivered to the President requesting that the he issue a memorandum to the Administrator of USAID to complete the process of restoring the Mexico City Policy by directing the Administrator to change a Contract Information Bulletin on the subject of the certifications required of foreign NGOs with respect to abortion.

March 28, 2001 (5)

The President issues a memorandum instructing the Administrator of USAID to complete the process of restoring the Mexico City Policy by amending the Contract Information Bulletin that governs the grants and cooperative agreements awarded by USAID for family planning assistance. This memorandum completed the process of restoring the Mexico City Policy and ensured that USAID implemented it.

June 7, 2001 (6)

The President signs the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA). This law doubled the maximum adoption tax credit from $5,000 to $10,000 per child and increased the adoption tax credit for children with special needs from $6,000 to $10,000. The law also increased the income threshold at which the credit begins to be phased out

from $75,000 to $150,000. EGTRRA permanently extended the credits, however, the expanded dollar amounts are set to expire in 2010.

November 5, 2001 (7)

The President issues a proclamation recognizing National Adoption Month, 2001. In the proclamation, the President notes the enactment of the expansion and extension of the adoption tax credits. The President also highlights his support for the Promoting Safe and Stable Families legislation, which would improve post-adoptive services.

January 17, 2002 (8)

The President signs the Promoting Safe and Stable Families Amendments of 2001, which included the $200 million increase proposed by the President's FY 2002 Budget. This legislation enabled States to develop and establish, or expand, and to operate coordinated programs of community-based family support services, family preservation services, time-limited family reunification services, and adoption promotion and support services to: 1) prevent child maltreatment among families at risk through the provision of supportive family services; 2) assure children's safety within the home and preserve intact families in which children have been maltreated, when the family's problems can be addressed effectively; 3) address the problems of families whose children have been placed in foster care so that reunification may occur in a safe and stable manner; and 4) support adoptive families by providing necessary support services.

January 18, 2002 (9)

The President issues a proclamation recognizing National Sanctity of Human Life Day, 2002.

January 22, 2002 (10)

The President calls March for Life participants. The annual pro-life rally has been held in the Washington, D.C. each year since 1974. In his remarks, the President underscores the value of human life, his opposition to partial-birth abortion and taxpayers funding abortion. The President also underscores the Administration's support for crisis pregnancy programs, adoption, and parental notification laws.

March 5, 2002 (11)

The Centers for Medicare and Medicaid Services (CMS) publishes a proposed rule to revise the definition of "child" under the State Children's Health Insurance Program (SCHIP) so that a State may elect to make individuals in the period between conception and birth eligible for coverage under the State plan (the "SCHIP Unborn Child Rule"). The rule's proposed definition would provide States with the option to consider an unborn child to be a targeted low-income child and therefore eligible for SCHIP if other applicable State eligibility requirements are met. The proposed rule would permit States to ensure that needed services are available to benefit unborn children independent of the mother's eligibility status.

June 19, 2002 (12)

A memorandum is delivered to the President regarding the amount of money that should be allocated to the United Nations Population Fund (UNFPA). Included in every Foreign Ops

appropriations bill since 1985, the Kemp-Kasten pro-life rider states that: "none of the funds made available by this act...may be made available to any organization or program, which, as determined by the President of the United States, supports or participates in the management or a program of coercive abortion or involuntary sterilization." This memo outlined the four options regarding the FY02 Foreign Ops bill and the UNFPA determination: 1) Fully fund UNFPA at $34 million; 2) Fund UNFPA at $25 million; 3) Fund UNFPA at $21.5 million and seek authority to reprogram funds for other programs for women and children; and 4) Zero fund UNFPA, but seek authority to reprogram funds for other programs to benefit women and children.

July 23, 2002 (13)

The President announces the first federal adoption website, www.AdoptUSKids.org and a new public service announcement campaign to promote adoption. The AdoptUSKids.org website features pictures and profiles of children who are available for adoption, maintains a database of prospective adoptive parents who have been approved by states, and serves as a resource for families who have already adopted a child.

Fact Sheet: Helping Children and Building Families Through Adoption (14)

August 5, 2002 (15)

The President signs the Born Alive Infants Protection Act, which ensures that every infant born alive—including an infant who survives an abortion procedure—is considered a person under federal law.

October 2, 2002 (16)

CMS publishes the final SCHIP Unborn Child rule ensuring that States now have the option to provide vital healthcare services to promote healthy pregnancies for women and their unborn children who would otherwise be ineligible for coverage under SCHIP. Under the final rule, States are also able to provide eligibility to unborn children of low-income immigrants, which results in access to important prenatal care.

November 1, 2002 (17)

The President issues a proclamation recognizing National Adoption Month, 2002. The proclamation highlights the launch of AdoptUSKids national campaign and website to increase awareness about adoption, and the enactment of legislation to extend and expand the Safe and Stable Families program in January 2002.

November 12, 2002 (18)

The Director of the Center for Medicaid and State Options at CMS issues a letter to State Health Officials informing them that in the interest of providing necessary prenatal care and other health services to children, CMS promulgated a final rule on October 2, 2002 that revised the definition of "child" to clarify that "child" means an individual from conception up to age 19. The letter further explained that the rule provides states with the option to consider an unborn child to be a targeted low-income child and therefore eligible for coverage under SCHIP, if other applicable state eligibility requirements are met and that states are permitted to provide vital healthcare services to promote healthy pregnancies and healthy children regardless of the mother's eligibility status.

January 14, 2003 (19)

The President issues a proclamation recognizing National Sanctity of Human Life Day, 2003.

January 22, 2003 (20)

The President calls participants of the 30th Annual March for Life on the National Mall. The President reiterates his commitment to building a culture of life and notes the progress the pro-life community has made toward this goal with the enactment of the Born Alive Infants Protection Act. In his remarks, the President calls on Congress to ban partial-birth abortion. The President also highlights that the Administration is offering compassionate alternative to abortion by promoting adoption and extending state health care coverage to unborn children.

February 10, 2003 (21)

A memorandum is delivered to the President regarding Mexico City Policy. This memorandum asked the President to consider if Mexico City Policy should be applied to all agencies that disburse funds pursuant to the Foreign Assistance Act and if grants not technically for family planning activities should be governed by Mexico City Policy (eg grants under the President's Emergency Plan for AIDS Relief).

March 13, 2003 (22)

The Senate passes the Partial-Birth Abortion Ban Act of 2003 (64-33), which banned the abhorrent procedure commonly known as partial-birth abortion. The President issues a statement commending the Senate passing legislation to ban the abhorrent procedure that offends the human dignity.

June 4, 2003 (23)

The House passes the Partial-Birth Abortion Ban Act of 2003 (passed without objection). The President issues a statement applauding the House for passing this legislation and urges Congress to quickly resolve any differences between the House and Senate passed bills so he can sign this legislation into law as soon as possible.

August 22, 2003 (24)

A memorandum is delivered to the President regarding Mexico City Policy. This memorandum follows up to the memorandum presented to the President on February 10, 2003, and puts forward policy recommendations regarding expanding the Mexico City Policy to cover the State Department family planning assistance on the same terms that were applicable to USAID family planning programs, which requires that foreign NGOs agree as a condition of their receipt of federal funds not to perform or actively promote abortion as a method of family planning.

August 29, 2003 (25)

The President issues a memorandum to the Secretary of State regarding assistance for voluntary population planning. This memo directed the Secretary of State to extend the Mexico City Policy requirements applicable to USAID family planning assistance to all assistance for voluntary population planning furnished to foreign nongovernmental organizations through the Foreign

Assistance Act, no matter which part of the State Department was furnishing the assistance. The memo clarified that the Mexico City Policy restrictions do not include multilateral organizations that are associations of governments and do not apply to foreign assistance furnished pursuant to the U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (PEPFAR).

October 2, 2003 (26)

The House passes the Conference report to the Partial-Birth Abortion Ban Act of 2003 (281-142). The President issues a statement applauding the House's action and encouraging the Senate to pass this measure so he can sign it into law.

October 8, 2003 (27)

The OMB Enrolled Bill Memorandum for H.R. 1925, the Runaway, Homeless, and Missing Children Protection Act, is delivered to the President. This bill amended current law to explicitly authorize the use of funds for maternity group homes as part of the transitional living program. In addition, the bill defined "maternity group homes" as a community-based, adult-supervised transitional living arrangement for pregnant or parenting youth and their children in which such pregnant or parenting youth are required to learn parenting skills and other skills to promote their long-term economic independence. The enrolled bill memo describes this provision.

October 10, 2003 (28)

The Administration issues a statement noting that the President signed the Runaway, Homeless, and Missing Children Protection Act, which included support for maternity group homes for pregnant and parenting youth.

October 21, 2003 (29)

The Senate passes the Conference report to the Partial-Birth Abortion Ban Act of 2003 (64-34). The President issues statement applauding the Senate for passing this bill and states his intent to sign it into law.

November 5, 2003 (30)

The President signs the Partial Birth Abortion Ban Act of 2003. In his remarks he states that the Executive Branch will vigorously defend this law against any who try to overturn it in the courts.

November 7, 2003 (31)

The President issues a proclamation recognizing National Adoption Month, 2003.

December 2, 2003 (1)

The President signs the Adoption Promotion Act of 2003, which reauthorized and expanded the adoption incentive payments program. This bill provided additional incentives for adoptions of older children, including older children from foster care, and increasing adoptions from foster care. Specifically, the bill amended the formula by which Adoption Incentive funds are allocated to states so that states place more children ages 9 and older from foster care into adoptive families

receive more money. The Administration sought to focus attention on the problem of older children aging out of the foster care program by proposing this new incentive.

January 16, 2004 (2)

The President issues a proclamation recognizing National Sanctity of Human Life Day, 2004.

January 22, 2004 (3)

The President calls participants of the Annual March for Life on the National Mall. The President reiterates his commitment to building a culture of life and notes the progress the pro-life community has made toward this goal with the enactment of the Born Alive Infants Protection Act and the Partial Birth Abortion Ban Act and the enactment of legislation supporting maternity group homes. In his remarks, the President underscores his support for the Unborn Victims of Violence Act and calls on Congress to pass this bill. The President also highlights crisis pregnancy centers, adoption, and parental notification laws.

February 26, 2004 (4)

The House passed the Unborn Victims of Violence Act of 2003 (254 - 163). The Unborn Victims of Violence Act, also referred to as the "Laci and Conner's Law," provides that any person who causes death or injury to a child in the womb shall be charged with a separate offense, in addition to any charges related to the mother. The President issues a statement applauding the House for passing the bill. The President had previously called on Congress to pass this bill in his remarks to Annual March for Life participants.

March 25, 2004 (5)

The Senate passed the Unborn Victims of Violence Act of 2003 (61 - 38). The President issues a statement applauding the Senate for its action and notes his intent to sign the bill into law.

April 1, 2004 (6)

The President signs the Unborn Victims of Violence Act. In his remarks the President notes that enactment of this legislation is an affirmation that our country is building a culture of life.

June 1, 2004 (7)

The U.S. District Court for the Northern District of California rules against the Partial Birth Abortion Act. The Press office issues a statement noting the President disagrees with the Court's ruling and affirms the Administration's commitment to defending this law.

November 4, 2004 (8)

The President issues a proclamation recognizing National Adoption Month, 2004.

January 15, 2005 (9)

The President issues a proclamation recognizing National Sanctity of Human Life Day, 2005.

January 24, 2005 (10)

The President calls participants of the annual March for Life and reiterates his commitment to building a culture of life. The President highlights the significant progress the Administration has made in building a culture of life through the enactment of the Born Alive Infants Protection Act, the Unborn Victims of Violence Act, and the Partial Birth Abortion Act.

March 17, 2005 (11)

The President issues a statement on Terri Schiavo, emphasizing that it should be our nation's goal to build a culture of life, and that this culture must extend to individuals with disabilities.

March 21, 2005

The President signs the Terri Schiavo Incapacitated Protection bill (S. 686). On March 18, 2005, pursuant to an order of the Circuit Court for Pinellas County, Florida, Mrs. Schiavo's feeding tube was removed. Since 1990, Mrs. Schiavo had been receiving artificial life support through a feeding tube. Since Mrs. Schiavo was diagnosed in 1997 as being in a persistent, non-cognitive, vegetative state with little or no likelihood for improvement, her husband, Mr. Schiavo had pursued legal actions in Florida courts to discontinue nourishment and hydration. This bill conferred jurisdiction upon the U.S. District Court for the Middle District of Florida to render judgment on an action brought by a parent of Theresa Marie Schiavo on her behalf for the alleged violation of her rights under the Constitution or laws relating to the withholding or withdrawal of food, fluids, or medical treatment necessary to sustain her life.

OMB Enrolled Bill Memo on S. 686 (12)
Statement by the Press Secretary on S. 686 (13)

March 31, 2005 (14)

The President discusses the passing of Terri Schiavo and affirms his belief in building a culture of life.

April 22, 2005

HHS issues guidance related to the Born Alive Infant Protection Act, instructing hospitals, states, and state survey and certification agencies that infants born alive at any stage of development - including after abortion procedures - are protected by the Emergency Medical Treatment and Labor Act and provisions of the Child Abuse Prevention and Treatment Act.

-HHS Press Release, released by request only (15)
-CMS letter to State Survey Agency Directors (16)
-ACF Guidance (17)

April 27, 2005 (18)

The House passed the Child Interstate Abortion Notification Act (270 – 157). The Child Interstate Abortion Notification Act would protect the health and safety of minors by ensuring that valid and constitutional State parental involvement laws are not circumvented. The President issues a statement commending the House on passing this bill.

May 12, 2005 (19)

A memorandum is delivered to the President regarding ongoing policy efforts for the defense of human dignity and nascent life and to assess emerging reforms regarding the rights of disabled patients in the wake of the Schiavo case. The last section of the memo is dedicated to issues related to end of life decision-making, which were brought to attention through the case of Terri Schiavo. While the memo points out that most issues connected to medical decision making are matters of state rather than federal jurisdiction, the memo proposes that federal legislation should strive for the following four goals: 1) when there is a serious doubt about the wishes of a patient who is now at the mercy of others, our society, laws, and courts should begin from a presumption in favor of life; 2) we must be confident that the guardians and medical proxies always have the interest of the patient first and foremost in their minds; 3) incapacitated or severely disabled persons must be treated with dignity and respect; and 4) must not create new burdens for families already struggling to do what is right for a loved one by introducing new complications.

November 2, 2005 (20)

The President issues a proclamation recognizing National Adoption Month, 2005.

January 20, 2006 (21)

The President issues a proclamation recognizing National Sanctity of Human Life Day, 2006.

January 23, 2006 (22)

The President calls participants of the annual March for Life and reiterates his commitment to building a culture of life and highlights the progress the Administration has made toward this goal, including restoring the Mexico City Policy, enacting legislation to ban partial birth abortion, and enacting the Unborn Victims of Violence Act. The President calls for passage of the Child Custody Protection Act. The President again highlights promoting parental notification laws, adoption, and crisis pregnancy programs.

July 25, 2006 (23)

The Senate passed the Child Custody Protection Act (65-34). The Child Custody Protection Act would prohibit taking minors across State lines in circumvention of laws requiring the involvement of parents in abortion decisions. The President issues a statement in appreciation of the Senate's action to advance this legislation.

October 30, 2006 (24)

The President issues a proclamation recognizing National Adoption Month, 2006.

January 19, 2007 (25)

The President issues a proclamation recognizing National Sanctity of Human Life Day, 2007.

January 22, 2007 (26)

The President calls participants of the annual March for Life and affirms his commitment to building a culture of life in which every child is welcome in life and protected into law.

April 18, 2007 (27)

The President issues a statement on the Supreme Court's decision to uphold the Partial Birth Abortion, noting that the Supreme Court's decision is an affirmation of the progress we made since the beginning of the Administration to protect human dignity and uphold the sanctity of life.

May 2, 2007 (28)

A memorandum is delivered to the President regarding a veto threat to protect pro-life policies. The memorandum advised the President that he should issue a letter to the Congress similar to a letter issued by President Bush (41) stating that he would veto any legislation that weakens current Federal policies and laws on abortion, or that encourages the destruction of human life at any stage.

May 3, 2007 (29)

The President sends letter to the Speaker of the House, Minority Leader in the House, Majority Leader in the Senate, and Minority Leader in the Senate making clear his intent to veto any legislation that weakens current Federal policies and laws on abortion or that encourages the destruction of human life at any stage.

October 31, 2007 (30)

The President issues a proclamation recognizing National Adoption Month, 2007.

November 15, 2007 (31)

A memorandum is delivered to the President regarding ratification of the Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption. The memo explains that the United States participated actively in the negotiation and adoption of the Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption in 1994. The convention provides a framework for the adoption of children living in one contracting state by persons living in another contracting state. It establishes procedures to be followed in such adoption cases and mandates safeguards to protect the best interests of the children. The Senate gave its advice and consent to ratification of the Convention on September 20, 2000. Since then, implementing legislation for the Convention was signed into law in October 2000 and the State Department promulgated the necessary regulations and took actions necessary to implement the Convention. With the President's signature on November 16, 2007, the United States was able to deposit the instrument of ratification.

November 16, 2007 (X)

The President celebrates National Adoption Day with an event in the East Room. The President emphasized the importance of helping young people find ove, stability, and support from families, and highlighted the steps the Administration has taken to promote awareness of and facilitate adoptions.

January 18, 2008 (X)

The President issues a proclamation recognizing National Sanctity of Human Life Day, 2008.

January 22, 2008 (X)

President Bush Speaks to March for Life Rally Participants. In his remarks, the President reaffirms many of the pro-life themes he has discussed with the rally participants in the previous years, including enactment of landmark pro-life legislation and promoting compassionate alternatives to abortion, such as adoption.

February 5, 2008 (X)

A memorandum is delivered to the President regarding proposed regulatory changes to HHS's Title X Family Planning Program. The memorandum proposed regulatory changes to HHS's Title X family program consistent with the 1988 Reagan Administration regulation, with some modifications, to restore compliance with the spirit for the program's prohibition that funds not go to programs where abortion is a method of family planning. Key issues addressed are collocation of Title X clinics with abortion clinics and providing counseling and referral for abortion as a method of family planning.

August 21, 2008 (X)

HHS proposes a rule to ensure that HHS funds do not support coercive or discriminatory policies or practices by increasing awareness of, and compliance with, three separate laws protecting federally funded healthcare providers' right of conscience. First, the Weldon Amendment to the HHS' fiscal year 2005 appropriations act, and to subsequent years' appropriations acts, prohibits the provision of HHS funds to any state or local government or federal agency or program that discriminates against institutional or individual health care entities on the basis that the entity does not provide, pay for, provide coverage of, or refer for abortion. Second, Section 245 of the Public Health Service Act prohibits the federal government and state or local governments that receive federal financial assistance from discriminating against individual and institutional healthcare providers, including participants in medical training programs, who refused to, among other things, receive training in abortions; require or provide such training; perform abortions; or provide referrals for, or make arrangements for, such training or abortions. Third, the Church Amendment protect healthcare providers and other individuals from discrimination by recipients of HHS funds on the basis of their refusal, due to religious belief or moral conviction, to perform or participate in abortion or any other health service or research activity.

HHS' proposed rule would: 1) clarify that non-discrimination protections apply to certain institutional healthcare providers and individual practitioners working for recipients of funds from HHS; 2) require recipients of certain HHS funds to certify their compliance with laws protecting provider conscience rights; 3) designate the HHS Office for Civil Rights as the entity to receive complaints of discrimination addressed by the existing statutes and the proposed regulation; and 4) charge HHS officials to work with any state or local government or entity that may be in violation of existing statutes and the proposed regulation to encourage voluntary steps to bring that government or entity into compliance with the law.

October 31, 2008 (X)

The President issues a proclamation recognizing National Adoption Month, 2008.

December 18, 2008 (X)

HHS issues the final healthcare providers' conscience regulation.

Memo to the Administrator for USAID on Mexico City Policy

January 22, 2001

MEMORANDUM FOR THE ADMINISTRATOR OF THE UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

SUBJECT: Restoration of the Mexico City Policy

The Mexico City Policy announced by President Reagan in 1984 required nongovernmental organizations to agree as a condition of their receipt of Federal funds that such organizations would neither perform nor actively promote abortion as a method of family planning in other nations. This policy was in effect until it was rescinded on January 22, 1993.

It is my conviction that taxpayer funds should not be used to pay for abortions or advocate or actively promote abortion, either here or abroad. It is therefore my belief that the Mexico City Policy should be restored. Accordingly, I hereby rescind the "Memorandum for the Acting Administrator of the Agency for International Development, Subject: AID Family Planning Grants/Mexico City Policy," dated January 22, 1993, and I direct the Administrator of the United States Agency for International Development to reinstate in full all of the requirements of the Mexico City Policy in effect on January 19, 1993.

GEORGE W. BUSH

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Statement by the Press Secretary

Restoration of the Mexico City Policy

January 22, 2001

The President is committed to maintaining the $425 million funding level provided for in the FY 2001 appropriation because he knows that one of the best ways to prevent abortion is by providing quality voluntary family planning services.

The President's clear intention is that any restrictions do not limit organizations from treating injuries or illnesses caused by legal or illegal abortions, for example, post abortion care. This position is allowed under previous policies that have had wide congressional support.

This policy recognizes our country's long history of providing international health care services, including voluntary family planning to couples around the world who want to make free and responsible decisions about the number and spacing of their children.

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THE WHITE HOUSE
PRESIDENT GEORGE W. BUSH

12. Strengthen Families

The President believes that every child deserves to live in a safe, permanent and caring family, with a loving father and mother. Unfortunately, the dramatic increase in the number of children living without fathers, or worse still languishing in foster care, means that for millions of children, this is not the case. The result is that countless children are growing up without the stability they need to fulfill their dreams.

Certainly, no law can make people love one another. Places of worship, faith-based organizations, and other value-shaping groups do the hard work of changing hearts and minds. Government should, however, wherever possible, cultivate a climate that helps families, and the individuals and groups that support them. With this goal in mind, the budget includes additional initiatives to strengthen and rebuild families.

Responsible Fatherhood

The President is determined to make committed, responsible fatherhood a national priority. Over the last four decades, there has been a dramatic increase in the number of children growing up in homes without fathers. In 1960, fewer than 10 million children did not live with their fathers. Today, the number is nearly 25 million. More than one-third of these children will not see their fathers at all during the course of a year. And, the trend is getting worse. By some estimates, 60 percent of children born in the 1990s will spend a significant portion of their childhood in a home without a father.

This is troubling news for our children. Experts agree that the lack of a father in the home has a negative impact on children. Research shows that nearly 75 percent of children in single-parent homes will experience poverty before they are 11 years old, compared with only 20 percent of children in two-parent families. Violent criminals are overwhelmingly males who grew up without fathers.

In contrast, the presence of two committed, involved parents contributes directly to better school performance, reduced substance abuse, less crime and delinquency, fewer emotional and other behavioral problems, less risk of abuse or neglect, and lower risk of teen suicide. The research is clear: fathers factor significantly in the lives of their children. There is simply no substitute for the love, involvement, and commitment of a responsible father.

Promoting a New Pro-Fatherhood Agenda: Government's traditional answer to the absence of fathers from the lives of children has been to focus on child support enforcement □ ensuring the financial support fathers owe is provided. Strong child support enforcement is critical to getting fathers who have the ability to pay to support their children. However, research shows that a large portion of fathers who do not pay child support are themselves poor. Many have limited education and are unemployed or underemployed.

While fathers must fulfill their financial commitments, they must also fulfill their emotional commitments. Dads play indispensable roles that cannot be measured in dollars and cents: nurturer, mentor, disciplinarian, moral instructor, and skills coach, among other roles.

A new Federal commitment to reverse the rise in father absence should improve the job skills of low income fathers; promote marriage among parents; help low-income fathers establish positive relationships with their children and the children's mothers; and enlist the potency of faith-based and community groups that are closest to the needs of, and can provide the most direct support to, fathers and families.

Promoting Responsible Fatherhood: The 2002 Budget provides $60 million for competitive grants for initiatives that promote responsible fatherhood. Grants will be awarded to faith-based and community organizations that

help unemployed or low-income fathers and their families avoid or leave cash welfare, as well as to programs that promote successful parenting and strengthen marriage. This initiative will spur new community-level approaches to working with low-income fathers and families, and to providing them with job training, subsidized employment, career-advancing education, skills-based marriage and parenting education, mentoring and related activities. The budget also provides $4 million in 2002 for projects of national significance that support expansion of State and local responsible fatherhood efforts and extends two jobs tax credits for an additional year.

Strong Families, Safe Children

The President also is committed to helping families in crisis and to protecting children from abuse and neglect. The Federal-State child welfare system needs to do more to support and preserve families. At the same time, once children are placed outside the home, the system too often leaves them languishing in foster care or other temporary living arrangements for months or years.

There are more than 568,000 children in foster care, some 118,000 of whom are legally available for adoption now. This substitute care population has grown many times faster than the rate of growth of the U.S. child population in general. For each of the years from 1983 through 1999, more children entered than exited substitute care. Tragically, one in four foster children remains in foster care for at least three to five years; in every State, there are children who have been in foster care more than seven years. A foster child, on average, lives with three different families, and experiencing 10 or more placements into different homes is not rare.

Providing Education and Training Vouchers for Older Foster Care Children: The personal and emotional costs are especially high for young people who leave foster care at age 18 without having been adopted. Research indicates that these young people experience alarming rates of homelessness, early pregnancy, mental illness, unemployment, and drug abuse in the first years after they leave the system.

This year, some 20,000 youths will leave foster care when they reach the age of majority. To help these children, the budget proposes to provide $60 million through the Foster Care Independence Program specifically for education and training vouchers to youth who age out of foster care. This initiative would help ensure that these young people are able to obtain the support they need to develop skills to lead independent and productive lives. Each voucher, worth up to $5,000, would be available to cover the costs of college tuition or vocational training.

Promoting Safe and Stable Families: The current child welfare system has three primary goals to ensure children's safety; to create permanency in children's living arrangements; and to promote healthy child development. The financing mechanism of the current system, however, does not always advance these goals. Approximately ninety percent of Federal child welfare funds are provided for the removal and placement of children outside their own homes, including adoption activities. By contrast, less than 10 percent is provided for services that could either prevent a child's removal from his or her family or support timely family reunification in cases in which temporary removal is necessary. Because the growth of funds for prevention services through grants such as the Promoting Safe and Stable Families program has been so restricted, States often do not have enough money to provide the services that could either prevent children's removal from their families, if appropriate and safe, or support timely reunification in cases in which temporary removal is necessary.

To strengthen States' ability to promote child safety, permanency, and well being, the budget proposes funding the Promoting Safe and Stable Families program at $505 million in 2002, a $200 million increase over the 2001 level. These additional resources will help States keep children with their biological families, if safe and appropriate, or to place children with adoptive families. By undertaking more preventative efforts to help families in crisis, the prospects for children to live in a permanent home are enhanced. A child will remain with his or her biological parents or will be removed and placed in temporary foster care. Attempts can be made to return the child from foster care back to the home. If the State can show that such preventative efforts have failed to safely keep the child in, or return the child to, the home, judges are more likely to terminate parental rights, making the child legally free for adoption. In addition, to help States comply with Federal requirements that children be safe from abuse and neglect, and not languish in foster care, the budget provides $2 million to expand collaborative Federal/State efforts to monitor State child welfare systems.

Encouraging Adoption and Helping Children from Foster Care: In 1996, Congress passed, and the President signed into law, a tax credit designed to increase the number of adoptions. The provision provides a $5,000 tax credit to families for expenses associated with the adoption of a child. The provision also provides a $5,000

exclusion from income for employer-provided assistance.

There are more than 118,000 children legally available for adoption in the United States. While adoptive parents do not need to be given financial incentives to welcome children into their homes, the costs of adoption can be high and many parents need help defraying those costs. To encourage more adoptions, the budget proposes to make the adoption tax credit permanent and increase it from $5,000 to $7,500.

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Memo to the President Regarding Mexico City Policy

March 27, 2001

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THE WHITE HOUSE
WASHINGTON

March 27, 2001

MEMORANDUM FOR THE PRESIDENT

FROM: Harriet E. Miers

SUBJECT: Mexico City Policy

On January 22, you issued a Presidential memorandum to the Administration of AID directing that the policy of requiring foreign nongovernmental organizations to agree as a condition of receiving Federal funds for family planning activities that the organizations would neither perform abortions nor actively promote abortion as a method of family planning (the Mexico City Policy) would be restored. (This policy had been rescinded by President Clinton.)

As was widely reported, last Friday, pursuant to your direction Judge Gonzales directed AID to change a Contract Information Bulletin on the subject of the certifications required of foreign nongovermental organizations with respect to abortion. The attached memorandum for your signature will complete the process of restoring the Mexico City Policy and ensure that AID will implement it.

Pursuant to your approval, the memorandum will be issued tomorrow.

Signed/Dtd: 3-28-2001
orig. to FR for publication: 3/28/2001
copies to USAID 3/28/2001

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Memo to the Administrator for USAID on Mexico City Policy

March 28, 2001

THE WHITE HOUSE

WASHINGTON

March 28, 2001

MEMORANDUM FOR THE ADMINISTRATOR OF THE UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

SUBJECT: Restoration of the Mexico City Policy

The Mexico City Policy announced by President Reagan in 1984 required foreign nongovernmental organizations to agree as a condition of their receipt of Federal funds for family planning activities that such organizations would neither perform nor actively promote abortion as a method of family planning in other nations. This policy was in effect until it was rescinded on January 22, 1993.

It is my conviction that taxpayer funds appropriated pursuant to the Foreign Assistance Act should not be given to foreign nongovernmental organizations that perform abortions or actively promote abortion as a method of family planning in other nations. Accordingly, I direct that, except as otherwise provided below in section III, the paragraphs set forth below be included, as specified, in the Standard Provision that was issued in Contract Information Bulletin 99-06 entitled "Voluntary Population Activities (March 1999)" for use in all new grants and cooperative agreements awarded by the United States Agency for International Development (USAID) that provide assistance for family planning activities.

In addition, except as otherwise provided below, these paragraphs are to be included in the Standard Provision when any existing grant or cooperative agreement for family planning activities is amended to add new funding. The FY 2000 population certification requirements issued in Contract Information Bulletin 00-04 remain in effect until September 30, 2001.

The foregoing directive accomplishes the objective of my January 22, 2001, Memorandum to the USAID Administrator -- to reinstate in full all of the requirements of the Mexico City Policy in effect on January 19, 1993 -- and is issued pursuant to the authority vested in me by the Constitution and the laws of the United States of America, including section 104 of the Foreign Assistance Act of 1961, as amended (22 U.S.C. 2151b).

I. Grants and Cooperative Agreements with U.S. Nongovernmental Organizations

Paragraph (e) is replaced by the following paragraphs (e) and (f), which are to be included in the Standard Provision for use in assistance agreements with United States nongovernmental organizations:

"(e) Ineligibility of Foreign Nongovernmental Organizations that Perform or Actively Promote Abortion as a Method of Family Planning.

(1) The recipient agrees that it will not furnish assistance for family planning under this award to any foreign nongovernmental organization that performs or actively promotes abortion as a method of family planning in USAID-recipient countries or that provides financial support to any other foreign nongovernmental organization that conducts such activities. For purposes of this paragraph (e), a foreign nongovernmental organization is a nongovernmental organization that is not organized under the laws of any State of the United States, the District of Columbia or the Commonwealth of Puerto Rico.

(2) Prior to furnishing funds provided under this award to another nongovernmental organization organized under the laws of any State of the United States, the District of Columbia, or the Commonwealth of Puerto Rico, the recipient shall obtain the written agreement of such organization that the organization shall not furnish assistance for family planning under this award to any foreign nongovernmental organization except under the conditions and requirements that are applicable to the recipient as set forth in this paragraph (e).

(3) The recipient may not furnish assistance for family planning under this award to a foreign nongovernmental organization (the subrecipient) unless:

(i) The subrecipient certifies in writing that it does not perform or actively promote abortion as a method of family planning in USAID-recipient countries and does not provide financial support to any other foreign nongovernmental organization that conducts such activities; and

(ii) The recipient obtains the written agreement of the subrecipient containing the undertakings described in subparagraph (4) below.

(4) Prior to furnishing assistance for family planning under this award to a subrecipient, the subrecipient must agree in writing that:

(i) The subrecipient will not, while receiving assistance under this award, perform or actively promote abortion as a method of family planning in USAID-recipient countries or provide financial support to other foreign nongovernmental organizations that conduct such activities;

(ii) The recipient and authorized representatives of USAID may, at any reasonable time: (A) inspect the documents and materials maintained or prepared by the subrecipient in the usual course of its operations that describe the family planning activities of the subrecipient, including reports, brochures and service statistics; (B) observe the family planning activity conducted by the subrecipient; (C) consult with family planning personnel of the subrecipient; and (D) obtain a copy of the audited financial statement or report of the subrecipient, if there is one;

(iii) In the event that the recipient or USAID has reasonable cause to believe that a subrecipient may have violated its undertaking not to perform or actively promote abortion as a method of family planning, the recipient shall review the family planning program of the subrecipient to determine whether a violation of the undertaking has occurred. The subrecipient shall make available to the recipient such books and records and other information as may be reasonably requested in order to conduct the review. USAID may also review the family planning program of the subrecipient under these circumstances, and USAID shall have access to such books and records and information for inspection upon request;

(iv) The subrecipient shall refund to the recipient the entire amount of assistance for family planning furnished to the subrecipient under this award in the event it is determined that the certification provided by the subrecipient under subparagraph (3), above, is false;

(v) Assistance for family planning provided to the subrecipient under this award shall be terminated if the subrecipient violates any undertaking in the agreement required by subparagraphs (3) and (4), and the subrecipient shall refund to the recipient the

value of any assistance furnished under this award that is used to perform or actively promote abortion as a method of family planning; and

(vi) The subrecipient may furnish assistance for family planning under this award to another foreign nongovernmental organization (the sub-subrecipient) only if: (A) the sub-subrecipient certifies in writing that it does not perform or actively promote abortion as a method of family planning in USAID-recipient countries and does not provide financial support to any other foreign nongovernmental organization that conducts

such activities; and (B) the subrecipient obtains the written agreement of the sub-subrecipient that contains the same undertakings and obligations to the subrecipient as those provided by the subrecipient to the recipient as described in subparagraphs (4)(i)-(v) above.

(5) Agreements with subrecipients and sub-subrecipients required under subparagraphs (3) and (4) shall contain the definitions set forth in subparagraph (10) of this paragraph (e).

(6) The recipient shall be liable to USAID for a refund for a violation of any requirement of this paragraph (e) only if: (i) the recipient knowingly furnishes assistance for family planning to a subrecipient who performs or actively promotes abortion as a method of family planning; or (ii) the certification provided by a subrecipient is false and the recipient failed to make reasonable efforts to verify the validity of the certification prior to furnishing assistance to the subrecipient; or (iii) the recipient knows or has reason to know, by virtue of the monitoring which the recipient is required to perform under the terms of this award, that a subrecipient has violated any of the undertakings required under subparagraph (4) and the recipient fails to terminate assistance for family planning to the subrecipient, or fails to require the subrecipient to terminate assistance to a sub-subrecipient that violates any undertaking of the agreement required under subparagraph 4(vi), above. If the recipient finds, in exercising its monitoring responsibility under this award, that a subrecipient or sub-subrecipient receives frequent requests for the information described in subparagraph (10)(iii)(A)(II), below, the recipient shall verify that this information is being provided properly in accordance with subparagraph (10)(iii)(A)(II) and shall describe to USAID the reasons for reaching its conclusion.

(7) In submitting a request to USAID for approval of a recipient's decision to furnish assistance for family planning to a subrecipient, the recipient shall include a description of the efforts made by the recipient to verify the validity of the certification provided by the subrecipient. USAID may request the recipient to make additional efforts to verify the validity of the certification. USAID will inform the recipient in writing when USAID is satisfied that reasonable efforts have been made. If USAID concludes that these efforts are reasonable within the meaning of subparagraph (6) above, the recipient shall not be liable to USAID for a refund in the event the subrecipient's certification is false unless the recipient knew the certification to be false or misrepresented to USAID the efforts made by the recipient to verify the validity of the certification.

(8) It is understood that USAID may make independent inquiries, in the community served by a subrecipient or sub-subrecipient, regarding whether it performs or actively promotes abortion as a method of family planning.

(9) A subrecipient must provide the certification required under subparagraph (3) and a sub-subrecipient must provide the certification required under subparagraph (4)(vi) each time a new agreement is executed with the subrecipient or sub-subrecipient in furnishing assistance for family planning under the award.

(10) The following definitions apply for purposes of this paragraph (e):

(i) Abortion is a method of family planning when it is for the purpose of spacing births. This includes, but is not limited to, abortions performed for the physical or mental health of the mother, but does not include abortions performed if the life of the mother would be endangered if the fetus were carried to term or abortions performed following rape or incest (since abortion under these circumstances is not a family planning act).

(ii) To perform abortions means to operate a facility where abortions are performed as a method of family planning. Excluded from this definition are clinics or hospitals that do not include abortion in their family

planning programs. Also excluded from this definition is the treatment of injuries or illnesses caused by legal or illegal abortions, for example, post-abortion care.

(iii) To actively promote abortion means for an organization to commit resources, financial or other, in a substantial or continuing effort to increase the availability or use of abortion as a method of family planning.

(A) This includes, but is not limited to, the following:

(I) Operating a family planning counseling service that includes, as part of the regular program, providing advice and information regarding the benefits and availability of abortion as a method of family planning;

(II) Providing advice that abortion is an available option in the event other methods of family planning are not used or are not successful or encouraging women to consider abortion (passively responding to a question regarding where a safe, legal abortion may be obtained is not considered active promotion if the question is specifically asked by a woman who is already pregnant, the woman clearly states that she has already decided to have a legal abortion, and the family planning counselor reasonably believes that the ethics of the medical profession in the country requires a response regarding where it may be obtained safely);

(III) Lobbying a foreign government to legalize or make available abortion as a method of family planning or lobbying such a government to continue the legality of abortion as a method of family planning; and

(IV) Conducting a public information campaign in USAID-recipient countries regarding the benefits and/or availability of abortion as a method of family planning.

(B) Excluded from the definition of active promotion of abortion as a method of family planning are referrals for abortion as a result of rape or incest, or if the life of the mother would be endangered if the fetus

were carried to term. Also excluded from this definition is the treatment of injuries or illnesses caused by legal or illegal abortions, for example, post-abortion care.

(C) Action by an individual acting in the individual's capacity shall not be attributed to an organization with which the individual is associated, provided that the organization neither endorses nor provides financial support for the action and takes reasonable steps to ensure that the individual does not improperly represent that the individual is acting on behalf of the organization.

(iv) To furnish assistance for family planning to a foreign nongovernmental organization means to provide financial support under this award to the family planning program of the organization, and includes the transfer of funds made available under this award or goods or services financed with such funds, but does not include the purchase of goods or services from an organization or the participation of an individual in the general training programs of the recipient, subrecipient or sub-subrecipient.

(v) To control an organization means the possession of the power to direct or cause the direction of the management and policies of an organization.

(11) In determining whether a foreign nongovernmental organization is eligible to be a subrecipient or sub-subrecipient of assistance for family planning under this award, the action of separate nongovernmental organizations shall not be imputed to the subrecipient or sub-subrecipient, unless, in the judgment of USAID, a separate nongovernmental organization is being used as a sham to avoid the restrictions of this paragraph (e). Separate nongovernmental organizations are those that have distinct legal existence in accordance with the laws of the countries in which they are organized. Foreign organizations that are separately organized shall not be considered separate, however, if one is controlled by the other. The recipient may request USAID's approval to treat as separate the family planning activities of two or more organizations, that would not be considered separate under the preceding sentence, if the recipient believes, and provides a written justification to USAID therefor, that the family planning activities of the organizations are sufficiently distinct so as to warrant not imputing the activity of one to the other.

(12) Assistance for family planning may be furnished under this award by a recipient, subrecipient or sub-subrecipient to a foreign government even though the government includes abortion in its family planning program, provided that no assistance may be furnished in support of the abortion activity of the government and any funds transferred to the government shall be placed in a segregated account to ensure that such funds may not be used to support the abortion activity of the government.

(13) The requirements of this paragraph are not applicable to child spacing assistance furnished to a foreign nongovernmental organization that is engaged primarily in providing health services if the objective of the assistance is to finance integrated health care services to mothers and children and child spacing is one of several health care services being provided by the organization as part of a larger child survival effort with the objective of reducing infant and child mortality.

(f) The recipient shall insert paragraphs (a), (b), (c), (d) and (f) of this provision in all subsequent subagreements and contracts involving family planning or population activities that will be supported in whole or in part from funds under this award. Paragraph (e) shall be inserted in subagreements and sub-subagreements in accordance with the terms of paragraph (e). The term subagreement means subgrants and subcooperative agreements."

II. Grants and Cooperative Agreements with Non-U.S., Nongovermental Organizations

Paragraph (e) is replaced by the following paragraphs (e) and (f), which are to be included in the Standard Provision for grants and cooperative agreements with non-United States, nongovernmental organizations:

"(e) Ineligibility of Foreign Nongovernmental Organizations that Perform or Actively Promote Abortion as a Method of Family Planning.

(1) The recipient certifies that it does not now and will not during the term of this award perform or actively promote abortion as a method of family planning in USAID-recipient countries or provide financial support to any other foreign nongovernmental organization that conducts such activities. For

purposes of this paragraph (e), a foreign nongovernmental organization is a nongovernmental organization that is not organized under the laws of any State of the United States, the District of Columbia or the Commonwealth of Puerto Rico.

(2) The recipient agrees that the authorized representative of USAID may, at any reasonable time: (i) inspect the documents and materials maintained or prepared by the recipient in the usual course of its operations that describe the family planning activities

of the recipient, including reports, brochures and service statistics; (ii) observe the family planning activity conducted by the recipient, (iii) consult with family planning personnel of the recipient; and (iv) obtain a copy of the audited financial statement or report of the recipient, if there is one.

(3) In the event USAID has reasonable cause to believe that the recipient may have violated its undertaking not to perform or actively promote abortion as a method of family planning, the recipient shall make available to USAID such books and records and other information as USAID may reasonably request in order to determine whether a violation of the undertaking has occurred.

(4) The recipient shall refund to USAID the entire amount of assistance for family planning furnished under this award in the event it is determined that the certification provided by the recipient under subparagraph (1), above, is false.

(5) Assistance for family planning to the recipient under this award shall be terminated if the recipient violates any undertaking required by this paragraph (e), and the recipient shall refund to USAID the value of any assistance furnished under this award that is used to perform or actively promote abortion as a method of family planning.

(6) The recipient may not furnish assistance for family planning under this award to a foreign nongovernmental organization (the subrecipient) unless: (i) the sub-recipient certifies in writing that it does not perform or actively promote abortion as a method of family planning in USAID-recipient countries and does not provide financial support to any other foreign nongovernmental organization that conducts such activities; and (ii) the recipient obtains the written agreement of the subrecipient containing the undertakings described in subparagraph (7), below.

(7) Prior to furnishing assistance for family planning under this award to a subrecipient, the subrecipient must agree in writing that:

(1) The subrecipient will not, while receiving assistance under this award, perform or actively promote abortion as a method of family planning in USAID-recipient countries or provide financial support to other nongovernmental organizations that conduct such activities.

(ii) The recipient and authorized representatives of USAID may, at any reasonable time: (A) inspect the documents and materials maintained or prepared by the subrecipient in the usual course of its operations that describe the family planning activities of the subrecipient, including reports, brochures and service statistics; (B) observe the family planning activity conducted by the subrecipient; (C) consult with family planning personnel of the subrecipient; and (D) obtain a copy of the audited financial statement or report of the subrecipient, if there is one.

(iii) In the event the recipient or USAID has reasonable cause to believe that a subrecipient may have violated its undertaking not to perform or actively promote abortion as a method of family planning, the recipient shall review the family planning program of the subrecipient to determine whether a violation of the undertaking has occurred. The subrecipient shall make available to the recipient such books and records and other information as may be reasonably requested in order to conduct the review. USAID may also review the family planning program of the subrecipient under these circumstances, and USAID shall have access to such books and records and information for inspection upon request.

(iv) The subrecipient shall refund to the recipient the entire amount of assistance for family planning furnished to the subrecipient under this award in the event it is determined that the certification provided by the subrecipient under subparagraph (6), above, is false.

(v) Assistance for family planning to the subrecipient under this award shall be terminated if the subrecipient violates any undertaking required by this paragraph (e), and the subrecipient shall refund to the recipient the value of any assistance furnished under this award that is used to perform or actively promote abortion as a method of family planning.

(vi) The subrecipient may furnish assistance for family planning under this award to another foreign nongovernmental organization (the sub-subrecipient) only if: (A) the sub-subrecipient certifies in writing that it does not perform or actively promote abortion as a method of family planning in USAID-recipient countries and does not provide financial support to any other foreign nongovernmental organization that conducts such activities; and (B) the subrecipient obtains the written agreement of the sub-subrecipient that contains the same undertakings and obligations to the subrecipient as those provided by the subrecipient to the recipient as described in subparagraphs (7)(i) - (v), above.

(8) Agreements with subrecipients and sub-subrecipients required under subparagraphs (6) and (7) shall contain the definitions set forth in subparagraph (13) of this paragraph (e).

(9) The recipient shall be liable to USAID for a refund for a violation by a subrecipient relating to its certification required under subparagraph (6) or by a subrecipient or a sub-subrecipient relating to its undertakings in the agreement required under subparagraphs (6) and (7) only if: (i) the recipient knowingly furnishes assistance for family planning to a subrecipient that performs or actively promotes abortion as a method of family planning; or (ii) the certification provided by a subrecipient is false and the recipient failed to make reasonable efforts to verify the validity of the certification prior to furnishing assistance to the subrecipient; or (iii) the recipient knows or has reason to know, by virtue of the monitoring that the recipient is required to perform under the terms of this award, that a subrecipient has violated any of the undertakings required under subparagraph (7) and the recipient fails to terminate assistance for family planning to the subrecipient, or fails to require the subrecipient to terminate assistance to a sub-subrecipient that violates any undertaking of the agreement required under subparagraph 7 (vi), above. If the recipient finds, in exercising its monitoring responsibility under this award, that a subrecipient or sub-subrecipient receives frequent requests for the information described in subparagraph (13)(iii)(A)(II), below, the recipient shall verify that this information is being provided properly in accordance with subparagraph 13(iii)(A)(II) and shall describe to USAID the reasons for reaching its conclusion.

(10) In submitting a request to USAID for approval of a recipient's decision to furnish assistance for family planning to a subrecipient, the recipient shall include a description of the efforts made by the recipient to verify the validity of the certification provided by the subrecipient. USAID may request the recipient to make additional efforts to verify the validity of the certification. USAID will inform the recipient in writing when USAID is satisfied that reasonable efforts have been made. If USAID concludes that these efforts are reasonable within the meaning of subparagraph (9) above, the recipient shall not be liable to USAID for a refund in the event the subrecipient's certification is false unless the recipient knew the certification to be false or misrepresented to USAID the efforts made by the recipient to verify the validity of the certification.

(11) It is understood that USAID may make independent inquiries, in the community served by a subrecipient or sub-subrecipient, regarding whether it performs or actively promotes abortion as a method of family planning.

(12) A subrecipient must provide the certification required under subparagraph (6) and a sub-subrecipient must provide the certification required under subparagraph (7)(vi) each time a new agreement is executed with the subrecipient or sub-subrecipient in furnishing assistance for family planning under this award.

(13) The following definitions apply for purposes of paragraph (e):

(i) Abortion is a method of family planning when it is for the purpose of spacing births. This includes, but is not limited to, abortions performed for the physical or mental health of the mother but does not include abortions performed if the life of the mother would be endangered if the fetus were carried to term or abortions performed following rape or incest (since abortion under these circumstances is not a family planning act).

(ii) To perform abortions means to operate a facility where abortions are performed as a method of family planning. Excluded from this definition are clinics or hospitals that do not include abortion in their family planning programs. Also excluded from this definition is the treatment of injuries or illnesses caused by legal or illegal abortions, for example, post-abortion care.

(iii) To actively promote abortion means for an organization to commit resources, financial or other, in a substantial or continuing effort to increase the availability or use of abortion as a method of family planning.

(A) This includes, but is not limited to, the following:

(I) Operating a family planning counseling service that includes, as part of the regular program, providing advice and information regarding the benefits and availability of abortion as a method of family planning;

(II) Providing advice that abortion is an available option in the event other methods of family planning are not used or are not successful or encouraging women to consider abortion (passively responding to a question regarding where a safe, legal abortion may be obtained is not considered active promotion if the question is specifically asked by a woman who is already pregnant, the woman clearly states that she has already decided to have a legal abortion, and the family planning counselor reasonably believes that the ethics of the medical profession in the country requires a response regarding where it may be obtained safely);

(III) Lobbying a foreign government to legalize or make available abortion as a method of family planning or lobbying such a government to continue the legality of abortion as a method of family planning; and

(IV) Conducting a public information campaign in USAID-recipient countries regarding the benefits and/or availability of abortion as a method of family planning.

(B) Excluded from the definition of active promotion of abortion as a method of family planning are referrals for abortion as a result of rape or incest or if the life of the mother would be endangered if the fetus were carried to term. Also excluded from this definition is the treatment of injuries or illnesses caused by legal or illegal abortions, for example, post-abortion care.

(C) Action by an individual acting in the individual's own capacity shall not be attributed to an organization with which the individual is associated, provided that the organization neither endorses nor provides financial support for the action and takes reasonable steps to ensure that the individual does not improperly represent the individual is acting on behalf of the organization.

(iv) To furnish assistance for family planning to a foreign nongovernmental organization means to provide financial support under this award to the family planning program of the organization, and includes the transfer of funds made available under this award or goods or services financed with such funds, but does not include the purchase of goods or services from an organization or the participation of an individual in the general training programs of the recipient, subrecipient or sub-subrecipient.

(v) To control an organization means the possession of the power to direct or cause the direction of the management and policies of an organization.

(14) In determining whether a foreign nongovernmental organization is eligible to be a recipient, subrecipient or sub-subrecipient of assistance for family planning under this award, the action of separate nongovernmental organizations shall not be imputed to the recipient, subrecipient or sub-subrecipient, unless, in the judgment of USAID, a separate nongovernmental organization is being used as a sham to avoid the restrictions of this paragraph (e). Separate nongovernmental organizations are those that have distinct legal existence in accordance with the laws of the countries in which they are organized. Foreign organizations that are separately organized shall not be considered separate, however, if one is controlled by the other. The recipient may request USAID's approval to treat as separate the family planning activities of two or more organizations, which would not be considered separate under the preceding sentence, if the recipient believes, and provides a written justification to USAID therefor, that the family planning activities of the organizations are sufficiently distinct so as to warrant not imputing the activity of one to the other.

(15) Assistance for family planning may be furnished under this award by a recipient, subrecipient or sub-subrecipient to a foreign government even though the government includes abortion in its family planning program, provided that no assistance may be furnished in support of the abortion activity of the government and any funds transferred to the government shall be placed in a segregated account to ensure that such funds may not be used to support the abortion activity of the government.

(16) The requirements of this paragraph are not applicable to child spacing assistance furnished to a foreign nongovernmental organization that is engaged primarily in providing health services if the objective of the assistance is to finance integrated health care services to mothers and children and child spacing is one of several health care services being provided by the organization as part of a larger child survival effort with the objective of reducing infant and child mortality.

(f) The recipient shall insert paragraphs (a), (b), (c), (d) and (f) of this provision in all subsequent subagreements and contracts involving family planning or population activities that will be supported in whole or in part from funds under this award. Paragraph (e) shall be inserted in subagreements and sub-subagreements in accordance with the terms of paragraph (e). The term subagreements means subgrants and subcooperative agreements."

III. Exceptions

The paragraphs set forth in sections (I) and (II) above may be omitted from the Standard Provision in the situations described below:

(1) While the paragraphs are to be used in grants and cooperative agreements (and assistance subagreements) that provide financing for family planning activity or activities, if family planning is a component of an activity involving assistance for other purposes, such as food and nutrition, health or education, paragraph (e), "Ineligibility of Foreign Nongovernmental Organizations that Perform or Actively Promote Abortion as a Method of Family Planning," applies only to the family planning component.

(2) When health or child survival funds are used to provide assistance for child spacing as well as health purposes, these paragraphs are applicable to such assistance unless: (a) the foreign nongovernmental organization is one that primarily provides health services; (b) the objective of the assistance is to finance integrated health care services to mothers and children; and (c) child spacing is one of several health care services being provided as part of a larger child survival effort with the objective of reducing infant and child mortality. These paragraphs need not be included in the assistance agreement if it indicates that assistance for child spacing will be provided only in this way. USAID support under these circumstances is considered a contribution to a health service delivery program and not to a family planning program. In such a case, these paragraphs need not be included in an assistance agreement.

(3) These paragraphs need not be included in assistance agreements with United States nongovernmental organizations for family planning purposes if implementation of the activity does not involve assistance to foreign nongovernmental organizations.

You are authorized and directed to publish this memorandum in the Federal Register.

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For Immediate Release
Office of the Press Secretary
June 7, 2001

Remarks by the President in Tax Cut Bill Signing Ceremony

East Room

9:58 A.M. EDT

THE PRESIDENT: Thank you. Sit down -- behave yourself, you're at the White House. (Laughter.)

Laura, thank you very much for being here on this historic moment. Mr. Vice President, Secretary O'Neill, Director Daniels, Secretary Evans and Chao are here, as well. Secretary Abraham, Administrator Christine Todd Whitman, members of the United States Senate, members of the House of Representatives, fellow Americans. Welcome.

Some months ago, in my speech to the Joint Session of Congress, I had the honor of introducing Steven Ramos to the nation. Steven is the network administrator for a school district. His wife, Josefina, teaches at a charter school. They have a little girl named Lianna. And they're trying to save for Lianna's college education.

High taxes made saving difficult. Last year, they paid nearly $8,000 in federal income taxes. Well, today, we're beginning to make life for the Ramos' a lot easier. Today, we start to return some of the Ramos' money -- and not only their money, but the money of everybody who paid taxes in the United States of America. (Applause.)

Across the board tax relief does not happen often in Washington, D.C. In fact, since World War II, it has happened only twice: President Kennedy's tax cut in the '60s and President Reagan's tax cuts in the 1980s. And now it's happening for the third time, and it's about time. (Applause.)

A year ago, tax relief was said to be a political impossibility. Six months ago, it was supposed to be a political liability. Today, it becomes reality. It becomes reality because of the bipartisan leadership of the members of the United States Congress. Members like Bill Thomas, of California; Ralph Hall, of Texas; Charles Grassley, of Iowa; Max Baucus of Montanna; Zell Miller, of Georgia; John Breaux, of Louisiana; Trent Lott, of Mississippi; and the entire leadership team in the Senate; and Denny Hastert of Illinois and the leadership team in the House of Representatives. Some Democrats, many Republicans, who worked tirelessly and effectively to produce this important result.

I also want to pay tribute to the members of my administration who worked with Congress to bring about this day: Vice President Cheney, Secretary O'Neill, Director Daniels and the team inside the White House of Andy Card and Larry Lindsey, Nick Calio and their staffs.

With us today are 15 of the many families I met as I toured our country making the case for tax relief, hard-working Americans. I was able to talk about their stories and their struggles and their hopes, which made the case for tax relief much stronger than my words could possible convey. And I want to thank you all for coming.

And here at the White House today are representatives of millions of Americans, including labor union members, small business owners and family farmers. Your persistence and determination helped bring us to this day. The American people should be proud of your efforts on their behalf, and I personally thank you all for coming.

Tax relief is a great achievement for the American people. Tax relief is the first achievement produced by the new tone in Washington, and it was produced in record time. (Applause.) Tax relief is an achievement for families struggling to enter the middle class. For hard working lower income families, we have cut the

bottom rate of federal income tax from 15 percent to 10 percent. We doubled the per-child tax credit to $1,000, and made it refundable. Tax relief is compassionate and it is now on the way.

Tax relief is an achievement for middle class families squeezed by high energy prices and credit card debt. Most families can look forward to a $600 tax rebate, before they have to pay the September back-to-school bills. And in the years ahead, taxpayers can look forward to steadily declining income tax rates.

Tax relief is an achievement for families that want the government tax policy to be fair and not penalize them for making good choices, good choices such as marriage and raising a family. So we cut the marriage penalty.

Tax relief makes the code more fair for small businesses and farmers and individuals by eliminating the death tax. (Applause.) Over the long haul, tax relief will encourage work and innovation. It will allow American workers to save more on their pension plan or individual retirement accounts. Tax relief expands individual freedom. The money we return, or don't take in the first place, can be saved for a child's education, spent on family needs, invested in a home or in a business or a mutual fund or used to reduce personal debt.

The message we send today, it's up to the American people; it's the American people's choice. We recognize loud and clear the surplus is not the government's money. The surplus is the people's money and we ought to trust them with their own money. (Applause.)

This tax relief plan is principled. We cut taxes for every income taxpayer. We target nobody in, we target nobody out. And tax relief is now on the way.

Today is a great day for America. It is the first major achievement of a new era, an era of steady cooperation. And more achievements are ahead. I thank the members of Congress in both parties who made today possible. Together, we will lead our country to new progress and new possibilities. It is now my honor to sign the first broad tax relief in a generation. (Applause.)

(The bill was signed.) (Applause.)

END
10:07 A.M. EDT

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For Immediate Release
Office of the Press Secretary
November 5, 2001

National Adoption Month Proclamation

By the President of the United States of America
A Proclamation

Children deserve to be raised in loving families with parents who protect and nurture them. For some children, adoption is their best chance for a healthy and happy life. Each year, American families adopt approximately 120,000 newborn or older children, providing them with a loving and supportive environment.

Despite this substantial number of annual adoptions, more than 134,000 children are currently waiting adoption. While our foster care system can provide a safe, temporary home for these children, adoption would give them the love and stability of a permanent family that would better enable them to develop to their full potential.

My Administration is working to help states promote and support adoptions. This year, 35 states and the District of Columbia received adoption incentive awards for increasing the number of children they placed from foster care into permanent homes. States have reinvested these bonuses to enhance their adoption and child welfare programs, which has resulted in an unprecedented 79 percent increase in adoptions from 28,000 in 1996 to 50,000 in 2000.

Although we have made dramatic advances in encouraging adoption, we must strengthen our efforts to find a safe, loving, and permanent home for every child awaiting one. One important way to advance towards this goal is to ease the financial burden on families that adopt children. The tax relief bill that I signed into law earlier this year extends and increases the adoption tax credit for qualified expenses from $5,000 to $10,000 per child. The new law also increases the tax credit for adoptive parents of children with special needs from $6,000 to $10,000 per child, regardless of expenses. Parents who adopt children with special needs will benefit from this meaningful tax credit because it will help cover unique adoption costs.

Ensuring the provision of post-adoptive services also plays an important role in facilitating successful adoptions. I sup-port the Promoting Safe and Stable Families proposal, currently before the Congress, which would improve post-adoptive services by -prioritizing research and evaluation for these services and establishing systems to ensure that they are available to meet the needs of adoptive families. In addition, this proposal provides for education and training vouchers to children adopted after the age of 15.

Adoptive parents have a special calling -- sharing a loving home with children in need, offering them hope for a brighter future. Federal, State, and local governments must continue supporting these quiet heroes as they make the considerable sacrifices and receive the countless blessings of parenthood that come from providing a child with the chance of a lifetime -- an upbringing in a happy and healthy home.

NOW, THEREFORE, I, GEORGE W. BUSH, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim November 2001, as National Adoption Month. I call on all Americans to observe this month with appropriate programs and activities to honor adoptive families and to participate in efforts to find permanent homes for waiting children.

IN WITNESS WHEREOF, I have hereunto set my hand this fifth day of November, in the year of our Lord two thousand one, and of the Independence of the United States of America the two hundred and twenty-sixth.

GEORGE W. BUSH ###

For Immediate Release
Office of the Press Secretary
January 17, 2002

President Bush Acts to Promote Strong Families, Safe Children

THE PRESIDENT: Thank you all. Please be seated. Well, thanks, Laura. I appreciate those kind words, and I love you a lot.

I want to welcome you all to the White House. It's our honor to entertain you all and to let you witness a piece of history here. The bill I'm going to sign rests on the belief that our strong nation is built on strong families. The legislation reaffirms our country's commitment to helping children grow up in secure and loving families by encouraging adoption; by helping young adults make their way in life after they leave foster care; and by expanding mentoring for children who have a mom and dad in prison.

I'm proud of the men and women of Congress who worked hard to make this happen. This is a really good piece of legislation. In this town, sometimes the really good pieces of legislation aren't really recognized, because there hadn't been a lot of fighting and hair-pulling and gnashing of teeth. But this bill, sponsored by both Democrats and Republicans, is a meaningful, real piece of legislation that's going to change people's lives.

I want to thank Mike DeWine, and I want to thank Ben Cardin, and I want to thank Deborah Price -- three of the bill's sponsors who have come today -- for your hard work. I am sorry that Jay Rockefeller of West Virginia, and Wally Herger of California, are not here, as well. But the five names I just named are responsible for getting this piece of legislation through the House and the Senate and to my desk. And thank you all. (Applause.)

I, too, want to thank Tommy. He's worked really hard. He's a good, compassionate man who cares deeply about our society. And, Tommy, thanks for your hard work. You tell your staff, thanks, too, for working.

The family is the foundation of this society. And here's what I know. It's the place where we find deep human fulfillment, and where we find love. It is where character of our nation is shaped, and where values are forged. Families provide us with comfort and encouragement, compassion and hope, mutual support and unconditional love. No family is perfect, but every family is important.

Promoting strong families was my firm commitment when I was the governor of Texas, and promoting strong families remains a priority for me as your President. We all know that children who are surrounded by love have a strong foundation for success as adults. When someone thinks a child is the most important person in the world, that child will grow up to be confident in their self, and loving toward others. She'll make her community stronger, and her nation better.

The Promoting Safe and Stable Families Program has a great goal, keeping families together whenever possible. It helps to prevent the removal of children from their homes. And if that must happen to protect a child's safety, it supports efforts to correct the problem that broke the family apart, and reunite the family safely and quickly.

It also supports adoption and post-adoptive services to place children with loving families, to ease a child's transition into a new family, and to help ensure that families stay strong and intact.

My budget next year will build on this good work, by requesting $505 million in funding for promoting the Safe and Stable Families Program, $130 million more than it receives this year. (Applause.)

The bill I sign today also supports children who grew up in foster homes by authorizing states to provide vouchers of up to $5,000 a year for education and vocational training to teens who have aged out of the foster care system. My budget next year will ask Congress for $60 million to fully fund this program.

I'm especially pleased that this bill authorizes funds for a crucial part of my armies of compassion initiative, mentoring children whose parents are in prison. These children don't see their parents every day, but, like all children, need help with homework, someone to play catch with, someone to hug them. Countless adults are willing to open their hearts to these children, and we should do all we can to support their compassion. Government cannot love a child, but it can support those who do -- parents and family members and neighbors, and caring adults who have heard the call.

We have some parents with us today who have heard the call, who share their love with their children and are building strong families through adoption. Derek and Cindy Baliles are police officers in Montgomery County, Maryland, thank you all for coming. They knew they had a lot of love to offer, and they knew as soon as they met Taylor and Gerald -- better known as G-man -- (laughter) -- that the boys would make great additions to their family. The boys obviously feel the same way. Thanks to their hard work -- thanks to the hard work of a county social worker, their adoption was finalized quickly, on the same day as their mother's birthday.

Willie and Sybil Gray originally planned to adopt one little girl who would become a sister to their son, Christopher. But an adoption agency told them that Kenyetta and Katrina, two sisters who needed a new home, needed to be adopted. The girls and their new parents quickly bonded, and Willie and Sybil will finalize their adoption in the next few months.

Adoptive parents like Willie and Sybil and Derek and Cindy give their children the most precious gift possible -- their love. Advocates for adoption, many of whom are in this room, know that when you find a loving family, it makes a huge difference in a child's life, and know that our national goal must be to find a loving family for every child that needs one. (Applause.)

Sadly, a great American and a strong advocate for adoption and stable families passed away this week. Dave Thomas was best known as the founder of Wendy's Restaurants. But people who devote their lives to helping children know that Dave Thomas shared their commitment.

As a child who was adopted, Dave once said, I feel strongly that all children deserve a secure and loving family. His own family provided the foundation that allowed him and encouraged him to become one of America's most successful entrepreneurs -- and one of America's most familiar faces.

Dave's vision of America was one in which all children would be a part of a loving family, so they could grow into healthy and happy and successful adults. This bill that I'm fixing to sign will bring us closer to his vision.

And now I'd like the members of the Congress and Secretary Thompson to join me as I sign the Promoting Safe and Stable Families legislation.

(The bill is signed.)

Thank you all for coming. (Applause.)

END 2:31 P.M. EST

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National Sanctity of Human Life Day, 2002

January 18, 2002

This Nation was founded upon the belief that every human being is endowed by our Creator with certain "unalienable rights." Chief among them is the right to life itself. The Signers of the Declaration of Independence pledged their own lives, fortunes, and honor to guarantee inalienable rights for all of the new country's citizens. These visionaries recognized that an essential human dignity attached to all persons by virtue of their very existence and not just to the strong, the independent, or the healthy. That value should apply to every American, including the elderly and the unprotected, the weak and the infirm, and even to the unwanted.

Thomas Jefferson wrote that, "[t]he care of human life and happiness and not their destruction is the first and only legitimate object of good government." President Jefferson was right. Life is an inalienable right, understood as given to each of us by our Creator.

President Jefferson's timeless principle obligates us to pursue a civil society that will democratically embrace its essential moral duties, including defending the elderly, strengthening the weak, protecting the defenseless, feeding the hungry, and caring for children -- born and unborn. Mindful of these and other obligations, we should join together in pursuit of a more compassionate society, rejecting the notion that some lives are less worthy of protection than others, whether because of age or illness, social circumstance or economic condition. Consistent with the core principles about which Thomas Jefferson wrote, and to which the Founders subscribed, we should peacefully commit ourselves to seeking a society that values life -- from its very beginnings to its natural end. Unborn children should be welcomed in life and protected in law.

On September 11, we saw clearly that evil exists in this world, and that it does not value life. The terrible events of that fateful day have given us, as a Nation, a greater understanding about the value and wonder of life. Every innocent life taken that day was the most important person on earth to somebody; and every death extinguished a world. Now we are engaged in a fight against evil and tyranny to preserve and protect life. In so doing, we are standing again for those core principles upon which our Nation was founded.

NOW, THEREFORE, I, GEORGE W. BUSH, President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States, do hereby proclaim Sunday, January 20, 2002, as National Sanctity of Human Life Day. I call upon all Americans to reflect upon the sanctity of human life. Let us recognize the day with appropriate ceremonies in our homes and places of worship, rededicate ourselves to compassionate service on behalf of the weak and defenseless, and reaffirm our commitment to respect the life and dignity of every human being.

IN WITNESS WHEREOF, I have hereunto set my hand this eighteenth day of January, in the year of our Lord two thousand two, and of the Independence of the United States of America the two hundred and twenty-sixth.

GEORGE W. BUSH ###

President's Phone Call to March for Life Participants

January 22, 2002

THE PRESIDENT: Nellie, thank you very much. I want to thank you very much, and I want to wish everybody a good afternoon. I'm calling from the state of West Virginia. (Applause.)

I want to begin, Nellie, by praising you and your dedication to the cause of human life. For almost 30 years, Americans from every state in the Union have gathered in the Washington Mall in order to march for life. This march is an example of an inspiring commitment and of deep human compassion.

Everyone there believes, as I do, that every life is valuable; that our society has a responsibility to defend the vulnerable and weak, the imperfect and even the unwanted; and that our nation should set a great goal that unborn children should be welcomed in life and protected in law. (Applause.)

Abortion is an issue that deeply divides our country. And we need to treat those with whom we disagree with respect and civility. We must overcome bitterness and rancor where we find it and seek common ground where we can. But we will continue to speak out on behalf of the most vulnerable members of our society.

We do so because we believe the promises of the Declaration of Independence are the common code of American life. They should apply to everyone, not just the healthy or the strong or the powerful. A generous society values all human life. A merciful society seeks to expand legal protection to every life, including early life. And a compassionate society will defend a simple, moral proposition, life should never be used as a tool, or a means to an end.

These are bedrock principles. and that is why my administration opposes partial-birth abortion and public funding for abortion; -- (applause) -- why we support teen abstinence and crisis pregnancy programs; adoption and parental notification laws; and why we are against all forms of human cloning. (Applause.)

And that is why I urge the United States Senate to support a comprehensive and effective ban on human cloning, a ban that was passed by an overwhelming and bipartisan vote of the House of Representatives last July. (Applause.)

We are a society with enough compassion and wealth and love to care for both mothers and their children, and to seek the promise and potential of every single life. You're working and marching on behalf of a noble cause, and affirming a culture of life. Thank you for your persistence, for defending human dignity, and for caring for every member of the human family.

May God continue to bless America. Thank you very much. (Applause.)

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SUPPLEMENTARY INFORMATION: The caption **ADDRESSES** on page 9223, column two, reads "The five meetings to conduct the negotiated rulemaking process will be held at the U.S. Department of Education, Barnard Auditorium, 400 Maryland Avenue, SW., Washington, DC 20202." It is corrected to read "The five meetings to conduct the negotiated rulemaking process will be held at the Sheraton Premiere At Tysons Corner, 8661 Leesburg Pike, Vienna, VA 22182." The published listing of individuals under the heading *Representing Principals and Teachers* on page 9224, column one, is corrected by adding to the list "David Sherman, Vice President, UFT, New York City (NY)". The published listing of individuals under the heading *Reprssenting local Administrators and Local School Boards* on page 9224, column one, is corrected by removing from the list "Nelson Smith, charter schools, Washington, DC" and adding, in its place, "Nelson Smith, Managing Director for New School Services, New American Schools, Arlington (VA); formerly Executive Director of the DC Public Charter School Board". The published Web site under the heading *Topics Selected for Negotiation* on page 9224, column two, reads "*www.ed.gov/nelb/*". It is corrected to read "*www.ed.gov/nclb/*".

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Note: The official version of this document is the document published in the **Federal Register**. Free Internet access to the official edition of the **Federal Register** and the Code of Federal Regulations is available on GPO access at: *http://www.access.gpo.gov/nara/index.html*

Dated: February 28, 2002.

Susan B. Neuman,

Assistant Secretary for Elementary and Secondary Education.

[FR Doc. 02–5256 Filed 3–1–02; 11:21 am]

BILLING CODE 4001–01–U

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

42 CFR Part 457

[CMS–2127–P]

RIN 0938–AL37

State Children's Health Insurance Program; Eligibility for Prenatal Care for Unborn Children

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: In order to provide prenatal care and other health services, this proposed rule would revise the definition of "child" under the State Children's Health Insurance Program (SCHIP) to clarify that an unborn child may be considered a "targeted low-income child" by the State and therefore eligible for SCHIP if other applicable State eligibility requirements are met. Under this definition, the State may elect to extend eligibility to unborn children for health benefits coverage, including prenatal care and delivery, consistent with SCHIP requirements.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on May 6, 2002.

ADDRESSES: In commenting, please refer to file code CMS–2127-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Mail written comments (one original and three copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2127-P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be timely received in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and three copies) to one of the following addresses:

Room 443-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or

Room C5–16–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Kathleen Farrell, (410) 786–3285.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone (410) 786–7195.

I. Background

Section 4901 of the Balanced Budget Act, (Public Law 105–33), as amended by Public Law 105–100, added title XXI to the Act. Title XXI authorizes the State Children's Health Insurance Program (SCHIP) to assist State efforts to initiate and expand the provision of child health assistance to uninsured, low-income children. Under title XXI, States may provide child health assistance primarily for obtaining health benefits coverage through (1) a separate child health program that meets the requirements specified under section 2103 of the Act; (2) expanding eligibility for benefits under the State's Medicaid plan under title XIX of the Act; or (3) a combination of the two approaches. To be eligible for funds under this program, States must submit a State child health plan (State plan), that meets the applicable requirements of title XXI and is approved by the Secretary.

The State Children's Health Insurance Program is jointly financed by the Federal and State governments and is administered by the States. Within broad Federal guidelines, each State determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. Under section 2102(b) of the Act, States have discretion to adopt eligibility standards that are related to age, and thus may extend SCHIP eligibility only to certain age groups of targeted low-income children (who must be under age 19). SCHIP provides a capped amount of funds to States on a matching basis for Federal fiscal years (FY) 1998 through 2007. Regulations implementing SCHIP are set forth at 42 CFR part 457.

II. Provisions of the Proposed Regulations

Section 2110 of the Act sets forth the definition of a targeted low-income child. In accordance with this section of

the Act, at § 457.310 we define a targeted low-income child as a child who meets the standards set forth at § 457.310 and the eligibility standards established by the State. The term "child" is defined at section 2110(c)(1) of the Act as an individual under 19 years of age. Under this framework and in accordance with the regulations promulgated by the Secretary, a State may elect the age groups of targeted low-income children under age 19 that will be eligible for SCHIP coverage under their State plans. For example, a State plan may permit eligibility of children only through age 12. This statutory definition is currently repeated in the regulations at § 457.10.

For reasons set forth below, in interest of providing necessary pre-natal care to children, we propose in this regulation to clarify and expand the definition of the term "child" so that a State may elect to make individuals in the period between conception and birth eligible for coverage as well under their State plan. Specifically, we would expand and revise the definition to clarify that "child" means an individual under the age of 19 and may include any period of time from conception to birth through age 19. This clarification of the definition of child will provide States with the option to consider an unborn child to be a targeted low-income child and therefore eligible for SCHIP if other applicable State eligibility requirements are met. This clarification would be consistent with the general statutory flexibility given States to elect the age groups of targeted low income children who must be under 19 years of age. Absent this clarification, under SCHIP there is a significant population of children who would be eligible at birth but who would not have had the benefit of needed prenatal care and delivery services. Currently, a pregnant woman under age 19 could be eligible as a targeted low income child and her child would benefit from needed prenatal care and delivery services by virtue of the mother's eligibility status. Absent this clarification, a pregnant woman over age 19 could not be eligible as a targeted low income child, and her child thus would not necessarily have the benefit of needed prenatal care and delivery services. This clarification would permit States to ensure that those needed services are available to benefit unborn children independent of the mother's eligibility status.

It is anticipated that the children covered by this regulation will become eligible for the SCHIP program after birth. By establishing eligibility prior to birth, the proposed change would improve continuity of care and simply allow states to establish eligibility at an earlier but medically critical point in time.

It is well established that access to prenatal care can improve health outcomes during infancy as well as over a child's life. Prenatal care includes monitoring the health of both the mother and the unborn child. The importance of prenatal care is widely accepted for the reasons summarized in the Department's 1999 report, *Trends in the Well-Being of America's Children and Youth*, "Receiving prenatal care late in a pregnancy, or receiving no prenatal care at all, can lead to negative health outcomes for mother and child." This 1999 report shows that while the percentage of women who receive late prenatal care (defined as seventh month or later) has declined for women in all racial and ethnic groups and ages, there are still significant differences by race and ethnicity and age. For example, five percent of women aged 20 to 24 receive late or no prenatal care compared to 3.9 percent of all women. This proposed rule change would allow states to provide coverage under SCHIP to the unborn children of those pregnant women if other eligibility criteria are met. Since low-income women are less likely to receive prenatal care, this rule would allow states to provide those needed services to a segment of the population that otherwise may not receive them.

The report explains,

> Adequate prenatal care is determined by both the early receipt of prenatal care (within the first trimester) and the receipt of an appropriate number of prenatal care visits for each stage of a pregnancy. Women whose prenatal care fails to meet these standards are at a greater risk for pregnancy complications and negative birth outcomes.

In the 2000 *Trends in the Well-Being of America's Children and Youth*, the Department states,

> Early prenatal care allows women and their health care providers to identify, and when possible, treat or correct health problems and health-compromising behaviors that can be particularly damaging during the initial stages of fetal development. Increasing the percentage of women who receive prenatal care, and who do so early in their pregnancies, can improve birth outcomes and lower health care costs by reducing the likelihood of complications during pregnancy and childbirth.

The 2000 Report explains,

> Babies born weighing less than 2,500 grams face an increased risk of physical and developmental complications and death. These babies account for four-fifths of all neonatal deaths (deaths under 28 days of age) and are 24 times more likely to die during the first year than are heavier infants.

According to the Report, low birthweight infants account for 7.6 percent of all infants born to mothers age 20 to 24 years.

Medical care is continually advancing and offers opportunities for services specifically targeted to the care of the unborn child. "Fetal medicine" or "fetology" is emerging as a distinct and important medical specialty which includes: obstetrics, maternal-fetal medicine, neonatology, pediatrics and fetal/neonatal pediatric surgery. Physicians specializing in fetal medicine use the pre-partum period to diagnosis potentially life threatening conditions in utero (*e.g.* congenital cystic adenomatoid malformation, congenital diaphragmatic hernia, congenital heart disease, gastroschisis, giant neck masses, hydrocephalus, obstructive uropathy omphalocele, spina bifida, sacrococcygeal teratoma). Once detected, such conditions can often be surgically or medically treated in utero, with beneficial consequences which can include: saving the life of the child; elimination of long neo-natal, post-partum medical care for the child; and ultimately lower post-partum medical care costs for the child and therefore the SCHIP plan. The Secretary would like to permit the States the flexibility to pay for the medical expenses related to unborn children because the Secretary has determined that provision of such services before birth should result in healthier infants, better long-term child growth and development and ultimate cost savings to the SCHIP plans (and the federal government through the SCHIP contribution process) through reduced expenditures for high cost neo-natal care.

This regulatory clarification is intended to benefit both the unborn children and their mothers by promoting continuity of important medical care. Healthy pregnancies should also result in significant savings in public expenditures over a child's lifetime.

In order to protect against the substitution of Title XXI enhanced payments for Medicaid payments, we have added a new subparagraph in section 457.626(a) Prevention of duplicate payments. This subparagraph would clarify that payment is not available under Title XXI when payment may be reasonably expected to be made under Medicaid on the basis of the Medicaid eligibility or enrollment of the pregnant woman. Under section 2105(c)(6)(B) of the SCHIP statute, payment under SCHIP is not available if payment can be reasonably expected under another federally financed health

benefits program. To permit shifting of claims for services that could be covered under Medicaid to the SCHIP program would not be consistent with this provision. The intent of this regulation is to provide prenatal services for unborn children who would otherwise not be covered by Medicaid or other coverage. We want to ensure that Title XXI funds do not substitute for Medicaid funds.

The purpose of the enhanced match in Title XXI is to encourage states to increase eligibility for health insurance coverage. So too is the purpose of this proposed rule. Consistent with congressional intent, the Department will work with states which seek to adopt this definition to ensure that coverage will be expanded beyond current Title XIX and Title XXI levels.

To the extent that a state elects to include unborn children in the SCHIP definition of children, as permitted by this rule, we believe that the state must also apply that same interpretation in assessing compliance with the Medicaid maintenance of effort provision of section 2105(d)(1). Since unborn children receive medical assistance under the Medicaid program through their mothers' status as pregnant women, more restrictive eligibility standards or methodologies for pregnant women in Medicaid would violate this maintenance of effort requirement. This requirement will be considered when state plan amendments to adopt the expanded definition are submitted. For the same reasons, a state that defines children under SCHIP to include unborn children would need to apply the same definition in the screen-and-enroll process described in SCHIP regulations at 42 CFR 457.350. We are proposing to modify these requirements to clarify that, for purposes of the screen and enroll process, individuals are properly enrolled in the appropriate program.

States will continue to have the authority to set eligibility requirements under their State plans, including age limits so long as the age limit is under 19 years of age, and hence States would not be required to extend coverage to this population. States that opt to extend eligibility to unborn children will submit a State plan amendment in accordance with § 457.60.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), agencies are required to provide a 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comments on the following issues:

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Section 457.60 requires a State to submit to CMS for approval an amendment to its approved State plan, whenever necessary, to reflect any changes in: (1) Federal law, regulations, policy interpretations, or court decisions, (2) State law, organization, policy or operation of the program, or (3) the source of the State share of funding. The burden associated with this requirement is the time and effort for a State to prepare and submit any necessary amendments to its State plan to CMS for approval. Based upon CMS's previous experiences with State plan amendments we estimate that on average, it will take a State 8 hours to complete and submit an amendment. We estimate that 13 States/territories will submit an amendment on an annual basis for a total burden of 104 hours.

IV. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Regulatory Impact Statement

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually).

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $25 million or less annually. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million.

This proposed rule would revise and clarify the definition of "child" under the State Children's Health Insurance Program (SCHIP) to provide that an unborn child may be considered a "targeted low-income child" by the State and therefore eligible for SCHIP if other applicable State eligibility requirements are met. We estimate that 13 states will elect to include this definition in their State plans. We also estimate that an additional 30,000 unborn children will benefit by this change. In States that adopt this option, the health status of children will improve to the extent that their mothers receive prenatal care. We estimate that the budget impact will be $320 million over a five-year period. Therefore, the provisions set forth in this proposed rule will not have an impact of $110 million or more annually. These are the best estimates available. However, we are interested in seeking comment from the public on estimates of the impact of this rule. Neither is this rule expected to impose an unfunded mandate on States exceeding $110 million annually. Therefore, we have not prepared an analysis of cost and benefits as required by E.O. 12866 and the Unfunded

Mandates Act for rules with significant economic impacts or that impose significant unfunded mandates on States. Also, we believe the changes being promulgated in this document will have very little direct impact on small entities as defined under the RFA or on small rural hospitals as defined under section 1102(b) of the Social Security Act. Therefore, we are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined, and we certify, that this rule will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has federalism implications. The option for States to extend coverage to unborn children promulgated in this proposed rule does not meet the criteria for having Federalism implications. This provision would not impose direct costs on states or local governments, nor does it preempt State laws. This new option only increases State flexibility and, therefore, prior consultation is not required. However, we welcome input from State and local governments through the notice and comment process.

List of Subjects in 42 CFR Part 457

Administrative practice and procedure, Grant programs—health, Children's Health Insurance Program, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, 42 CFR part 457 is proposed to be amended as set forth below:

PART 457—ALLOTMENTS AND GRANTS TO STATES

1. The authority citation for part 457 continues to read as follows:

Authority: Section 1102 of the Social Security Act (42 U.S.C. 1302).

Subpart A—Introduction; State Plans for Child Health Insurance Programs and Outreach Strategies

2. In § 457.10, the definition of "Child" is revised to read as follows:

§ 457.10 Definitions and use of terms.

* * * * *

Child means an individual under the age of 19 including the period from conception to birth.

* * * * *

Subpart C—State Plan Requirements: Eligibility, Screening, Applications, and Enrollment

3. Amend § 457.350 as follows:

A. Redesignate the text of paragraph (b) following the heading as paragraph (b)(1).

B. Add paragraph (b)(2) to read as follows:

§ 457.350 Eligibility screening and facilitation of Medicaid enrollment.

* * * * *

(b) Screening objectives. (1) * * *

(2) Screening procedures must also identify any applicant or enrollee who would be potentially eligible for Medicaid services based on the eligibility of his or her mother under one of the poverty level groups described in 1902(l) of the Act, section 1931 of the Act or a Medicaid demonstration project approved under section 1115 of the Act.

* * * * *

Subpart F—Payment to States

4. Revise § 457.622(c)(5) to read as follows:

§ 457.622 Rate of FFP for State expenditures.

* * * * *

(c) * * *

(5) The state does not adopt eligibility standards and methodologies for purposes of determining a child's eligibility under the Medicaid State plan that were more restrictive than those applied under policies of the State plan in effect on June 1, 1997. This limitation applies also to more restrictive standards and methodologies for determining eligibility for services for a child based on the eligibility of a pregnant woman.

* * * * *

5. Amend § 457.626 to add a new paragraph (a)(3) to read as follows:

§ 457.626 Prevention of duplicate payments.

(a) * * *

(3) Services are for an unborn child and are payable under Medicaid as a service to an eligible pregnant woman under that program.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.767, State Children's Health Insurance Program)

Dated: February 18, 2002.

Thomas A Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: February 22, 2002.

Tommy G. Thompson,

Secretary.

[FR Doc. 02-5217 Filed 3-1-02; 2:00 pm]

BILLING CODE 4120-01-P

DEPARTMENT OF TRANSPORTATION

Coast Guard

46 CFR Parts 28, 109, 122, 131, 169, 185, and 199

[USCG-2001-11118]

RIN 2115-AG28

Liferaft Servicing Intervals

AGENCY: Coast Guard, DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Coast Guard proposes to amend its commercial vessel regulations to provide consistency in the requirements for servicing of inflatable liferafts and inflatable buoyant apparatus (IBA). We are proposing this rule to eliminate an unnecessary burden on vessel operators and to eliminate confusion among the public and Coast Guard field personnel. The proposed rule would defer the first servicing of a new liferaft or IBA to two years after initial packing on all commercial vessels not certificated under the International Convention for the Safety of Life at Sea (SOLAS).

DATES: Comments and related material must reach the Docket Management Facility on or before May 6, 2002.

ADDRESSES: To make sure that your comments and related material are not entered more than once in the docket, please submit them by only one of the following means:

(1) By mail to the Docket Management Facility (USCG-2001-11118), U.S. Department of Transportation, room PL-401, 400 Seventh Street SW., Washington, DC 20590-0001.

(2) By delivery to room PL-401 on the Plaza level of the Nassif Building, 400 Seventh Street SW., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The telephone number is 202-366-9329.

(3) By fax to the Docket Management Facility at 202-493-2251.

(4) Electronically through the Web Site for the Docket Management System at *http://dms.dot.gov.*

The Docket Management Facility maintains the public docket for this

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Withdrawal Marker
The George W. Bush Library

FORM	SUBJECT/TITLE	PAGES	DATE	RESTRICTION(S)
Memorandum	UNFPA - To: POTUS - From: Jay Lefkowitz	5	06/19/2002	P5;

This marker identifies the original location of the withdrawn item listed above. For a complete list of items withdrawn from this folder, see the Withdrawal/Redaction Sheet at the front of the folder.

COLLECTION:
Staff Secretary, White House Office of the

SERIES:
Von Der Heydt, Thomas (Tommy) - Bush Record Policy Memos

FOLDER TITLE:
Pro-Life Legacy: A Timeline (2001 - 2008)

FRC ID:
13894

OA Num.:
14457

NARA Num.:
14246

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the 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 advise 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 record misfile defined in accordance with 44 U.S.C. 2201(3).

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b(1) National security classified information [(b)(1) of the FOIA]
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b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

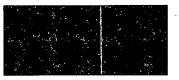
This Document was withdrawn on 4/24/2012 by MAL

For Immediate Release
Office of the Press Secretary
July 23, 2002

President, Mrs. Bush & Bruce Willis Announce Adoption Initiative

Remarks by the President and Bruce Willis, Spokesperson for Children in Foster Care at Launch of Adoption PSA Campaign
The East Room

2:33 P.M. EDT



THE PRESIDENT: Thank you, Laura. Laura loves children a lot, and I'm really proud to call her wife, and she's doing a fine as our First Lady, and I'm proud of the job she's doing. (Applause.)

Here's what I love about adoption: It reveals the good heart of America. That's what adoption does. Extending the welcome of family to a vulnerable child is a great commitment, but it's an extraordinary act of love. Adoptive families and foster families deserve our nation's thanks, and our nation's recognition. So, thanks.

Every year, American families adopt tens of thousands of children. Many of these children come from America's foster care system. Yet there are many more in that system whose deepest desire is to become a member of a family. Today, I'm proud to announce some steps that will make adoption easier and a more common part of our life in America.

But, first, I want to thank Laura, and I want to thank Congresswoman Anne Northup, an adoptive mom, for being here, state of Kentucky. And I appreciate Ben Cardin from Maryland being here, as well. Thank you both for coming. I want to thank my Assistant to the President for Economic Policy, Larry Lindsey, for being here. Larry's an adoptive dad. Thank you for coming, Larry. I'm glad my sister-in-law, Margaret, is here, and Marshall. Thank you both for coming.

I appreciate so very much Bruce Willis in his role in this, what you're about to see. It's awfully generous and kind of a person who is a busy person to say, what can I do to help? How can I lend my fame to make America a better place? And we appreciate that spirit of giving. I also want to recognize the fact that his daughters are with us today, Rumer and Scout and Tallulah. I want to welcome you all.

Tallulah -- actually, Tallulah Belle -- (laughter) -- followed her Dad's example of serving something greater than self in life. She wrote me a letter informing me that she and her Girl Scout troop had raised 36 -- money to buy 36,000 boxes of Girl Scout cookies to send to the children of Afghanistan. (Applause.)

And we want to thank Demi Moore for coming, as well. Welcome to the White House -- the Mom of the three girls. (Applause.)

I appreciate so very much and want to welcome the families created through adoption who are with us today. It is our great privilege to welcome you to the people's house, and we hope you enjoy your stay as much as we are enjoying our stay. It's a beautiful place. (Laughter.) And it's a great place to welcome some of our -- America's heroes, people who are making a huge difference in the lives of our fellow citizens.

I also appreciate the Department of Health and Human Services Children's Bureau for their good work. I want to thank you all very much for helping to promote this noble cause.

Common sense and social science lead to the same conclusion: Children thrive in secure, loving and stable homes. Providing that kind of home through adoption can be a long and a time-consuming process. I understand that. Adopting a child can add to the normal challenges of one's daily life. I fully understand that, as well. Yet adoption changes a single life forever, and it brings countless blessings to the lives of parents.

Mitch Pearlstein and his wife, Diane, live in Minneapolis. They couldn't be with us today, but I want to share with you some of his -- their quick story -- their story in a quick way. They adopted their daughter, Nicole, when she was five years old. Nicole was born to a mom who used crack cocaine during her pregnancy, and a dad who was a drug dealer. Nicole lived in more than a dozen foster care and emergency placement homes before she was adopted by Mitch and Diane.

Here's what Mitch says. "Adopting Nicole was the most difficult thing we've done in our lives, period. And adopting Nicole was the best thing we've done in our lives, period." I bet some people here understand what they were saying.

As I mention, my brother, Marvin, and Margaret have two children who are adopted, and many members of my administration do, as well. My Secretary of Commerce, and great friend from Midland, Texas, Don Evans, adopted a little boy. And Larry and his wife have adopted children -- three children. And many here have adopted. Adoptive parents have a special calling, and you deserve our gratitude.

There are many children in America, toddlers, teens, brothers and sisters, who need to stay together, and children from every background. They urgently need love and permanent homes. Finding that home may determine a more hopeful course for their entire life. Right now there are about 130,000 children in our nation's foster care system waiting to be adopted -- 130,000 precious lives hoping to find a permanent home. Good foster care is essential; yet children hunger for the stability of a permanent home. And every child deserves to be a part of a permanent, loving family. That's our hope.

Promoting adoption is an issue where all Americans of both political parties can agree. It's one of those issues -- it's not a partisan issue. And for those of us who support the dignity of every human life, we have a responsibility to encourage hopeful lives for children who are born.

Earlier this year, I signed into law the Promoting Safe and Stable Families Act, which supports adoption and post-adoptive services to place children with loving families. It helps ease a child's transition into a new family. It helps ensure that families stay strong and intact. It also provides for educational and training vouchers to children adopted after the age of 16, as well as older foster youth.

The tax relief bill I signed into law last year eases the financial burden on families that adopt children. It doubled the maximum adoption tax credit up to $10,000 for adoption-related expenses. And parents who adopt children with special needs will automatically get the full credit once the adoption is finalized.

These are practical ways to help. We're using the tax code to help, providing federal dollars to help. We've eased the burdens on adoption, but now we must encourage more Americans to choose adoption. And that's what we're here to talk about today.

And so, today, I'm pleased to announce the first federal adoption website. It's called AdoptUSKids.org. In its first year of operation, the website will feature pictures and profiles of more than 6,500 children who are available for adoption, as well as maintain a database of prospective adoptive parents who have been approved by the states.

AdoptUSKids.org will help overcome geographic barriers to adoption, and shorten the time a child may have to wait in foster care. And that's important. In addition, the site is a great resource for families who have already adopted. I urge parents across America to visit this site, and as they visit the site, examine their hearts to find a place in their home for a waiting child.

Today, I'm also unveiling a new public service announcement campaign to promote adoption. This PSA urges families to consider adopting children in foster care. It features the new website I mentioned and provides a toll-free number that families can call to receive useful information on how to adopt. The PSA will raise public awareness, and our hope is that they will make a difference in the lives of a lot of children.

I'm pleased to tell you that the PSA will feature two distinguished Americans. I hand-picked them myself -- (laughter) -- well, not exactly. But Laura and Bruce Willis have agreed to serve in the PSA. (Applause.)

We all know Bruce is a tough guy on the -- in the movies. Truth of the matter is, he has a tender heart. He has a tender heart for children. And I'm thrilled he's our new national Spokesman for Children in Foster Care. It's my honor to welcome to the podium Bruce Willis. (Applause.)

MR. WILLIS: Thank you, Mr. President, for that really wonderful introduction. And thank you for your commitment to children in need of adoption and foster care. I am honored that you have chosen me to be the National Spokesperson for Children in Foster Care.

And thanks to Mrs. Bush, a strong advocate, to serve a cause higher -- I'm sorry, thanks to Mrs. Bush, a strong advocate for children, and a co-star -- my newest co-star -- (laughter) -- in the public service announcement that we're about to see today.

Mr. President, you have asked all Americans to serve a cause higher than themselves, and to recognize that these children are our highest priority. You called on all of us to do what we can to make America better. A few years ago I became aware of the real needs of so many children in our foster care system. When I began to look more closely into this problem, I realized that too many children in foster care are falling through the cracks, and many are leaving the system as young adults without any support to help them reach their full potential. I also learned that there are many, many people in this country who would welcome the chance to help children in foster care, if only someone showed them how they could do it.

As a dad, I know how important it is for children to be raised in a loving home. And as a public figure, I realized that I could lend my time and energy to help raise public awareness of children in foster care. I'm looking forward to helping the thousands of young boys and girls in foster care to find the kind of loving family I know exists in our country.

Last February I met with the White House and expressed my interest in helping these children, in doing this -- and in doing these PSAs. Mr. President, Mrs. Bush, thank you for your focus on this issue. I know that if we help these kids, and help those people in this country who want to help them, we'll be doing our part to make America a much better place. Thank you very much.

THE PRESIDENT: Thank you, Bruce. Now we're going to watch the PSA, I believe.

MR. WILLIS: Yes. I'm pleased to announce this new adoption public service announcement.

(The PSA is shown.) (Applause.)

THE PRESIDENT: Looks like one of those Oscar-winning performances to me. (Laughter.) Anyway, thank you both for doing this. I think it's going to make a big difference, I do. I want to thank you all for coming again.

You know, we live in a great country. It's a country full of really loving and decent people. And there's no doubt in my mind, when people hear the call, they will respond to the needs of a lot of our children, just like parents have here today. Laura and I had the honor of greeting some adoptive parents to the White House today, and we want to thank you all for coming.

May God bless your work, and may God bless America. Thank you.

END 2:47 P.M. EDT

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For Immediate Release
Office of the Press Secretary
July 23, 2002

Helping Children and Building Families Through Adoption

Today's Presidential Action: President George W. Bush and First Lady Laura Bush announced a new initiative to increase public awareness and encourage Americans to consider adoption of children in foster care.

- President Bush announced a new public service advertising campaign, featuring First Lady Laura Bush and actor Bruce Willis, to encourage Americans to adopt children in foster care. The President also tapped Bruce Willis to serve as a national spokesperson for children in foster care.

- The President also announced the creation of the first federal and only national web site that focuses on waiting children – **www.AdoptUSKids.org** – that will reduce the geographic barriers and waiting time needed to connect children from across the country with adoptive families. In its first year, it will feature pictures and profiles of over 6,500 children from 46 states who are available for adoption, as well as a database of approved adoptive families.

Background on Today's Presidential Action

More than 130,000 of the 565,000 American children in foster care, ranging in age from toddlers to teenagers, are waiting to be adopted. On average, these children have been in foster care for almost four years. Most of these children have special needs that limit their ability to be adopted, such as being part of a sibling group that wishes to stay together, belonging to a particular ethnic group, or having physical or emotional challenges. These children are adoptable; in fact, in 2000, over 50,000 children in foster care were adopted. But recruiting a family that can meet the special needs of a particular child can be challenging, especially when the right family may live in a different state or county.

President Bush believes that every child in America deserves to live in a safe, permanent and loving family. Today, the President announced:

- **Adoption Public Service Advertisement (PSA)**: The adoption PSA will feature the First Lady and actor Bruce Willis. It will also highlight a new website and toll-free number for interested families to receive adoption information and be referred to their State adoption specialist. Additionally, President Bush has asked Bruce Willis to serve as a national spokesperson for children in foster care.

- **First Federal Adoption Web Site and Internet Photolisting**: **AdoptUSKids.org**, an Internet adoption photolisting service, will help connect waiting children from across the country with loving adoptive families. The site provides prospective adoptive parents with a private, secure place to communicate interactively with other families and adoption experts - especially useful for families living in rural areas. Social workers will be able to follow inquiries from families approved to adopt and respond to them instantly through the site. AdoptUSKids is an initiative of the Children's Bureau of the Department of Health and Human Services, and it is currently operated by the National Adoption Center.

President Bush's Commitment to Promoting Adoption

- **Promoting adoption and supporting families who adopt**: On January 17, 2002, the President signed the Promoting Safe and Stable Families Amendment Act to help States provide services to promote adoption for children in foster care and provide post-adoption support to families so that they can stay strong and their children reach their potential. The President's FY 03 budget

strongly supports the Promoting Safe and Stable Families program with an increase of more than $130 million over FY 02 levels.

- **Adoption Tax Credit**: The tax relief bill that the President signed last year permanently extends and increases the adoption tax credit from $5,000 per child to $10,000 per child for qualified adoption expenses. For special needs adoptions, it increases the credit from $6,000, for qualified adoption expenses, to $10,000, regardless of expenses.

For more information on the President's initiatives, please visit **www.whitehouse.gov**.

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President Signs Born-Alive Infants Protection Act

Remarks by the President in Signing of H.R. 2175, Born Alive Infants Protection Act
Pittsburgh Hilton
Pittsburgh, Pennsylvania

August 5, 2002

THE PRESIDENT: Well, thank you all very much for this bill signing ceremony. I'm pleased to sign it in the great city of Pittsburgh, Pennsylvania. The history of our country is the story of a promise, a promise of life and liberty made at our founding and fulfilled over the centuries in our laws. It is a story of expanding inclusion and protection for the ignored and the weak and the powerless. And now we extend the promise and protection to the most vulnerable members of our society.

Today I sign the Born Alive Infants Protection Act. This important legislation ensures that every infant born alive – including an infant who survives an abortion procedure – is considered a person under federal law. (Applause.) This reform was passed with the overwhelming support of both political parties, and it is about to become the law of the land.

I appreciate so very much Senator Rick Santorum and Congressman Steve Chabot from Ohio for sponsoring this important piece of legislation. I also appreciate Senator Arlen Specter of Pennsylvania and Congresswoman Melissa Hart for coming, as well. I want to thank the Bishop of the Diocese of Pittsburgh, Bishop Wuerl, for being here. It's good to see you again, Bishop. I appreciate Hadley Arkes, the Professor of Jurisprudence and American Institutions at Amherst University. I want to thank Jill Stanek, registered nurse, Labor and Delivery Unit, Christ Hospital and Medical Center, for being here, as well. I appreciate Gianna Jessen, who is an abortion survivor and a pro-life advocate. I want to thank Dr. Watson Bowes, who is a Professor Emeritus of Gynecology and Obstetrics at the University of North Carolina.

I want to thank you all for coming. It's important that you're here, to send a signal that you're dedicated to the protection of human life. The issue of abortion divides Americans, no question about it. Yet today we stand on common ground. The Born Alive Infants Protection Act establishes a principle in America law and American conscience: there is no right to destroy a child who has been born alive. (Applause.) A child who is born has intrinsic worth and must have the full protection of our laws.

Today, through sonograms and other technology, we can clearly – see clearly that unborn children are members of the human family, as well. (Applause.) They reflect our image, and they are created in God's own image.

The Born Alive Infants Protection Act is a step toward the day when every child is welcomed in life and protected in law. (Applause.) It is a step toward the day when the promises of the Declaration of Independence will apply to everyone, not just those with the voice and power to defend their rights. This law is a step toward the day when America fully becomes, in the words of Pope John Paul II, "a hospitable, a welcoming culture."

Our society has enough compassion, wealth and love to care for mothers and their children, and to see the promise and potential of every life. In protecting the vulnerable and the weak, the imperfect and the unwanted, you are affirming a culture of life.

I'm grateful for your perseverance on behalf of this noble cause. I want to thank you for your hard work. I appreciate your care for every member of the human family. Thank you for coming today. It's now my honor and pleasure to sign into law the Born Alive Infants Protection Act. (Applause.)

(The act is signed.) (Applause.)

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Federal Register

Wednesday,
October 2, 2002

Part II

Department of Health and Human Services

Centers for Medicare and Medicaid Services

42 CFR Part 457

State Children's Health Insurance Program; Eligibility for Prenatal Care and Other Health Services for Unborn Children; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

42 CFR Part 457

[CMS–2127–F]

RIN 0938–AL37

State Children's Health Insurance Program; Eligibility for Prenatal Care and Other Health Services for Unborn Children

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: In order to provide prenatal care and other health services, this final rule revises the definition of "child" under the State Children's Health Insurance Program (SCHIP) to clarify that an unborn child may be considered a "targeted low-income child" by the State and therefore eligible for SCHIP if other applicable State eligibility requirements are met. Under this definition, the State may elect to extend eligibility to unborn children for health benefits coverage, including prenatal care and delivery, consistent with SCHIP requirements.

EFFECTIVE DATE: These regulations are effective on November 1, 2002.

FOR FURTHER INFORMATION CONTACT: Kathleen Farrell, (410) 786–1236.

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I. Background

Section 4901 of the Balanced Budget Act, (Pub. L. 105–33), as amended by Public Law 105–100, added title XXI to the Act. Title XXI authorizes the State Children's Health Insurance Program (SCHIP) to assist State efforts to initiate and expand the provision of child health assistance to uninsured, low-income children. Under title XXI, States may provide child health assistance primarily for obtaining health benefits coverage through (1) a separate child health program that meets the requirements specified under section 2103 of the Act; (2) expanding eligibility for benefits under the State's Medicaid plan under title XIX of the Act; or (3) a combination of the two approaches. To be eligible for funds under this program, States must submit a State child health plan (State plan), that meets the applicable requirements of title XXI and is approved by the Secretary.

Benefits under SCHIP are jointly financed by the Federal and State governments and are administered by the States. Within broad Federal guidelines, each State determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. Under section 2102(b) of the Act, States have discretion to adopt eligibility standards that are related to age, and thus may extend SCHIP eligibility only to certain age groups of targeted low-income children (who must be under age 19). SCHIP provides a capped amount of funds to States on a matching basis for Federal fiscal years (FY) 1998 through 2007. Regulations implementing SCHIP are set forth at 42 CFR 457.

II. Provisions of the Proposed Regulations

On March 5, 2002, we published a proposed rule in the **Federal Register** that proposed to revise the definition of "child" under the SCHIP program (67 FR 9936). In the interest of providing necessary prenatal care and other health services to children, we proposed to clarify and expand the definition of the term "child" so that a State may elect to make individuals in the period between conception and birth eligible for coverage under the State plan. Specifically, we proposed to revise the definition at § 457.10 to clarify that "child" means an individual under the age of 19 and may include any period of time from conception to birth up to age 19. In this rule, we explained that while a pregnant woman under age 19 could be eligible as a targeted low-income child, and her child would benefit from needed prenatal care and delivery services by virtue of the mother's eligibility status, a pregnant woman over age 19 could not be eligible as a targeted low-income child.

We stated that the proposed definition would provide States with the option to consider an unborn child to be a targeted low-income child and therefore eligible for SCHIP if other applicable State eligibility requirements are met. This would permit States to ensure that needed services are available to benefit unborn children independent of the mother's eligibility status. We also discussed in detail the Department's 1999 report, *Trends in the Well-Being of America's Children and Youth*, which describes the benefits of prenatal care for the mother and the child. We stated that our proposed revisions were intended to benefit both the unborn children and their mothers by promoting continuity of important medical care.

In order to protect against the substitution of title XXI enhanced payments for Medicaid payments, we proposed to add a new paragraph (a)(3) to § 457.626(a), Prevention of duplicate payments, to clarify that payment is not available under title XXI when payment may be reasonably expected to be made under Medicaid on the basis of the Medicaid eligibility or enrollment of the pregnant woman.

With regard to maintenance of effort requirements, we proposed that if a State elects to include unborn children in the SCHIP definition of children, the State must also apply that same interpretation in assessing compliance with the Medicaid maintenance of effort provision of section 2105(d)(1) of the Act. Specifically, we proposed to revise § 457.622, Rate of Federal Financial Participation (FFP) for State expenditures, to provide that the State does not adopt eligibility standards and methodologies for purposes of determining a child's eligibility under the Medicaid State plan that were more restrictive than those applied under policies of the State plan in effect on June 1, 1997. This limitation applies also to more restrictive standards and methodologies for determining eligibility for services for a child based on the eligibility of a pregnant woman.

We also stated that, a State that defines children under SCHIP to include unborn children would need to apply the same definition in the screen-and-enroll process described in SCHIP regulations at § 457.350, Eligibility screening and facilitation of Medicaid enrollment. We proposed to add a new § 457.350(b)(2) to clarify that screening

procedures must identify any applicant or enrollee who would be potentially eligible for Medicaid services based on the eligibility of his or her mother under one of the poverty level groups described in section 1902(l) of the Act, section 1931 of the Act, or a Medicaid demonstration project approved under section 1115 of the Act.

We noted that under our proposed regulation, States would continue to have the authority to set eligibility requirements under their State plans, including age limits so long as the age limit is under 19 years of age. Hence, States would not be required to extend coverage to this population. States that opt to extend eligibility to unborn children must submit a State plan amendment in accordance with § 457.60. States can use the preprinted application template for the State Children's Health Insurance Program, sections 4.1.2 and 4.4, and the preprinted budget template in submitting this State plan amendment.

III. Analysis of and Responses to Public Comments

We received and accepted 7,783 comments. The majority of these were form letters that were part of write-in campaigns. Because of possible residual delays in the Washington, DC mail, resulting from new security procedures, we accepted comments that were postmarked up to and including May 13, 2002. All public comments have been summarized and are discussed in detail in the following discussion.

1. General Comments

In this section, we have summarized and responded to general public comments on the program or the proposed rule as a whole and not to any particular provision of this rule. All other public comments are addressed below in the context of the particular subpart.

Comment: We received a great number of comments from people who viewed the proposed rule as having a hidden agenda of providing unborn children with formal legal rights as the first step in abolishing abortion.

Commenters stated that since the child in the womb would be recognized as a patient, there would never be a case where abortion is justified. Another commenter stated that the unborn child's status as a patient in need of health care has long enjoyed international recognition and cited the United Nations Declaration on the Rights of the Child and the 1990 Convention implementing its principles, which declared that the child needs special safeguards and care, including appropriate legal protection, before as well as after birth. Other commenters viewed the proposed rule as empowering lower-income women to choose life for their children and enhance their ability to raise their families with dignity.

Many commenters expressed opposing views on this issue, saying that this is an anti-choice proposal disguised as a health care proposal. Commenters considered the proposal as the Administration's attempt to create legal precedent for viewing unborn children as separate physical and legal entities, which they believe devalues women as persons and is counterproductive to the health and well being of both women and children. Commenters stated that the underlying purpose of the proposed rule is to advance fetal personhood and deny the right of every woman to determine the direction of her own life. They believe the proposed rule would undermine the foundation of the right to choose abortion and threatens a woman's reproductive freedom. They said the proposed rule would lay the legal groundwork for an adversarial relationship between a woman and her unborn child.

Commenters expressed the opinion that the proposed rule is a tactic for extending the rights of a person under the constitution to an unborn child through the regulatory process as a means of circumventing the legislative process where it can be debated and voted on openly by elected representatives. Many commenters considered the proposed rule an attempt to provoke controversy over *Roe* v. *Wade* and provide the groundwork for having it overturned with the long-term goal of having abortion declared illegal.

Response: CMS does not believe that this revised definition of "child" is inconsistent with the United Nations Declaration on the Rights of the Child or with *Roe* v. *Wade*.

At the core of a number of commenters' arguments against the rule is a fundamental misconception that this rule would set up an adversarial relationship between the mother and her unborn child that might threaten the mother's autonomy.

Such reasoning overlooks the reality that the SCHIP program is a voluntary assistance program that begins when an individual applies for the benefit. If the woman did not want the health insurance coverage offered by the State's SCHIP program, she simply would not apply for it or would discontinue her participation in the program.

This rule, rather than limiting an uninsured woman's choices in fact expands them by offering important health care that may not otherwise be available to her.

In general, patient education literature affirms that prenatal care benefits both the mother and the unborn child. For example, the Web site of the American College of Obstetricians and Gynecologists (ACOG) provides excerpts from its patient education material. ACOG Education Pamphlet AP098—Special Tests for Monitoring Fetal Health explains that, "[e]arly prenatal care gives your doctor a chance to check on your health and the progress of your pregnancy. Based on the results of routine prenatal care, your doctor may suggest tests to check the health of the baby. Most of the time, these tests help assure you and your doctor that all is going well. Monitoring helps you and your doctor during your pregnancy by telling more about the well being of the baby. Monitoring may be done during pregnancy to help assess the health, activity level, and growth of the unborn child. Some of the tests used for monitoring check the movement, heartbeat, blood flow, and rate of growth of the unborn child. If so, the baby may need special care or may need to be delivered right away."

In another article, "Nutrition During Pregnancy," available through the *Medem.com* Web site, ACOG explains that, "[a] balanced diet is a basic part of good health at all times in your life. During pregnancy, diet is even more important. The foods you eat are the main source of the nutrients for your baby. As your baby grows, you will need more of most nutrients."

This rule reflects the common understanding that prenatal care benefits both mother and child and therefore does not create tension between them.

It is also useful to bear in mind that these generally are children who will otherwise be eligible for their respective SCHIP program in a State at birth. It only makes sense, and indeed is medically obvious that establishing eligibility during the prenatal stage advances the likelihood of a healthy pregnancy, healthy birth, and healthy life.

Comment: Many of the commenters asserted that if the intent of the proposed regulation is to provide additional health care to pregnant women, it could be done through existing regulations. Commenters were concerned that the designation of the unborn child as a child would raise legal and operational issues that would take years to resolve, resulting in litigation that would prevent many pregnant women from receiving needed

health care. For this reason, numerous commenters recommended the withdrawal of this rule. One commenter mentioned that for States to adopt this rule, they would be required to act through their State legislatures to redefine a "child" as being from conception through age 19, which would cause enormous tension in State capitals across the country and unproductive bipartisan politics, which would not further the health care needs of pregnant women or children.

Since States already have the means to cover pregnant women, the commenter urged HHS to facilitate the process and not complicate it and many commenters stated that they believe the regulation is unnecessary. As examples, commenters cited the States of New Jersey and Rhode Island that have applied for and received section 1115 waivers to expand coverage to low-income women. They noted that SCHIP waivers are relatively easy for States to secure since under the existing SCHIP waiver program, the Federal government does not require "budget neutrality", States can spend additional funds up to the State's unspent SCHIP allotment and there is already a template in place to streamline the waiver application process.

Commenters suggested alternative options to HHS rather than implementing the rule that included: use options under Medicaid to provide comprehensive prenatal and pregnancy-related care to women; use the existing authority of approving waivers and implement a process for expediting the approval of waiver applications; amend the SCHIP statute to provide prenatal care for pregnant women by expanding eligibility to the woman rather than to the unborn child; and support and work with the Congress to approve pending legislation that would provide access to prenatal care for uninsured women as well as additional funding for States.

Response: This regulation bridges a gap in eligibility between the Medicaid and the SCHIP programs that has now existed for five years. Members of the Congress have also recognized this gap and have introduced various pieces of legislation over the years to address this gap. The opportunity to expand vital health insurance coverage during a critical time is at hand.

We welcome all of these suggestions for expanding health insurance coverage and indeed States and the Secretary have already used the flexibility in current regulations. However, there are still gaps. We also welcome support for the actions of the Secretary in granting waivers to States that expand eligibility for individuals who would not otherwise be eligible for Medicaid or SCHIP. But the Secretary's ability to intervene through one mechanism (a waiver) should not be the sole option for States and may in fact be an inferior option. Waivers are discretionary on the part of the Secretary and time limited while State plan amendments are permanent, and are subject to allotment neutrality.

Commenters recognize that certain low-income pregnant women are not currently eligible for coverage under either Medicaid or SCHIP. We recognize that States already have the ability to provide prenatal care to pregnant women through expanding their title XIX coverage of pregnant women either through an amendment to their approved State Plan or through a demonstration project under section 1115 of the Act. However, States have been reluctant to do so under the regular Medicaid match rate. It is the enhanced match under title XXI that has proven to be the incentive for States to increase eligibility.

The approval process for a SCHIP demonstration project to extend coverage to pregnant women under section 1115 is a relatively streamlined process. However, as the commenters also acknowledge, only five States have applied to cover pregnant women (Colorado, Maryland, Michigan, New Jersey and Rhode Island) of which two have been approved as of July 2002 (New Jersey and Rhode Island).

States may decide not to pursue this option because of the local political climate, the need for State legislative modifications or a variety of other reasons. Our regulation is simply an option to make it faster and easier for States that want to use SCHIP funds to expand prenatal services for low-income women and to do so without having to go through the 1115 process or wait for the passage of legislation.

With respect to comments relating to potential legislative changes to the Medicaid and SCHIP statute, discussion of such changes are beyond the scope of this regulation.

Comment: One commenter said that another way the Administration could help ensure prenatal care was to change the Medicaid system to make it less confusing and more accessible, by reducing the complexity of the eligibility process, the burdensome application forms and by addressing the lack of knowledge surrounding access and other regulatory barriers that prevent women from accessing this health care insurance.

Response: Many States in fact have taken action to lower barriers to enrollment, renewal, and access. Barriers to enrollment have been one of the major areas CMS has worked on with States in recent years. States were given significant flexibility to simplify the eligibility process in the SCHIP statute and regulations, and CMS has encouraged States to take similar steps within the framework of Medicaid requirements. States have the option to provide presumptive eligibility for pregnant women and the Medicaid regulations have mandated simplification and streamlining of the enrollment process. It is the State's option how they choose to accomplish this. However, administrative simplification has its limits and cannot bridge the eligibility gap as the proposed regulation would.

Comment: A commenter noted that the unborn child was a feature of the Medicaid program until 1986 when it was replaced with a coverage category tied directly to the woman's pregnancy status (Pub. L. 99–509, the Budget Reconciliation Act of 1986). The commenter considered that option to be an invaluable means of permitting coverage of certain children whose mothers could not for a variety of reasons qualify for Medicaid coverage. The commenter believes that the recognition of this option in SCHIP at least partially restores this State flexibility, which was lost 16 years ago, and positions State programs to extend public health insurance to pregnant women who are currently unqualified in their own right.

Response: We appreciate the commenter's support and agree that the intent of this regulation is to provide States with flexibility in selecting the options that are available to them in providing this vital care.

The proposed regulation in fact would restore flexibility that the previous Federal policy provided that allowed welfare and Medicaid coverage for not-yet-born children.

As early as 1941, the Bureau of Public Assistance, a predecessor agency within the Department of Health, Education and Welfare (HEW), determined that unborn children could be covered under the Social Security Act of 1935. It was determined that under the Act, Federal funds could be provided to the States for the aid of unborn children. The Agency's 1946 Handbook of Public Assistance Administration permitted the inclusion of unborn children among those eligible for State-plan aid "on the basis of the same eligibility conditions as apply to other children." The operating policy remained unchanged through 1971. The option remained with State welfare plans to determine whether to include unborn children as

dependents. At the time of the institution of the Medicaid program, many State social service agencies adopted similar eligibility definitions for the purposes of qualifying for Medicaid under a State plan. The approaches were later changed through a decision by the HEW Secretary. While this change was in part a reaction to the determination with respect the historic Aid to Families with Dependent Children program in *Burns* v. *Alcala*, 420 U.S. 575 (1975) that States were not required to extend eligibility based on unborn children, this decision is not applicable to the SCHIP statute and does not reflect the congressional intent to provide broad State flexibility under SCHIP to expand the provision of child health assistance. These precedents are important as we look for ways for all women to receive prenatal care.

Comment: A commenter noted that several States have sought and obtained waivers allowing them to provide SCHIP coverage to unborn children as beneficiaries of SCHIP and felt that this offers in itself a strong argument for making that inclusion uniform among the States and independent of the waiver process.

Response: We agree with the commenter, but note that States still retain the option to apply for section 1115 waivers to provide prenatal coverage to low-income pregnant women.

Comment: A commenter noted that the U.S. House of Representatives also recognizes the value of Secretary Thompson's decision and has, therefore, drafted a Congressional Resolution (H.R. Res. 346) commending the decision to recognize that pregnant mothers and unborn children are deserving of concern about their health and well being. Another commenter mentioned the bills currently being considered by the Congress that would allow States to provide low-income women with prenatal coverage under SCHIP, specifically the "Start Healthy, Stay Healthy Act of 2001 (S. 1016/H.R. 3729), the "Mothers and Newborns Health Insurance Act of 2001 (S. 724/H.R. 2610), and the "Legal Immigrant Children's Health Improvement Act of 2001 (S. 582/H.R. 1143) on which the Congress has yet to schedule action. The commenters said that absent the change in statute, they are pleased that, once finalized, the proposed CMS regulation will allow States to extend coverage to pregnant women without delay. Commenters concluded that extending eligibility for SCHIP coverage to unborn children, including prenatal care and delivery, as consistent with SCHIP requirements, is the best way to provide needed medical care to those low-income children and pregnant women that would otherwise be without health insurance.

Response: We agree and appreciate the commenters' support.

2. Definition of Targeted Low-Income Child

Comment: The commenters expressed their belief that life begins at conception and unborn children are human beings who should be eligible for health care. The commenters asserted that any threshold for eligibility other than conception is inevitably arbitrary, because conception is the point when an individual human life comes into existence. Commenters stated that the proposed rule reflects the medical reality that the life of a child begins before birth at conception, and is thoroughly consistent with precedent, according legal significance to, and protecting the life of the unborn child. The commenters stated that the proposed rule's definition of "child" is consistent with a vast body of scientific literature, and with modern medical practice, which recognizes that the life of a child begins at conception and continues until adulthood.

The commenters mentioned that the statute defines the maximum age of eligibility for services as 19, but specifies no minimum age. Thus, without this regulatory clarification, it is possible that many otherwise eligible children would not receive prenatal care under this program, and might suffer severe health consequences as a result. Another commenter noted that *Pediatrics*, Vol 81, #5, May 1988, p. 736, defines commitment to the health of the individual as beginning at conception. The commenter supported the proposed rule based on the importance of ensuring adequate health care for children, both before and after birth, and the health of their mothers.

Response: We appreciate all of the comments as important contributions to the public record, which helps shape the Secretary's decision-making. We recognize that while the intent of this rule is to extend health insurance coverage, policy determinations are often carried into other important public discussions. We agree with these commenters that conception can be a logical point to recognize a targeted low income child, and thus, we are retaining our revised definition to permit States the option in administering the SCHIP program.

Comment: Commenters stated that the proposed rule has ample legal precedent. Outside the abortion context, they stated that unborn children are often recognized as persons who warrant the law's protection. As examples, the commenters said that most States allow recovery in one form or another for prenatal injuries. Thus, several commenters cited *Roe* v. *Wade*, 410 U.S. 113, 161–2 (1973) and an article by Paul Benjamin Linton, *Planned Parenthood* v. *Casey*, 13 St. Louis U. Public Law Rev. 15, 46–64 (1993). Another commenter noted that roughly half the States criminalize fetal homicide. Commenters said that unborn children have long been recognized as persons for purposes of inheritance, *Roe*, 410 U.S., at 162, and a child unborn at the time of his or her father's wrongful death has been held to be among the children for whose benefit a wrongful death action may be brought, 22A Am.Jur.2d death § 99 (1988). A commenter cited a Kansas bill (HB2797) that would treat a fetus as "an unborn child" and declare the "unborn child" to be a "person or human being" so as to allow, under State criminal law, prosecution following the "death or injury of a fetus." (See Hanna, AP/Topeka Capital-Journal, April 2, 2002.)

One commenter said that Federal statute similarly recognizes the unborn child as a human subject deserving protection from harmful research as soon as pregnancy is confirmed, 42 U.S.C. 289g(b); 45 CFR part 46 §§ 46.203 *et seq.* Therefore, the commenters did not consider it to be an innovation to treat an unborn child as a human individual for the purpose of providing quality prenatal care to the child and his or her mother.

Response: We appreciate all of the comments as important contributions to the public record, which helps shape the Secretary's decision-making. We recognize that while the intent of this rule is to extend health insurance coverage, policy determinations are often carried into other important public discussions. We agree with these commenters that unborn children are often recognized for other purposes under State law, and thus are retaining our revised definition to permit States such an option in administering the SCHIP program.

Comment: Commenters said that defining unborn children as children is not an appropriate administrative decision. Commenters considered defining a child in this way to be arbitrary and they asserted that most of this country's population does not agree with this position. The commenters go on to say that this approach will enforce a minority point of view, is highly political, and is not in the best interests of women and their children. One commenter noted that the government should not be in the business of

deciding when life begins. Another commenter noted that to define childhood as beginning at conception is an idea not universally held by religious or medical experts and imposes a particular theological view on the American public. Another commenter noted that the proposed rule is both cynical and futile given the widespread disagreement and confusion about what constitutes life and when an unborn child becomes a person. They went on to say that there is no ethical or medical justification for expanding the definition of "child" to include the unborn under the SCHIP provisions, when all medical services offered to an unborn child must be performed on a pregnant woman. Another commenter noted that it is inconceivable that a child be defined as "from conception to 19 years of age." If all of the world's greatest theologians, sociologists and scientists and other great minds cannot determine when life begins, the commenter asserted, then DHHS certainly cannot. Another commenter expressed concern that these rules have the hidden agenda of attempting to define "when life beings"—a deeply divisive issue around which the American public has not achieved consensus. The commenter stated that the fact of existence outside the body of its mother has consistently been the point at which legal personhood (including the ability to receive benefits) has been distinguished from the unborn child, which is not yet a legal person. The commenter believes that changing this understanding by an executive department must inevitably lead to Constitutional challenges.

Response: We appreciate all of the comments as important contributions to the public record, which helps shape the Secretary's decision-making. We recognize that while the intent of this rule is to extend health insurance coverage, policy determinations are often carried into other important public discussions. We disagree with these commenters' contention that there is only one appropriate interpretation of the statutory term at issue, and we believe the range of comments supports our view that States should have the option to include unborn children as eligible targeted low income children. We are therefore retaining a revised definition that does not attempt to define when life begins but permits States maximum flexibility in extending SCHIP eligibility.

Comment: The commenters said that in their view, unborn children are not children who should be deemed eligible for health care. The commenters stated that until birth occurs, mother and the unborn child are one and not two different people. Another commenter said that the proposed change would make an arbitrary separation between a woman and her developing unborn child and goes onto say that such a separation can only be a concept, for the unborn child is a functioning part of the mother, sharing physical systems. Other commenters noted that the unborn child is a part of the mother's body that cannot survive without the use of the mother's heart, the mother's lungs and so forth. The commenters asserted that as a society we must allow women to control their own bodies and not turn them into mere holding vessels for an unborn child. The commenters believe that the emphasis should be placed upon the pregnant woman on whom the unborn child's health care is completely dependent. They believe that life begins at birth, not at conception and noted that defining childhood as beginning at conception is not an idea universally held by religious or medical experts.

Response: We appreciate all of the comments as important contributions to the public record, which helps shape the Secretary's decision-making. We recognize that while the intent of this rule is to extend health insurance coverage, policy determinations are often carried into other important public discussions. We disagree with these commenters that extending SCHIP eligibility to unborn children would work to the disadvantage of, or devalue the role of, the mother. Indeed, we believe the extension of SCHIP eligibility will be in the best interest of both mother and child, and thus are retaining our revised definition to permit States such an option in administering the SCHIP program.

Comment: Two commenters asked what the status of zygotes held in infertility clinics would be. They asked if such clinics would be faced with criminal suits for the practice of destroying embryos? Another commenter asked why sperm are not classified as children so sexually active men could receive funding to maintain the health of their sperm. The commenters asked who will arbitrate when a third party decides the interests of the woman conflict with those of the unborn child she is carrying? And, will the State decide whether to save the life of the mother or her unborn child? Commenters also asked if another person could be appointed the guardian of an unborn child?

Response: While the questions raised by the commenters are interesting, they are well beyond the issue of providing eligibility under a publicly funded health insurance program. The important medical and ethical issues raised in the comments existed prior to the promulgation of the proposed regulation and are resolved separately from the specific issue of eligibility for a publicly funded health insurance program. Guardianship is established through legal proceedings and is unlikely to be an issue in the routine application, enrollment, and participation process.

Comment: Commenters discussed the language of the majority in *Roe* v. *Wade* that they believe clearly States "the word 'person' as used in the 14th Amendment does not include the unborn." The commenters asserted that the Administration does not have the right to reverse this clear and unambiguous statement unilaterally in a regulation. The commenters stated that the unborn child is not recognized as a person in our legal system, where mothers and fathers are responsible for decision making when it comes to health care for their offspring.

Response: While we understand the views of the commenters, we do not believe that limiting the definition of child is consistent with the flexibility that Congress accorded to States under the SCHIP statute. We believe that the range of comments supports our view that States should have the option to include unborn children as eligible targeted low income children. We are therefore retaining a revised definition that permits States maximum flexibility in extending SCHIP eligibility.

We appreciate all of the comments as important contributions to the public record, which helps shape the Secretary's decision-making. We recognize that while the intent of this rule is to extend health insurance coverage, policy determinations are often carried into other important public discussions.

Comment: Commenters asked if defining the unborn child as a person means that we will restructure the National Census and tax forms to include this new population of citizens? They asked if we will rethink our welfare policies to consider unborn children in deciding an individual's or family's benefits? Commenters expressed concern that the proposed rule will lay the legal groundwork for an adversarial relationship between a woman and her unborn child by defining the unborn child as a person, who would then have full legal status, equal to that of the woman. A commenter noted that an unborn child is not given a social security number; it is not a Medicaid beneficiary; pregnant women do not receive an exemption on their income taxes for the unborn child;

and census-takers count only born individuals.

Response: These comments extend beyond the scope of this regulation, which concerns only the ability of States to extend SCHIP eligibility to unborn children, and would not change any other Federal programs. The only government forms affected are those directly connected to the SCHIP program.

Comment: Commenters expressed concern that for women of color, distinguishing the needs of the unborn child from those of the mother has more than once resulted in adverse consequences for the mother. The commenters referred to *Ferguson* v. *City of Charleston*, 532 U.S. 67 (2001), where the Supreme Court considered issues related to a South Carolina hospital that, pursuant to State law, reported women, all of color, to the police because her unborn child in the third trimester or her newborn tested positive for drugs. Consequently, the commenters asked us to reconsider the definition in this rule.

Response: We appreciate all of the comments as important contributions to the public record, which helps shape the Secretary's decision-making. We recognize that while the intent of this rule is to extend health insurance coverage, policy determinations are often carried into other important public discussions.

While we understand the commenters' concern, we do not agree that extending SCHIP eligibility to unborn children would work to the disadvantage of, or devalue the role of, the mother. Indeed, we believe the extension of SCHIP eligibility will be in the best interest of both mother and child. Furthermore, we believe that it is consistent with congressional intent to provide broad State flexibility under SCHIP to expand the provision of child health assistance.

Comment: Commenters stated that language in SCHIP suggests that the term "child" does not include an unborn child because the statute makes reference to the State in which the child "resides," 42 U.S.C. section. 1397jj(b)(1)(ii)(III). Commenters asserted that in ordinary usage, an unborn child is not considered to have a "reside[nce]." And, the commenters continued that Federal courts have ruled that in other Federal benefits programs, including AFDC and Medicaid, that the term "child" does not include a fetus. Therefore, the commenters asserted, the same reasoning applies here, and it is clear that the Congress did not intend the phrase "individual under 19 years of age" to include the "unborn."

Response: As previously mentioned, recognition of the unborn child in Federal assistance programs can be traced back more than half a century. Currently some Federally funded programs such as Medicaid include, (or as in SCHIP, provide States with the option to include), the unborn child in the size of a family for purposes of determining eligibility for members of that family. Eligibility for some families may indeed rest on counting the unborn child.

Comment: The commenter stated that in numerous cases related to child abuse statutes, courts have ruled that the term "child" does not include "unborn children" and as such, this rule's "clarification" is without merit. In support of this argument, the commenter cited *U.S.* v. *Spencer*, 839 F.2d 1341 (9th Cir. 1988) in which the defendant's infliction of injuries on an unborn child, who was born alive, but died as a result of such injuries, was within the Federal statutory definition of murder. The commenter mentioned that the key to the holding in that case was that the unborn child was born alive. Under the Uniform Code of Military Justice, the term "human being" was defined as a child that was "born alive." *U.S.* v. *Nelson*, 53 M.J. 319 (U.S. Armed Forces, 2000). Moreover, in numerous other cases, courts have held that the term "child" contained in a State's child abuse statute does not include "unborn children." As an example, commenters cited *In re Unborn Child*, 18 P.3d342 (Okla.2001) (holding fetus is not a "child" for purposes of State children's code); *State* v. *Dunn*, 916 P.2d 952 (Wash. Ct. App.1996) (dismissing child mistreatment charges, finding that the legislature did not intend to include unborn children within the scope of the term "child," which was defined as a "person under eighteen years of age"); *Reinesto* v. *Superior Court*, 894 P.2d 733, 735 (Ariz. Ct. App. 1995) (ordinary meaning of "child" does not include "activity that affects fetuses"); *State* v. *Gray*, 584 N.E. 2d 710, 711-713 (Ohio 1992) (same).

Response: We recognize there is not a single, uniform standard for treating an unborn child under all State and Federal statutes. We do not agree with the commenter's basic premise that the interpretation of the term "child" under SCHIP must be controlled by the interpretation of that term under other, unrelated statutes that deal with criminal issues or other purposes. Thus we are retaining our revised definition in this final rule.

Comment: Commenters stated their belief that the statutory language is clear regarding the age determination as post-birth. Commenters asserted that the Congress does not mention care for unborn children in SCHIP and that, by omission, Congress has spoken on this issue. Commenters cited *Chevron* v. *Natural Resources Defense Council, Inc. et al.*, for the proposition that, in constructing a statute, primary weight must go to whether Congress has spoken on the issue and only when Congress has not spoken is weight given to a permissible agency construction of the statute." Commenters cited *State of Wyoming* v. *United States of America et al.*, 279 F. 3d 1214, 1230 (10th Cir. 2002) and said the "question of whether Federal law authorized certain Federal agency action is one of congressional intent." The commenters asserted that it cannot be assumed that the Congress would have intended "child" to mean a fertilized egg, embryo or fetus unless it had been explicitly discussed. As an example, commenters cited *State* v. *Ashley*, 701 So.2d 338, 342–43 (Fla. 1997) (rejecting homicide prosecution of a woman who shot herself in the abdomen while pregnant, causing premature birth and the subsequent death of her unborn child).

The commenters stated that in the months leading up to the creation of the SCHIP program there was extensive discussion in the Congress about the need for a comprehensive children's health insurance program. And, the commenters said that when describing the problem of uninsured children, the very first statistic Senator Daschle used was that "[e] very 48 seconds a child is born without insurance" [emphasis added]. Commenters mentioned that in the House, Congresswoman Furse promoted as a model an Oregon policy that "cover[ed] a child from birth to 18 years." The commenters asserted that not once in the legislative history does the Congress mention including fetuses or embryos as beneficiaries of a children's health insurance program, and the problems it identified were problems afflicting children, not embryos and fetuses. Commenters continued, that when the Congress spoke of the need for health insurance for prenatal care, "uninsured pregnant women were specifically mentioned."

The commenters continued by stating that an examination of the Congress' intent in passing the SCHIP statute demonstrates that the Secretary's action in promulgating this rule is ultra vires. They asserted that although the Secretary's interpretation of the term "child" is consistent with a possible legal meaning of the word, it is entirely inconsistent with the legislative history and the structure of the legislation.

First, they asserted, there is no evidence from any of the Congressional debates on the SCHIP statute that the Congress intended to extend SCHIP benefits to include "unborn children." And, they stated, it seems unlikely that the Congress would have intended the statute to cover this group unless it had been explicitly discussed.

The commenters argued that this is further supported by the fact that the Congress deliberately chose to include "well-baby and well-child care" in the list of benefits that must be included in a basic benefit package to determine actuarial equivalence under SCHIP. If the Congress had intended that the children covered by this statute would include "unborn children" then including these specific benefits would have been unnecessary. The commenters said that it seems unlikely that coverage for unborn children was intended because it was not included on the list.

Furthermore, the commenters noted that the Balanced Budget Act of 1997 (BBA), contains other sections that explicitly use the term "unborn child." Title IV of that Act amended sections of the Medicare and Medicaid statutes to define the term "emergency medical condition" as a medical condition which "place[s] the health of the individual) or, with respect to a pregnant woman, the health of the woman or her *unborn child*) in serious jeopardy. BBA of 1997, Pub. L. No. 105–33, §§ 4001, 4704, 111 Stat. 251, 290, 496 (1997) (codified as amended at 42 U.S. C. § 1395w-22(d)(3)(B)(i) and 42 U.S.C. 1396u-2(b)(2)(C)(i)) [emphasis added].

The commenters asserted that if the Congress intended to include a fetus as a "child" eligible for SCHIP, it would have explicitly used the term "unborn child" in this section of the Act as it did in the Medicare and Medicaid sections of the same statute. The proposed amendment to the SCHIP regulations is therefore unauthorized. The commenters concluded by stating that the proposed change appears to use a rule change to advance an ideological position on the "personhood" of an unborn " a position never contemplated by the Congress during debate on this program.

Response: We do not believe that Congress directly spoke to the issue of whether the term "child" could include unborn children, because the statute contains no limitation on such an interpretation. We believe the commenters effectively conceded that point by focusing on congressional silence and raising peripheral issues and statements by individual legislators taken out of context. The argument that Congress explicitly used the term "unborn child" in a number of legislative enactments and did not do so in SCHIP goes both ways, because while Congress did not expressly include unborn children, Congress did not exclude them either. Instead, Congress clearly sought to provide a maximum level of State flexibility under SCHIP. Thus we do not see a compelling reason to change our proposed interpretation in this final rule.

The reference to "well child" benefits in the statute simply means that the Congress chose to specify some benefits rather than others as it gave States wide latitude and broad authority to establish what benefits would be offered to those enrolled in the program. The suggestion that the Congress limited benefits to those expressly defined is wrong as indicated by the language of section 2103 (c)(3), "Nothing in this subsection shall be construed as preventing a State child health plan from providing coverage of benefits that are not within a category of services described in paragraph (1) or (2)." Furthermore, the definition of "child health assistance" at section 2110(a)(9) expressly includes prenatal care.

The construction of title XXI is a broad delegation of authority to the Secretary and the States. The Congress considered various forms of expanding health insurance including one limited solely to the expansion of Medicaid. The Congress chose not to duplicate the Medicaid program, but rather constructed a program that left a great deal of authority up to the Secretary and the States to design eligibility and benefits.

Comment: Commenters stated that no regulation or Federal statute currently on the books treats the unborn child as the equivalent of a person and no Federal regulation should do so. The commenters asserted that the SCHIP statute nowhere states or suggests that "child" as used in the statute includes a fetus and they asserted that defining a "child" to include a fetus is inconsistent with the plain and ordinary meaning of the term.

Commenters mentioned that Federal courts have been asked to rule on whether AFDC and Medicaid apply to fetuses and in both contexts, Federal courts have concluded that the term "child" does not include a fetus. In *Burns* v. *Alcala*, 420 U.S. 575 (1975), the Supreme Court held that the term "dependent child," as used in the AFDC statute, does not include "unborn children." 420 U.S. at 580–81. Likewise, the commenters asserted, in *Lewis* v. *Grinker*, 794 F. Supp. 1193 (E.D.N.Y.1991), *aff'd on other grounds*, 965 F.2d 1206 (2d Cir. 1992), the Federal district concluded that fetuses are not eligible for Medicaid. 794 F. Supp.at 1198. Commenters stated that it held that in all events, the phrase "individuals under the age of 21" does not easily apply to unborn children under ordinary usage. The unborn are not "persons" under the Constitution. *Roe* v. *Wade*, 410 U.S. 113, 93 S. Ct. 705, 35 L. Ed.2d 147 (1973).

In addition, one commenter noted that the "age" of any individual is normally computed from birth. The commenter asserted that while the statute does not require calculation of the precise age "under 21," it is apparent that any construction of the phrase "individuals under the age of 21," which will accommodate the unborn is not ordinary usage. Accordingly, this commenter concluded that the Congress did not intend the phrase "individuals under the age of 21" to include the unborn.

Other commenters asserted that the same reasoning applies here: under ordinary rules of statutory construction, it is clear that the Congress did not intend the phrase "individual under 19 years of age," within the meaning of the SCHIP statute, to include the "unborn."

For this reason, commenters asserted that the Secretary lacks the authority to promulgate the proposed regulation. The commenters contended that the definition can only be changed by amending the current statute and that is far beyond the reach of the Department. The commenters went onto say that what the Department calls a "clarification" of the definition is an attempt to change what the Congress intended to include in the definition of child for the purposes of SCHIP eligibility.

Response: As noted above, the SCHIP statute is silent on the issue of eligibility for unborn children, and we do not believe that the interpretation of the term "child," is appropriately controlled by the cases cited, which involved other programs and situations. We believe instead that Congress had a broader purpose under title XXI, which included maximizing State flexibility in offering access to child health assistance under SCHIP.

There is little doubt that the purpose of title XXI is to provide access to health insurance. This regulation would provide eligibility at an earlier point in time that is also one of the most critical times in the lifecycle.

The statute clearly established an age ceiling of 19 that could not be circumvented absent a waiver. However, other broad eligibility standards were

left to the States. A State has the authority to target to different ages below age 19. For example, Federal statute requires Medicaid eligibility at 133 percent of the Federal poverty level up to age 6. After age 6, the Federal minimum is 100 percent of poverty. To fill the gap in Medicaid eligibility, a State could have used the enhanced funding provided by title XXI and designed their SCHIP program to simply cover children at 133 percent of poverty between the ages of 6 and 19.

A State could target resources to younger children as an early childhood development program and thus create an eligibility category at higher income levels specifically for infants and children up to age 4 for example.

Many commenters who oppose this rule have indicated their belief that the Secretary does have authority to extend eligibility to a pregnant woman who is over the age limit set by statute and indeed have indicated support for such a waiver. We believe the Secretary's authority extends to the adoption of definitions through the rulemaking process.

Comment: One commenter suggested that the Secretary might be exceeding his authority by applying the revised SCHIP definition of child in assessing compliance with the Medicaid maintenance of effort provision of section 2105(d)(1), as stated in the preamble to the proposed rule at 67 FR 9938.

Response: We disagree with the commenter because we believe the Secretary's authority clearly extends to the interpretation of statutory terms such as the SCHIP term "child." Furthermore, in this instance, we have used rulemaking procedures to ensure that we have fully considered the issues. We clarify that we interpret the maintenance of effort provision at 2105(d)(1) for purposes of the SCHIP statute, consistent with our overall definition of the term "child." Thus, because a State may extend SCHIP eligibility to unborn children, we will review compliance with SCHIP maintenance of effort provisions by including unborn children in our review. The provision at issue is a SCHIP provision, and it ensures that SCHIP funds will not be used to replace Medicaid coverage.

Comment: Commenters stated that by defining an egg as a child and consequently, when life begins, DHHS is imposing a religious belief on all women. The commenters stated that for each group of people whose religion teaches them that an unborn child is a child at any stage of development, there is another whose religion teaches them precisely the contrary. One commenter mentioned that forcing people to proceed against their religious beliefs in order to access a public benefit is almost certainly illegal and to dangle prenatal care in front of needy women who do not happen to share a particular religious viewpoint would not only be illegal, it would be morally reprehensible.

In support of this position, one of the commenters stated that the Supreme Court found as much in the seminal case of *Sherbert* v. *Verner*, 374 U.S. 398 (1963), while more recently holding that a State may deny unemployment benefits for illegal conduct, even if that conduct is religiously motivated.

The commenter continued by saying, that the free exercise of religion means, first and foremost, the right to believe and profess whatever religious doctrine one desires. Thus, the commenter asserted that the *First Amendment* obviously excludes all "governmental regulation of religious beliefs as such" and cited *Sherbert* v. *Verner*, supra, at 402. The commenter asserted that the government may not compel affirmation of religious belief, and cited several cases in support of this argument, including *Torcaso* v. *Watkins*, 367 U.S. 488 (1961), *United States* v. *Ballard*, 322 U.S. 78, 86–88 (1944), *McDaniel* v. *Paty*, 435 U.S. 618 (1978); *Fowler* v. *Rhode Island*, 345 U.S. 67, 69 (1953); cf. *Larson* v. *Valente*, 456 U.S. 228, 245 (1982), *Presbyterian Church in U.S.* v. *Mary Elizabeth Blue Hull Memorial Presbyterian Church*, 393 U.S. 440, 445–452 (1969); *Kedroff* v. *St. Nicholas Cathedral*, 344 U.S. 94, 95–119 (1952); Serbian Eastern Orthodox Diocese1 v. *Milivojevich*, 426 U.S. 696, 706–725 (1976), *Employment Div. of Oregon* v. *Smith*, 494 U.S. 872, 877 (1990).

The commenter stated that in the Sherbert case, a person was denied unemployment benefits on the basis of work related misconduct because she refused to work on her Sabbath. The Court ruled that forcing a person to choose between following her religious beliefs and receiving a public benefit violates the First Amendment, and in the absence of criminal behavior, that remains the statute today.

The commenter contended that the regime proposed by CMS will confront many pregnant women with just such a choice in that they must either be willing to publicly declare the unborn child they are carrying to be a human being, even if their religion teaches them otherwise, or they must forego perhaps prenatal care and delivery services. The commenter asserted that CMS would be attempting to "lend its power to one or the other side in controversies over religious authority or dogma." *Smith*, supra at 877.

Response: Application for SCHIP benefits is voluntary, and there is nothing in the SCHIP statute that forces a mother to accept SCHIP benefits. While it is certainly possible that acceptance of SCHIP benefits for an unborn child may be contrary to some women's religious beliefs, we do not believe this should preclude States from offering such benefits. If a woman has a religious objection, she simply would not accept SCHIP benefits.

Comment: Commenters stated that by establishing eligibility benefits from the point of conception, a woman's right to make decisions about her health care is undermined. The commenters pointed out that the U.S. Supreme Court has consistently ruled that women's health interests may not be supplanted by State or fetal health interests and cited the following cases: in *Stenberg* v. *Carhart*, the Court struck down a State law imposing government restrictions on abortion that failed to provide an adequate exception for preservation of the woman's health; and in *Colautti* v. *Franklin*, the Court invalidated a statute that failed to guarantee that a woman's health would always prevail over the life and health of her unborn child.

The commenters believe that this rule opens up the possibility for the government or others to claim the right to represent such fetal interests, and thus the right to make decisions about a woman's pregnancy over her objections. The commenters asserted that amending the definition of a covered "child" to include "the period from conception to birth," thereby allowing health insurance coverage for a zygote, embryo and fetus *in utero* has legal and practical problems and could actually undermine the health of the pregnant woman. The commenters stated that current constitutional statute allows States to place limited restrictions on a woman's access to abortion, but a pregnant woman holds an absolute right to make decisions about her pregnancy during the first trimester, including decisions about her health care.

The commenters believe the proposed regulation is inconsistent with the constitutionally protected right of a woman to determine the course of her pregnancy.

Response: As stated previously, enrollment and participation in the SCHIP program is voluntary. There is no conflict as the services to be provided benefit both mother and child.

Comment: One commenter stated that the term "conception" should be understood to mean at the time of

fertilization when the new genetically complete and unique individual begins his or her existence. The commenter said it would be good to define clearly what is meant by "conception" since there are other potentially confusing definitions being used.

Response: We do not generally believe there is any confusion about the term "conception." To the extent that there is, however, we believe States should have flexibility to adopt any reasonable definition of that term.

3. Program Eligibility

Comment: Several commenters asked about when coverage of the unborn child would begin, given the logistical difficulties in establishing the exact date of conception. These commenters also asked whether or not the pregnancy would need to be medically verified, and whether coverage could be retroactive to the date of conception.

Response: Under title XXI, States have discretion in adopting administrative procedures regarding eligibility for coverage. States, at their option, may elect to offer retroactive coverage or may require medical confirmation of the pregnancy before any prenatal care would be provided. If the application had been filed prior to such confirmation and it turned out that the woman was not pregnant, the costs of the pregnancy test could be paid as an administrative cost, at the State's option. If the pregnancy were confirmed, the cost of the pregnancy test and any prenatal care subsequently provided could be treated as child health assistance.

Comment: One commenter asked whether Medicaid rules should be applied to SCHIP. A few commenters asked about whose income would be used to determine the unborn child's eligibility. One specifically asked whether States would need the mother's income and resource information. Another asked whether income from the parents of an unwed pregnant teen living at home should be counted, as would be the case if the teenager were applying for coverage as a pregnant woman under Medicaid. This commenter also asked whether child support enforcement requirements apply to the unborn child or to the mother.

Response: Medicaid eligibility rules only apply when a State has implemented its SCHIP through a Medicaid expansion program. Medicaid eligibility rules do not apply to separate child health programs. States have broad discretion in defining "family income" for purposes of determining eligibility under a separate child health program. States have discretion to determine whose income shall be considered in determining a child's eligibility. Similarly, States have broad discretion on whether to have a resource test for their separate child health program and, if so, whose resources to count. Thus, in the example cited by one commenter, a State could opt to count the income and/or resources of a pregnant teen's parents in determining eligibility. However, it is not required to do so.

There are no Federal child support enforcement requirements for separate child health programs. Thus, while States can impose such requirements, they are not required to do so.

Comment: One commenter asked whether the baby would be eligible for a year of presumptive eligibility.

Response: In general, infants born to mothers who were eligible for and receiving Medicaid at the time of the infant's birth automatically are eligible for Medicaid for one year. It is unclear whether this commenter is asking if babies, who were covered by SCHIP while in utero, would be covered by this rule, or whether the commenter is asking if such babies would be eligible for one year of presumptive eligibility under SCHIP. We will respond to both questions.

Under 42 CFR 457.350(b) regarding the SCHIP regulation's screen and enroll requirements, if a mother is Medicaid eligible, the unborn child cannot be eligible for SCHIP. Conversely, if the unborn child is covered under SCHIP, that means that the State determined, in the screening and eligibility process, that the mother was not eligible for, or receiving, Medicaid. Accordingly, the automatic one-year eligibility enjoyed by infants born to mothers on Medicaid would not apply to infants covered by SCHIP while in utero.

If a State has adopted presumptive eligibility for its separate child health program, an unborn child could be determined to be presumptively eligible, to the same extent as any other child, consistent with the regulations at 42 CFR 457.355. However, presumptive eligibility cannot be applied to a child once the child has been determined to be eligible for coverage under SCHIP. This basic principle is true for a child determined eligible for coverage while in utero, as well as one who is first determined eligible after birth.

This does not mean, however, that an infant eligible in utero loses coverage at birth. Under current regulations at 42 CFR 457.320(e)(2), States have the flexibility to establish an eligibility period of up to 12 months. A child's eligibility for a separate child health program must be redetermined at the end of the eligibility period adopted by the State. Between regularly scheduled redeterminations, States are not required to reevaluate a child's continued eligibility, regardless of changes in circumstances (other than the child turning 19).

Under this regulation, the term "targeted low-income child" is defined to include an unborn child, who otherwise meets the State's income eligibility criteria. Thus, whatever period of eligibility the State has adopted for children covered under its separate child health program also would apply to an unborn child. Birth in and of itself does not alter the baby's status as a "targeted low-income child." Thus, once born, the infant would remain eligible for coverage under the separate child health program until the next regularly scheduled redetermination.

For example, suppose that a State has adopted a 12-month eligibility period and that an unborn child was determined eligible for SCHIP three months prior to birth. At birth, the infant would remain eligible for coverage under the State's separate child health program for 1 year from the date of initial eligibility, or, in this case, nine months from the date of birth.

Note that, at any point a parent or other caretaker has the right to file a Medicaid application on behalf of the infant. If such an application were filed, the State then would be required to determine the infant's eligibility for Medicaid.

Comment: One commenter asked if the continuous eligibility afforded to pregnant women by Medicaid " under which pregnant women retain eligibility for the duration of their pregnancy and postpartum period regardless of changes in income—would be available to unborn children eligible for SCHIP under this regulation.

Response: No. As explained above, Medicaid rules do not apply to separate child health programs. However, as also explained above, under current regulations at 42 CFR 457.320(e)(2), States can adopt continuous eligibility for children eligible for their separate child health program, with an eligibility period of up to 12 months. A child's eligibility must be redetermined at the end of the eligibility period adopted by the State. Between regularly scheduled redeterminations, States are not required to reevaluate a child's continued eligibility, regardless of changes in income or other circumstances (other than the child turning 19).

Comment: One commenter asked whether an unborn child could be eligible for SCHIP if the mother is not eligible for Medicaid because she does not satisfy the State's residency requirement.

Response: Subject to the provisions of 42 CFR 457.320(d), States may establish residency requirements for their separate child health programs. An application for an unborn child for this program would be treated the same as any other application for coverage. Thus, it also would be subject to the residency requirements established by the State.

Comment: One commenter asked whether States would need the mother's social security number (SSN).

Response: States are not permitted to require the SSN of anyone, other than the child applying for coverage, as a condition of eligibility. This rule does not change that situation. Thus, States may not require that the unborn child's mother provide her SSN. However, States would likely assign a unique identifier to every unborn child that is found eligible for coverage and enrolled in a separate child health program in order to perform normal administrative functions. The mechanism used to assign such an identifier is left to the discretion of each State.

As in current practice, a State may request the pregnant woman's SSN as long as the State makes it clear for what purpose her SSN would be used; and that she is not required to provide her SSN and that eligibility will not be affected if she does not do so.

Comment: One commenter asked whether either parent would be able to submit an application on behalf of the unborn child.

Response: Under title XXI of the Social Security Act, States have broad discretion to adopt administrative procedures governing the filing and processing of applications. Thus, States can, but are not required, to place restrictions on who can file an application on behalf of a child. There is nothing in this regulation, however, that would permit any individual to compel another to seek or use health care services.

Comment: A few commenters asked whether an unborn child would have to be issued a SSN or other unique identifier. These commenters also asked what method the State would use to track services provided to the unborn child.

Response: We are not aware of any circumstances in which the Social Security Administration assigns a SSN to an individual prior to birth. This rule does not request, let alone require, that it do so.

Therefore, we do not anticipate that an unborn child that is determined to be eligible for coverage under a separate child health program would be given a SSN. Consequently, it will be necessary for States to assign a unique identifier to appropriately process claims. The mechanism used to assign the identifier is left to the discretion of each State.

The data collection and reporting requirements for separate child health programs are set forth at 42 CFR subpart G. Regulations governing payment for and verification of services provided are found at 42 CFR 457.950 and 42 CFR 457.980. States are required to comply with these requirements with respect to coverage of all enrolled individuals. This rule does not impose any additional requirements on States with respect to services provided to an unborn child.

Comment: In the March 5, 2002 proposed rule, we explained that this regulation will give States the option to consider an unborn child to be a targeted low-income child and therefore eligible for SCHIP "if other applicable eligibility criteria are met." One commenter asked whether the "other eligibility criteria" applies to the unborn child or the pregnant woman.

Response: The "other eligibility criteria" pertain to the unborn child.

Comment: One commenter emphasized the importance of the screen and enroll requirements.

Response: We agree with the commenter that the screen and enroll requirements are very important. As we explained in the March 5, 2002 proposed rule, the purpose of the rule is to encourage States to increase the availability of prenatal care. In order to ensure that funding for prenatal care under SCHIP does not replace funding for prenatal care under Medicaid, we explained that States must apply the screen and enroll process described in the SCHIP regulations at 42 CFR 457.350. Consistent with the terms of that regulation, States must screen the unborn child's mother for Medicaid eligibility. If the State determines that the mother is potentially eligible for Medicaid, then the State must assist her in completing the Medicaid application process, again, consistent with the requirements set forth in 42 CFR 457.350.

Comment: One commenter asked whether a State could include this group in an existing Medicaid waiver, such as the family planning and Healthy Start waivers.

Response: Section 1115 waivers are demonstration projects awarded to States at the Secretary's discretion on a case by case basis. As such, consideration of this eligibility group could be considered for inclusion in an existing waiver but a sufficient rationale would need to be provided by the State. Also, it may not make sense to include this group, as in the case of family planning waivers, for example.

Comment: Two commenters said that all States should be required to cover the unborn child.

Response: We cannot require States to cover unborn children. The statute does not require that States cover all children who meet the definition of a targeted low-income child. Section 2102(b)(1) of the Act and implementing regulations at 42 CFR 457.320(a)(2) specifically permit States to adopt eligibility standards based on age. Thus, we are precluded from mandating that all States cover unborn children.

4. Immigration Status

Comment: Commenters stated that the proposed regulations do not address how the unborn child will be classified in determining its citizenship or immigration status. Many commenters urged the Department to make clear in the final rule that unborn children will be eligible for SCHIP benefits under the rule, regardless of the immigration status of their mothers. The commenters asserted that since no unborn child is a citizen or a qualified immigrant, there is no basis for making distinctions among unborn children on nationality and immigration status grounds.

Commenters stated that low-income pregnant women who are either recent legal immigrants (subject to the 5 year bar on receipt of Federal public benefits) or are undocumented immigrants are often unable to secure prenatal care, and such an exclusion is likely to result in serious harm to the unborn child.

Yet, commenters noted, the babies born to these women in the United States will become citizens immediately upon their birth. Commenters asserted that effective health care for these children, no less than others, must begin with access to prenatal care. In addition, this would provide effective coverage for the maximum number of unborn children. One commenter noted that the proposed regulation would permit States to ensure that essential prenatal services are available "to benefit unborn children regardless of the mother's eligibility status." (67 FR 9937) The commenter noted that this position is consistent with existing statute and practice since many children whose parents would not be eligible for SCHIP are currently enrolled in the SCHIP program. These include children whose

parents are subject to the 5-year bar. The commenter states that with the exception of income available to the child, parents' eligibility for SCHIP is irrelevant. They noted that SCHIP eligibility is based upon the age, immigration status, insurance coverage and other factors specific to the child. 42 U.S.C. 1397bb(b)(1)(A); 42 CFR 457.320, as amended by interim final rule published at 66 FR 33810 (June 25, 2001).

The commenters stated that HHS should amend the proposed regulation to clarify that all unborn children will be treated equally for SCHIP eligibility purposes. One commenter specifically requested that we amend § 457.320(b)(6) to state that "In establishing eligibility standards and methodologies a State may not exclude individuals based on citizenship or nationality to the extent that the children are U.S. citizens, which includes unborn children from conception to birth who upon birth will be U.S. citizens, U.S. nationals or qualified aliens." Commenters contended that if the regulation were adopted, treating all unborn children as constructively born in the U.S. would be the most straightforward way to accomplish this end and cited *Lewis* v. *Thompson*, 252 F.3rd 567, 581 (2d Cir. 2001), (discussing the "constructive birth" provisions of 42 U.S.C. 1396d(n)(1)(A), which treats a childless pregnant woman as a parent with one child for TANF eligibility purposes.)

Response: We agree with the commenters that requiring exclusion of unborn children on the basis of immigration status is neither legally mandated nor desirable. Unborn children do not have immigration status as "aliens" and thus are not precluded from receiving Federal means-tested benefits under the provisions of Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law No. 104–193. Under PRWORA, these restrictions apply only to "aliens" who are not "qualified aliens"; since unborn children are not "aliens," they are not within the scope of this preclusion nor are unborn children subject to the 5-year bar. Furthermore, as we stated in the preamble to the proposed rule, the goal is to permit States to ensure that needed services are "available to benefit unborn children independent of the mother's eligibility status" (67 FR 9937). Because prenatal care is a key element to ensuring healthy infants and children, this goal would maximize the availability of prenatal care and, consequently, promote the overall health of infants and children. It would be inconsistent with this goal to tie services for prenatal care to the immigration status of the mother.

We do not, however, believe that it is necessary to explicitly amend the proposed rule to express this interpretation of applicable law. Since unborn children would not be precluded from receiving benefits under applicable law, there is no reason to further address the issue in the regulation text.

Comment: One commenter noted that the unborn child of an ineligible immigrant woman is indistinguishable from that of any other woman present in that State. In the real world, upon birth, that unborn child becomes a child and a U.S. citizen. This commenter asked, "But if CMS adopts a position that deems that fetus a "child" in utero, then what possible justification could there be for denying SCHIP benefits to such a "child"?" Another commenter recommended that the proposed regulation should not be clarified to deny coverage to the unborn children of immigrant women merely because the women would themselves be ineligible to receive benefits under Federal statute. This commenter stated that any clarification of the regulation should make explicit that the women's immigration status is irrelevant to the provision of SCHIP benefits. If the proposed regulation is adopted, there is no principal basis on which to distinguish the unborn children of immigrant women from the unborn children of citizen women. The commenter said that although Federal statute provides that "an alien who is not a qualified alien is not eligible for any Federal public benefit * * *" 8 U.S.C. 1611(a), an unborn child has no citizenship or immigration status whatsoever, and is therefore not made ineligible for coverage by reason of 8 U.S.C. 1611(a) or any other immigration-related eligibility restriction. The commenter stated that any exclusion of the unborn children of ineligible immigrant women would thus have to be accomplished by altering the proposed regulation to exclude such unborn children explicitly. The commenter contended that such a change would be contrary to the avowed purpose of the proposed regulation and would have no basis in logic, given that the regulation is premised entirely on the unborn child's status and not the woman's and in support of this position cited *Plyler* v. *Doe*, 457 U.S. 202, 220 (1982) (invalidating State law denying public schooling to the children of undocumented immigrants because the denial "directed the onus of a parent's misconduct against his children").

Response: We agree that it is does not make sense to try to impute an immigration status to an unborn child based on the status of the mother. As discussed above, an unborn child is not an alien, and the status of the child is not necessarily tied to the status of the mother. Moreover, to do so would not be consistent with the purpose of providing States with the flexibility to maximize the availability of prenatal care to ensure healthy infants and children.

Comment: Commenters stated that the rule should be clarified to make clear that undocumented immigrants may not be reported to immigration authorities for seeking medical care for their unborn children. Commenters were concerned that in the absence of such a protection, undocumented immigrant mothers may not seek medical care, and their unborn children will not receive care they need to help ensure a healthy birth and are entitled to as a U.S. citizen. Commenters stated that since the pregnant woman will never be the recipient, it would seem that a State, pursuant to the "Tri-Agency Guidance" issued by the Departments of Health and Human Services and Agriculture (on 9/21/00), would be prohibited from inquiring about her immigration status.

Response: Nothing in this regulation alters section 434 of the 1996 welfare reform statute, which prohibits the Federal government from restricting State or local government entities from sending to or receiving from the Immigration and Naturalization Service information regarding the immigration status of an alien in the U.S. Further, nothing in this regulation alters the Tri-Agency Guidance with respect to inquiries about immigration status of nonapplicants.

Comment: The commenter was concerned about the additional cost of covering all unborn children conceived in the United States by illegal immigrant women. The commenter believes that under this rule, the unborn child should be eligible for benefits if (she is conceived in the United States. The commenter was concerned that if women are permitted to self-declare whether conception occurred in United States that the Administration's cost estimate is too low because of the large numbers of undocumented immigrants who would be receiving coverage.

Response: The question of where conception occurred is irrelevant to the question of the unborn child's immigration status or this final rule. This regulation provides states with the flexibility to assure essential prenatal care to the maximum number of unborn children, regardless of the immigration

status of their mothers. States, in deciding whether or not to adopt this option under their title XXI state plan, will certainly weigh, along with numerous other factors, the potential costs associated with providing coverage to unborn children since States cannot receive Federal funding that exceeds title XXI allotment.

Comment: One commenter stated that prenatal care is even more important among Latinas, who suffer from higher rates of pregnancy-induced hypertension and maternal mortality. The commenter noted that 12 States offer prenatal care to immigrant women who are ineligible for Federally funded medical assistance, which has lessened the effects of PRWORA. The commenter stated that if the new regulation explicitly covers children of undocumented immigrants, it would increase the number of States that provide prenatal care services to pregnant immigrant women and provide an incentive for those States that have seen a large influx of Latina immigrants in recent years.

Response: This rule ensures that States have maximum flexibility to extend SCHIP eligibility to unborn children, independent of the immigration status of the mother. We believe that this rule addresses the concerns of the commenter since the intent of this rule is to benefit both the unborn child and their mothers by promoting continuity of important medical care.

5. Benefits

Comment: Commenters, whether in favor of this rule or not, expressed their belief that all women should receive regular and adequate prenatal care because there is overwhelming data that shows that there are still too many women who receive no or less than adequate care during pregnancy. Commenters agreed that health care should be provided from the prenatal stage.

Many commenters, in support of this rule, expressed their belief that all women should be able to receive prenatal services that increase the chances of every child being born healthy. This regulation would allow pregnant women and unborn children to receive the medical treatment they need. Commenters noted that the lack of prenatal care results in increased health costs for taxpayers in caring for problems and complications after birth, and some noted that coverage of the unborn child may result in the incidental improvement in the health of the mother. But, all too often proper prenatal care has been cost prohibitive to low-income women, and the commenters view this proposal as assisting the millions of women of childbearing age who lose or lack health insurance. Proper prenatal care can prevent avoidable birth defects. Fetal surgery is able to correct many life-threatening congenital disorders. There is no reason the unborn child should be denied the lifesaving procedures that will permit him or her to live a full, normal life after birth, particularly with the recent medical advances that will continue to develop and evolve. Providing this care is a benefit, not only for the unborn child, but for women and families as well. Commenters stated that this policy provides a way for the mother to make positive choices with regard to caring for her unborn child and herself.

Some commenters noted that coverage would decrease infant mortality rates. Two commenters cited a DHHS report, "Trends in the Well-Being of America's Children & Youth 2000," that indicated prenatal care can improve birth outcomes and decrease health costs. Two commenters also cited an American Academy of Pediatrics (AAP) policy that indicates "* * * physical and psychosocial growth, development, and health of the individual begins prior to birth when conception is apparent * * * the responsibility of pediatrics may therefore begin with the fetus * * *."

Commenters expressed a concern that it is in the public's interest to assure that expectant mothers have access to quality prenatal health care coverage as highlighted in Healthy People 2010. Additionally, commenters noted that it is less expensive to care for healthy babies than unhealthy babies and that access to prenatal care means long-term reduction in the cost of health care for these children. Expanding Federal health programs to give more low-income pregnant women access to prenatal care is an important step in making sure children get a healthy start in life.

Response: We appreciate the commenters' support of our goal in developing this rule. By providing States with the option of ensuring that needed prenatal care is available under SCHIP to benefit unborn children, uninsured low-income women, who are less likely to receive prenatal care, would be able to access crucial services that they may not otherwise be able to receive. This regulatory clarification is intended to benefit both the unborn child and the mother by promoting continuity of important medical care. We agree that healthy pregnancies should also result in significant savings in public expenditures over a child's lifetime.

Comment: While commenters agreed with the importance of prenatal care as essential for the mother and child, many disagreed with the mechanism this Administration has taken for accessing that care. They feel very strongly that eligibility should be extended to the pregnant woman and not to the unborn child. Several commenters opposed this approach as a false separation of the woman and child. Commenters were concerned that the medical needs of the embryo would take precedence over the needs of the mother and stressed their belief that the benefit should be conferred to the woman and not to the unborn child. They expressed concern that this regulation may create a conflict of interest between the woman and the unborn child.

They believe that a crucial question is whose needs take priority? Many felt that treating the unborn child as if it exists separately and should be considered before and above the health of the woman carrying the unborn child is a false separation that would ultimately prove detrimental to the health of many women as well as to their unborn children or newborns. They believe that this proposal interferes with women's autonomy to make medical care decisions and represents an arbitrary separation of the woman and child (since one cannot be cared for without the other also receiving care). One commenter indicated that conflicts of interest between the mother and child would not arise if the woman was determined the patient, as under the Medicaid program (42 U.S.C. 1396a(a)(10)(A)(i)(III), (IV), (VI), (VII), (A)(ii) and (1).)

Response: We understand the commenters' concerns. The intent of this rule is to maximize the availability of SCHIP benefits in the interest of both pregnant women and unborn children. The statutory provisions of title XXI are very clear that only targeted low-income children can be eligible for the program. Although, under § 457.1010 States do have the option of applying for a variance to purchase family coverage through which a pregnant woman over the age of 19 could be determined SCHIP eligible.

States do have options available if they wish to expand eligibility to a pregnant woman over the age of 19 whose income is over the current Medicaid income guidelines rather than to the unborn child, which include: a title XIX expansion under one of their poverty groups; or a section 1115 waiver demonstration. However, absent a

waiver, eligibility can only be conferred to the targeted low-income child.

That being said, nothing in this rule is intended to affect the traditional relationship between the pregnant mother and the physician. Questions of medical treatment for the pregnant woman and/or her unborn are a decision between the pregnant woman and her physician and nothing in this rule would circumvent or alter that relationship.

Comment: Commenters were concerned that a woman could possibly be denied medical treatments such as prescription drugs, psychotropic medications to treat psychiatric illnesses, and life-saving radiation or chemotherapy treatments because of the effects they would have on the unborn child.

Commenters asked if the pregnant woman would be denied other care that might be harmful to the unborn child, thus effectively pitting her needs against those of the unborn child? One commenter asked whether the State would be subjecting women to drug and alcohol tests on the alleged ground that it is protecting its patient-beneficiary? Several commenters referred to this policy as medically unsound, ethically unacceptable, and/or poor public policy. Commenters questioned if physicians would be required to consult with the unborn child's father or another legal guardian if these types of issues exist. Several questioned what entities would have the authority to assert the rights of the unborn child (such as, State, Federal government, physician, pregnant woman, father?).

To illustrate their point, two commenters cited a court case (*In re A.C.*, 573 A. 2d 1235, 1235 (D.C.1990) in which a woman was compelled by the court to undergo a caesarean section, following which both the mother and unborn child died (Veronica E. B. Kolder *et. al*, Court-Ordered Obstetrical Interventions, 316, *New Engl. J. Med.* 1192, 1195 (1987).

Several commenters also raised the question as to what happens in cases where continuing the pregnancy itself endangers the life of the mother, since the assumption made by the commenters is that the life of the unborn child would take precedence over the life of the mother or that both would be allowed to die.

Response: These comments extend beyond the scope of this regulation, which concerns only the ability of States to extend SCHIP eligibility to unborn children. As in Medicaid, nothing in this rule is intended to affect the traditional relationship between the pregnant mother and the physician. Questions of medical treatment for the pregnant woman and/or her unborn are a decision between the pregnant woman and her physician and nothing in this rule would circumvent or alter that relationship.

Comment: Commenters expressed concern that certain benefits that would provide comfort for the pregnant women would not be covered, such as epidurals or anesthesia during delivery.

Response: Within the options for benefit coverage selected by a State, as described at § 457.410, a State selecting this SCHIP option has the flexibility in defining its benefit package to provide benefits it deems necessary.

Regarding the specific question asked by the commenters, while analgesia given as an epidural and/or intramuscular intravenous injections of pain relievers, and/or anesthesia given as regional or general anesthesia is primarily provided during labor and delivery to relieve the mother's pain from uterine contractions or to perform surgery, that is, C-section, if a woman's pain during labor and delivery is not reduced or properly relieved, adverse and sometimes disastrous effects can occur for the unborn child. There is no question that analgesia/anesthesia is required in order to perform a C-section and such a procedure cannot even be considered if some form of pain relief is not provided. In terms of vaginal deliveries, without relieving the mother's pain from uterine contractions, the progress and labor may be interrupted and not efficient, which in turn can cause fetal complications, such as fetal distress and infection from prolonged labor and prolonged rupture of membranes and other complications. Therefore, we would expect that this coverage would be provided.

Comment: Several commenters were concerned about whether States would have the flexibility to use enhanced Federal funds to provide comprehensive benefits to pregnant women and stated that the failure to provide a comprehensive range of services for all of a pregnant woman's health care needs and treatment of some stated diseases, could compromise her health, as well as, that of the unborn child.

Although many commenters supported expanded access to prenatal care among low-income, uninsured women, many believed that the benefit should be given to the woman, in addition to or instead of her unborn child. One commenter stated that one cannot effectively treat an unborn child without treating the woman carrying it, believing that a healthy pregnancy resulting in the delivery of a healthy baby requires a healthy mother. One commenter stated that low-income women deserve actual, not merely incidental, health insurance coverage that covers all of their health needs. Several commenters indicated that women deserve comprehensive care, not simply care related to the unborn child, and several referred to the proposal as "reducing women to vessels."

Commenters also felt that extending comprehensive care to the mother would result in women who are healthier and ultimately would result in better birth outcomes. One commenter felt that targeting coverage for the unborn child, not the mother raised ethical issues and puts the mother's health at risk by providing inadequate coverage.

Commenters expressed concern or questioned whether care would be extended to women for injury or disease not related to the pregnancy, such as skin melanoma, emergencies, accidents, broken bones, or mental illness. One commenter advocated for coverage of drug treatment programs for mothers who were addicted.

Several commenters indicated that the focus should be on addressing the health care needs of millions of uninsured women, and one advocated expanded access to uninsured women to "take care of those already here."

Response: The SCHIP statute provides States with broad flexibility in defining those services for which they choose to provide coverage under their State plan. States have the flexibility to define and provide comprehensive services that are related to the pregnancy or to conditions that could complicate the pregnancy. Under the regulation, States would define what services would be included. Services related to conditions that could complicate the pregnancy include those for diagnosis or treatment of illnesses or medical conditions that might threaten the carrying of the unborn child to full term or the safe delivery of the unborn child. Within these parameters, States have discretion in the services for which coverage can be provided.

However, SCHIP eligibility is limited by statute to targeted low-income children and there must be a connection between the benefits provided and the health of the unborn child.

We would point out that the regulation is intended to reach individuals who are currently uninsured and who therefore lack access to any services.

Comment: Commenters believe that, by permitting States to extend SCHIP coverage to unborn children, this rule would effectively deny women access to needed postpartum care. They felt that pregnancy-related care should be

viewed as a continuum comprising three distinctly important periods: prenatal, intrapartum (during labor and delivery), and postpartum care. Commenters stressed that a woman's pregnancy-related health care needs do not end the moment her child is born. The commenters stated that the woman still requires many pregnancy-related services and optimal maternal health is important for overall family health. Under the proposed regulation, covered care would be available only during "the period from conception to birth." These commenters are concerned that the moment after the birth of the child, a woman would lose any incidental covered care that she had received as a result of having an SCHIP-covered unborn child in utero. The commenters continued with their concern that woman would therefore not be eligible for any care during the postpartum period including but not limited to the treatment of hemorrhage, infection, episiotomy repair, C-section repair, family planning counseling, treatment of complications after delivery, and postpartum depression. Several cited this proposal as bad public policy that will ultimately result in increased health care costs.

One commenter questioned whether hospitals and practitioners would be compelled to release women immediately after delivery due to lack of maternal coverage. Others expressed concern that some women will leave the hospital immediately after birth to avoid expenses, against ACOG and AAP recommendations, while others will not attend the four to six week recommended follow-up visits (resulting in decreased maternal health).

Several commenters noted that if the mother is ill and does not get the care she needs, she may not be able to take care of her children, especially an infant, appropriately. This indirectly jeopardizes the health of women, children and families, and will inevitably result in compromised health outcomes for both the woman and the unborn child.

Commenters quoted ACOG and AAP's recommendation that four to six weeks after delivery the mother should receive a postpartum review and examination. Several commenters referenced Medicaid statute and regulations as an illustration of how public programs rely on established medical standards (§ 1902(1) of the Act as defined in § 1902(a)(10)(a) (clause VII)).

One commenter also indicated that lack of family planning counseling creates greater risk of unintended pregnancy with serious social and economic costs to the woman, State, and community. Others noted that maternal mortality represents a serious health problem, particularly for African-American women.

One commenter stated that coverage for postpartum care and assistance in enrollment in Medicaid or SCHIP should be a requirement for States electing to implement this rule, even in cases where the child is not born alive.

Commenters asked clarifying questions such as: would postpartum follow-up be covered; would emergencies arising to the mother following delivery be covered; and would benefits such as the 60 days postpartum care available through Medicaid be provided?

Response: Again, the intent of this rule is to extend access to individuals who are currently uninsured. We believe that the benefits that would be available to the mother and unborn child are indeed vital.

The SCHIP statute provides States with flexibility in defining those services for which they choose to provide coverage under their State plan. States have the flexibility to define and provide services that are related to the pregnancy or to conditions that could complicate the pregnancy. Within these parameters, States have significant flexibility in the services for which coverage can be provided.

Commenters are correct that care after delivery, such as postpartum services could not be covered as part of the title XXI State Plan, (unless the mother is under age 19 and eligible for SCHIP in her own right), because they are not services for an eligible child.

Comment: One commenter expressed concern that there are those who would define care to include abortion, which the commenter felt would be a complete twisting of the term "care." This commenter did not want abortions covered by the government.

Response: FFP is available in expenditures for abortions under SCHIP only as specifically authorized by the Congress in the statute and this will not change with this regulation. Section 2105(c)(1) and (c)(7) of the Act sets limitations on payment for abortion services under SCHIP. Section 457.475 of the January 2001 SCHIP final regulation, specifies that FFP is not available for expenditures for abortion, or for expenditures for the purchase of health benefits coverage that includes coverage of abortion services, unless the abortion is necessary to save the life of the mother or the abortion is performed to terminate a pregnancy resulting from an act of rape or incest. Additionally, FFP is not available to a State for expenditures of any amount under its title XXI plan to assist in the purchase, in whole or in part, of health benefits coverage that includes coverage of abortion other than to save the life of the mother or resulting from an act of rape or incest.

Comment: Commenters asserted that fetal surgery saves lives, as in the case of spina bifida or repair of heart defects and asserted that this type of coverage should be offered to unborn children.

Response: We provided a discussion of "fetal medicine" or "fetology" in the preamble to this rule as an example of a distinct and important medical specialty that represents emerging opportunities for services specifically targeted to the care of the unborn child.

Consistent with section 2103 of the Act, States have flexibility in defining the benefits that are included as part of the health coverage provided to targeted low-income children. The specific prenatal and pregnancy related benefits included in a State's benefit package would be the decision of the State.

Comment: The commenters stated that the practices of "fetal surgery," as described in the March 5, 2002 proposed rule, have been deeply plagued by both clinical and ethical problems. The commenters wanted to make clear that there is no such thing as fetal surgery independent of the mother, and that surgery on the unborn child occurs only through the woman's body and can occur only with her consent. Commenters stated that surgery on the fetus presents significant risks to the pregnant woman's life and health and the impact this surgery can have on pregnant woman should be recognized and strongly considered. Commenters continued that modest improvements (or no improvements at all) in the outcomes for fetuses with neonatal operations often happen in conjunction with severe obstetrical complications for the woman.

In support of the medical and ethical controversy surrounding fetal surgery, one commenter cited several articles: Bruner *et al*, Fetal surgery for myelomeningocele and the incidence of shunt dependent hydrocephalus JAMA 1999;282;1819–25; Sutton *et al*, Improvement in hindbrain herniation demonstrated by serial fetal magnetic resonance imaging following fetal surgery for myelomeningocele JAMA 1999;282:1826–31; Simpson JL, Fetal surgery for myelomeningocele: Promise, progress, problems JAMA 1999;282;1873–4; Lyerly *et al*, Attitudes of maternal-fetal specialists concerning maternal-fetal surgery, American Journal of Obstetrics and Gynecology 2001;185;1052–8; Lyerly et al, Toward the ethical evaluation and use of

maternal-fetal surgery. Obstetrics and Gynecology 2001;98:689–97. This commenter also cited a National Institutes of Health conference examining the scientific, clinical, and ethical issues related to maternal-fetal surgery.

The commenters stressed that a review of the medical literature shows that maternal-fetal surgery is still considered experimental or investigational by such medical professional organizations as the American College of Obstetricians and Gynecologists. One commenter quoted a member survey of the Society for Maternal-Fetal Medicine, which found that 57 percent of respondents believed that a moratorium should be imposed on open fetal surgery for nonlethal conditions until a multicenter controlled trial is completed. The commenter noted that most of the conditions listed by the March 5, 2002 proposed rule are exceptionally rare and the mortality rates following surgery have been high. Another commenter indicated that current Medicaid programs and most private insurers do not cover experimental procedures.

In addition, the commenters expressed concern that there is no research or data to support the assertion that fetal surgery can ultimately lower postpartum medical care costs. They indicated that while long-term research in this field may someday produce such results, the March 5, 2002 proposed rule's claims that cost-savings currently exist is without support.

The commenters noted that despite the fact that fetal surgery is at this stage largely experimental, the March 5, 2002 proposed rule states that the "Secretary would like to permit the States the flexibility to pay for the medical expenses related to unborn children," suggesting a departure from longstanding State and Federal policy regarding denying coverage for experimental treatments. One commenter indicated that this rule seems to signal a radical shift in policy regarding experimental treatments, and if this is the case, there are many patients suffering from cancer and other diseases who might benefit from an overall change in policy regarding experimental treatments. The commenter refers to a May 26, 1993, letter to State Medicaid Directors and cites the following: *Miller by Miller* v. *Whitburn*, 10 F.3d 1315 (7th Cir. 1993); *Rush* v. *Parham*, 625 F.2d 1150, 1156 (5th Cir. 1980); *Weaver* v. *Reagan*, 886 F.2d 194 (8th Cir. 1989).

In addition, commenters are concerned that since fetal surgery is so new and lacking in proven benefits that it really should be considered research. Commenters asserted that this would make it appear, then, that this rule is promoting unreviewed and unapproved research on pregnant human subjects, in conflict with statutes regarding human subjects of medical research (Anne E. Drapkin Lyerly, MD *et al.* Toward the Ethical Evaluation and Use of Maternal-Fetal Surgery, 98 ACOG 689 (2001).) They also stated that fetal surgery is experimental and it is highly unlikely that this would be covered by Medicaid or any other insurance program (45 CFR 46.101 through 45 CFR 46.409, promulgated pursuant to the Health Research Extension Act, 42 U.S.C. 289.)

Response: As we have said previously, nothing in this rule is intended to affect the traditional relationship between the pregnant woman and her physician. Questions of medical treatment for the pregnant woman and/or her fetus are a decision between the pregnant woman and her physician and nothing in this rule would circumvent or alter that relationship.

Additionally, we are not saying that States that choose to extend coverage to the unborn child must provide fetal medicine or fetology. Consistent with section 2103 of the Act, States have flexibility in defining the benefits that are included as part of the health coverage provided to targeted low-income children. As such, States have always had the ability under SCHIP to provide treatments or surgery that may be considered investigational or experimental if they determine they are medically necessary. We note that States have the same option for providing such coverage under Medicaid. But, the specific prenatal and pregnancy related benefits included in a State's benefit package would be the decision of the State.

We do not have data that fetal surgery can ultimately lower postpartum medical care costs and did not make this assertion. In the preamble to the proposed rule we said that conditions in utero that can be medically or surgically corrected can have beneficial consequences that can include saving the life of the child; elimination of long neo-natal, post-partum medical care for the child and ultimately lower post-partum medical care costs for the child and therefore the SCHIP plan.

Comment: Commenters stated that according to this rule, the unborn child is the patient and the one eligible for services and, as such, they asked, "When the needs of the fetus and mother diverge, to whom is the medical professional's ethical duty owed?" They asked whether SCHIP or Medicaid would still pay for surgery if the unborn child were endangered to save the life of the pregnant women? Commenters stated that this proposal raises troubling ethical issues for physicians because ancillary health care potentially puts women's health at risk.

Response: We understand the commenters' concerns, and want to be very clear that nothing in this rule is intended to affect the traditional relationship between the pregnant woman and her physician. Questions of medical treatment for the pregnant woman and/or her unborn child are a decision between the woman and her physician and nothing in this rule would circumvent or alter that relationship.

Comment: Many commenters were also concerned that coverage would not be extended in the case of miscarriage or stillbirth since the SCHIP beneficiary would no longer exist. Many cited such a policy as disrespectful to women.

Response: Services provided under those circumstances would be allowable costs. We believe that providing uninsured women with access to health insurance coverage that benefits both mother and child contributes to the respect of women. This proposed regulation is one option that would become available to States and is one action out of many that the Secretary has taken to promote the health of women.

Comment: Another commenter indicated that the rule allows for unscrupulous providers to bill twice for some services—once on the mother's account and a second time on the unborn child's account.

Response: We believe that States with separate SCHIP programs have implemented sufficient safeguards to address the commenter's concerns. Specifically, § 457.980 of the June 25, 2001 SCHIP implementing rule requires States to establish and maintain systems to identify, report, and verify the accuracy of claims for those enrolled children who meet the requirements of section 2105(a) of the Act, where enhanced Federal medical assistance computations apply. Additionally, States are required by § 457.915 of the January 2001 SCHIP final rule to establish procedures for ensuring program integrity and detecting fraudulent or abusive activity.

Comment: The commenter questioned why prenatal care should be provided to an expectant mother and indicated care should wait until after delivery.

Response: Prenatal care has been clearly shown to reduce the likelihood of premature delivery or low birth weight, both of which are associated

with a wide range of congenital disabilities as well as infant mortality. Moreover, proper prenatal care can detect a great number of serious and even life-threatening disabilities, many of which can now be successfully treated in utero. Ensuring prenatal care for more children will significantly help reduce infant mortality and morbidity rates and will spare many infants from the burden of congenital disabilities and reduce the cost of treating those congenital disabilities after birth.

Comment: The commenter noted that States have the option under SCHIP to offer a benefit package that is equivalent to benchmark coverage, coverage under a State-based plan, or Secretary-approved coverage. The commenter questioned how a State would determine a comparable or actuarially equivalent benefit package for unborn children.

Response: Rather than carving out services and establishing a benefit package exclusively for unborn children as the commenter suggests, we would expect the prenatal benefits for unborn children to be part of the State's overall health benefits coverage package that is consistent with section 2103 of the Act and § 457.410 of the final regulation.

The definition of child health assistance at § 457.402 provides a comprehensive listing of services that includes prenatal care along with other services that would be pregnancy-related. These are services that many States already provide to SCHIP eligible children who become pregnant as part of their current benefit coverage

Comment: One commenter asked whether Medicaid currently covers the types of services listed in the March 5, 2002 proposed rule. If so, the commenter asked how this could be so, since unborn children are not covered under Medicaid. If not, the commenter asked whether there are estimates of the cost of providing fetology services to Medicaid eligibles, since States cannot offer higher income children greater benefits than lower income children.

Response: Under Medicaid, coverage may include services for pregnant women that are related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy. Within those parameters, States have broad discretion in what services to cover in their Medicaid State plan. While these types of services are available to eligible pregnant women under Medicaid, this rule would authorize SCHIP coverage of these types of services to unborn children whose mothers are not eligible under Medicaid.

Medicaid and SCHIP are different programs, authorized through title XIX and title XXI respectively although States can expand their Medicaid program through the enhanced funding made available by title XXI. As in Medicaid, the specific prenatal services, which any given State will cover under SCHIP is left to the discretion of the State. Inasmuch as States are not required to cover the same package of benefits relating to prenatal care under Medicaid and SCHIP, States can cover the same, fewer or more services under SCHIP than Medicaid. In the event that a State decided to cover certain prenatal services provided to an unborn child under SCHIP, but not to pregnant women under Medicaid, the commenter seems concerned that the State would be in violation of section 2102(b)(1)(B)(i) of the Act.

Section 2102(b)(1)(B)(i) of the Act prohibits States from covering targeted low-income children at a higher income level without covering children at a lower-income level within any defined group of targeted low-income children. An unborn child who is eligible under SCHIP and a lower-income pregnant woman who is eligible under Medicaid are not within the same defined group of targeted low income children under SCHIP. Accordingly, the provisions of section 2102(b)(1)(B)(i) of the Act would not apply.

6. Maintenance of Effort

Comment: One commenter underscored that the Maintenance of Effort requirements under title XXI should apply to unborn children to the same extent that they apply to born children. Several other commenters opposed application of the maintenance of effort requirements to unborn children. These commenters felt that doing so punishes States that already have expanded Medicaid coverage to pregnant women beyond the minimum required and may discourage States from expanding coverage to new populations in the future. They also suggested revising the final rule to clarify that any State that expanded eligibility for pregnant women after June 1, 1997 be permitted to convert that expansion to SCHIP.

One commenter asked whether a proposal to convert optional coverage for pregnant women with incomes from 150 percent to 185 percent of the Federal poverty level (FPL) from title XIX to title XXI funding would be consistent with the March 5, 2002 proposed rule. This commenter asked specifically whether a State could shift the current optional coverage of pregnant women under Medicaid up to 185 percent of the FPL to SCHIP, expand the income limit to 200 percent of the FPL and use the savings to fund the expansion.

A final commenter felt that the purpose of the maintenance of effort provision in the March 5, 2002 proposed rule was unclear. This commenter advocated an interpretation that "SCHIP coverage for fetuses picks up where Medicaid coverage of pregnant women ends." However, the commenter was concerned that, through application of the maintenance of effort provisions of title XXI, we might be purporting to redefine a child for purposes of Medicaid.

Response: We agree with the first commenter that title XXI's maintenance of effort requirements apply equally to unborn and born children. We do not agree that such application is punitive. By including section 2105(d) in the SCHIP legislation, the Congress sought to ensure that title XXI funds were used by States to expand coverage to new populations, not to take the place of Medicaid expenditures for populations already covered. Application of this principle is no different when coverage of prenatal care for an unborn child is at issue, than when coverage of children post-birth is at issue.

Accordingly, in applying the maintenance of effort requirements in the case of unborn children, enhanced Federal Medical Assistance Percentages (FMAP) will not be available if a State adopts income and resource standards and methodologies for purposes of determining eligibility for Medicaid under a group for pregnant women that are more restrictive than those applied under the policies of the State plan in effect on June 1, 1997. We are applying the maintenance of effort requirements to the Medicaid eligibility groups for pregnant women because the unborn child of a pregnant woman who is eligible for Medicaid receives the benefits of the prenatal care covered by Medicaid. Thus, to allow States to cover this an unborn child under SCHIP would result in precisely the kind of cost shifting between Medicaid and SCHIP that the Congress intended to preclude in § 2105(d) of the Act. Application of the maintenance of effort requirements in this way does not in any way alter the definition of child for purposes of Medicaid.

We agree with the commenters that the maintenance of effort requirements do not apply with respect to expansions of coverage for pregnant women implemented after June 1, 1997 (just as they do not apply to expansions of Medicaid coverage of children implemented after June 1, 1997.)

However, we do not believe that revision of this rule is necessary, as this fact is clearly stated in section 2105(d) of the Act as well as the implementing regulations at 42 CFR 433.11(b)(1).

Thus, States generally will not be permitted to drop optional coverage of pregnant women under Medicaid and pick up coverage of unborn children in the same income range under SCHIP, because most States expanded Medicaid coverage of pregnant women prior to June 1, 1997. However, as stated above, expansions implemented after June 1, 1997 are not subject to the maintenance of effort requirements. Thus, a State could eliminate an optional expansion of Medicaid coverage for pregnant women implemented after June 1, 1997 and pick up coverage for the unborn children of the affected women under SCHIP. Similarly, if a State does not already cover pregnant women between 185 percent and 200 percent of the Federal poverty level under Medicaid, it could extend coverage to unborn children in that income range under this regulation.

To permit a State to eliminate coverage of pregnant women implemented on or before June 1, 1997, and pick up coverage of their unborn children under SCHIP, would require that the Secretary waive the maintenance of effort requirements found in section 2105(d) of the Act. The Secretary has never approved a waiver of these requirements in the past and we do not believe that doing so would be consistent with the objectives of title XXI, as required by section 1115 of the Act.

7. Budget Implications

Comment: Numerous commenters noted that this rule does not bring new funding to SCHIP. Some stated that this rule also would increase the financial burden on SCHIP by expanding eligibility and could potentially result in inadequate funds for SCHIP coverage. Others noted that some States already are having trouble maintaining their SCHIP programs and may be freezing enrollment of currently eligible children. Some also noted that the high costs of in utero treatments make expanding care under this regulation less likely. One commenter stated that the expansion in eligibility should be accompanied by additional funds to allow for an increase in enrollment, not just a shift in priorities of the "type" of uninsured child to be covered.

One commenter felt that the lack of funds for this rule means that States also would have access to less Federal funds to provide care to poor immigrant women. Another commenter cited concern that because the current funding for SCHIP is not adequate to support comprehensive care, the rule could represent an unfunded mandate on States.

A number of these commenters argued that the Department should be making efforts to address the lack of funds to cover existing children. Some suggested that money should be added to other programs to provide prenatal care. One commenter noted in particular that the Administration's new budget contains no additional funding for the Maternal and Child Health grants, which could provide additional resources to pregnant women and their children. Some of the commenters noted that some bills currently pending before the Congress include additional funds for coverage of pregnant women, and that these funds would be available to States that already have expanded coverage to pregnant women under Medicaid.

Response: We recognize that States do not have access to unlimited Federal matching funds for SCHIP. As a result, each State will have to set its own priorities regarding the populations and services to be covered under its SCHIP program. This rule gives States an additional option—to cover prenatal care for unborn children under SCHIP. Some States may not choose to exercise this option, because they lack sufficient funds or for other reasons. This choice is left to each State.

Nearly all States still have unspent SCHIP funds and the President has proposed that the Congress extend the allotments from previous years that would otherwise be returned to the Federal treasury.

Finally, inasmuch as the regulation provides States with an option to extend coverage to unborn children under SCHIP, but does not mandate that they do so, it does not represent an unfunded mandate for States.

Comment: Some commenters mentioned that healthy babies are less expensive to care for than unhealthy babies, so that the cost of prenatal care can be recouped through reduced expenditures on subsequent intervention and surgeries. The commenters noted that this rule will prevent taxpayers from having to bear the burden of unhealthy babies, teens, and adults.

Response: We agree with the commenters. As explained in the March 5, 2002 proposed rule, it is well established that access to prenatal care can improve health outcomes during infancy as well as over a child's life. Since healthy babies and children require less medical care than babies and children with health problems, provision of prenatal care will result in lower medical expenditures for the affected children in the long run.

Comment: One commenter noted that this rule is more costly than other options, since States will receive the enhanced match available for services provided under SCHIP instead of their regular Medicaid match. The commenter further notes that, with the strict budget neutrality requirements of Health Insurance Flexibility and Accountability (HIFA), States are cutting back benefits to provide coverage. The commenter argues that cost savings derived from providing prenatal services through Medicaid could be used to provide benefits under HIFA.

Response: We agree that States can accomplish the goal of this regulation—increased access to prenatal care—by expanding Medicaid coverage of pregnant women, just as States can expand coverage to children under Medicaid, and that FFP would be available for services provided under the expansion at the State's regular Medicaid match.

With the passage of title XXI, the Congress created a greater incentive for States to expand coverage of low-income children. By expanding the definition of targeted low-income child to include an unborn child, we are extending the increased incentive created by the Congress to include coverage of prenatal services for unborn children.

HIFA provides a vehicle for States seeking to expand Medicaid coverage to populations not typically covered under Medicaid. Nothing in this regulation would preclude States from incorporating the provision of prenatal care into a HIFA waiver proposal, and CMS staff is available to work with any State that may want to do so.

8. Miscellaneous

Comment: Several commenters noted that generally, an American citizen is only counted for taxation purposes after they are born. They asked if granting of legal personhood under this rule mean that unborn children could be taxed inside the womb? Alternatively, the commenters asked, could they be claimed as a deduction before they are born?

Response: The regulation does not purport, nor do we have the authority, to alter the definition of a child or individual for purposes of Federal or State tax statutes or regulations.

IV. Provisions of the Final Rule

In the preamble of the March 5, 2002 proposed rule, we noted an error that we have corrected. The preamble stated that we proposed to revise the definition at § 457.10 to clarify that "child" means an individual under the age of 19 and may include any period of time from conception to birth through age 19. This should have been stated as up to age 19 and has been corrected. In this final rule, we are adopting the provisions of the March 5, 2002 proposed rule, without change.

V. Collection of Information Requirements

States that opt to extend eligibility to unborn children must submit a State plan amendment in accordance with § 457.60. OMB has approved information collection requirements associated with SCHIP State plan amendments under OMB approval number OMB–0938–0841.

VI. Regulatory Impact Statement

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 to $29 million in any 1 year. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications. The option for States to extend coverage to unborn children promulgated in this final rule does not meet the criteria for having Federalism implications. This provision does not impose direct costs on States or local governments, nor does it preempt State laws. This new option only increases State flexibility and, therefore, prior consultation is not required.

This final rule revises and clarifies the definition of "child" under the State Children's Health Insurance Program (SCHIP) to provide that an unborn child may be considered a "targeted low-income child" by the State and therefore eligible for SCHIP if other applicable State eligibility requirements are met. We estimate that 13 States will elect to include this definition in their State plans. We also estimate that an additional 30,000 unborn children will benefit by this change. In States that adopt this option, the health status of children will improve to the extent that their mothers receive prenatal care.

We developed cost estimates based on the following assumptions and calculations. We excluded from the calculations a few States that already have eligibility for pregnant women under SCHIP, as well as those that appear likely to exhaust their Federal SCHIP funding at some point. We assumed that each remaining State would have a one-third probability of taking the proposed option to cover unborn children. The increase in SCHIP spending for a State picking up the option was based on Current Population Survey data on the number of infants relative to the total population of children between 100 percent and 200 percent of poverty in the State. The infant count was used as a proxy for pregnant women. Per-person costs were assumed to be twice that of a child on SCHIP.

The costs also include an increase in Medicaid spending as a result of the rule. The reason for this is that, with more SCHIP allotments being spent on unborn children, less is available for redistribution to States that expend all their allotments. Some of these States will run short of funds, and those that are using Medicaid expansions in their SCHIPs will get FFP at the regular matching rate, thus increasing title XIX expenditures.

Regarding state take-up: The estimating model is based on iterative simulations using the one-third participation probability assumption, so there is not a specific set of States that we assume will take the option. Although on average the number of states participating is about a dozen.

Based on the assumptions, we estimate that the budget impact will be $330 million over a 5-year period. Please see the table below.

NET MEDICAID AND SCHIP COSTS—WITH BUYOUT OF POST-BBA

	2003	2004	2005	2006	2007	2003–7
Federal cost	98	44	61	93	14	330

Therefore, the provisions set forth in this rule will not have an impact of $110 million or more in any one year. Neither is this rule expected to impose an unfunded mandate on States exceeding $110 million in any 1 year. Therefore, we have not prepared an analysis of cost and benefits as required by E.O. 12866 and the Unfunded Mandates Act for rules with significant economic impacts or that impose significant unfunded mandates on States. Also, we believe the changes being promulgated in this document will have very little direct impact on small entities as defined under the RFA or on small rural hospitals as defined under section 1102(b) of the Social Security Act. Therefore, we are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined,

and we certify, that this rule will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 457

Administrative practice and procedure, Grant programs-health, Children's Health Insurance Program, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, 42 CFR part 457 is amended as set forth below:

PART 457—ALLOTMENTS AND GRANTS TO STATES

1. The authority citation for part 457 continues to read as follows:

Authority: Section 1102 of the Social Security Act (42 U.S.C. 1302).

Subpart A—Introduction; State Plans for Child Health Insurance Programs and Outreach Strategies

2. In § 457.10, the definition of "child" is revised to read as follows:

§ 457.10 Definitions and use of terms.

* * * * *

Child means an individual under the age of 19 including the period from conception to birth.

* * * * *

Subpart C—State Plan Requirements: Eligibility, Screening, Applications, and Enrollment

3. Amend § 457.350 as follows:

A. Redesignate the text of paragraph (b) following the heading as (b)(1).

B. Add a new paragraph (b)(2) to read as follows:

§ 457.350 Eligibility screening and facilitation of Medicaid enrollment.

* * * * *

(b) Screening objectives. (1) * * *

(2) Screening procedures must also identify any applicant or enrollee who would be potentially eligible for Medicaid services based on the eligibility of his or her mother under one of the poverty level groups described in section 1902(l) of the Act, section 1931 of the Act, or a Medicaid demonstration project approved under section 1115 of the Act.

* * * * *

Subpart F—Payment to States

4. Revise § 457.622(c)(5) to read as follows:

§ 457.622 Rate of FFP for State expenditures.

* * * * *

(c) * * *

(5) For States that elect to extend eligibility to unborn children under the approved Child Health Plan, the State does not adopt eligibility standards and methodologies for purposes of determining a child's eligibility under the Medicaid State plan that were more restrictive than those applied under policies of the State plan in effect on June 1, 1997. This limitation applies also to more restrictive standards and methodologies for determining eligibility for services for a child based on the eligibility of a pregnant woman.

* * * * *

5. Amend § 457.626 by adding a new paragraph (a)(3) to read as follows:

§ 457.626 Prevention of duplicate payments.

(a) * * *

(3) Services are for an unborn child and are payable under Medicaid as a service to an eligible pregnant woman under that program.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.767, State Children's Health Insurance Program)

Dated: August 4, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: August 8, 2002.

Tommy G. Thompson,

Secretary.

[FR Doc. 02-24856 Filed 9-27-02; 8:45 am]

BILLING CODE 4120-01-P

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For Immediate Release
Office of the Press Secretary
November 1, 2002

National Adoption Month, 2002

By the President of the United States of America
A Proclamation

Every year, thousands of American families are blessed by adoption. Whether through domestic or international adoption or through the adoption of children from foster care, the love of compassionate families embraces children of all ages and from every background. During National Adoption Month, we recognize the heartfelt commitment of these good citizens, and we renew our pledge to make adoption a more accessible and positive path for American families.

Children thrive in loving families where they are nurtured, comforted, and protected. We are making important progress in placing children in foster care with adoptive families; and the overall number of children being adopted continues to rise. In the past 5 years, adoptions have increased dramatically; and thus far in 2002, tens of thousands of children have already been adopted.

Twenty-three States and the Commonwealth of Puerto Rico received adoption incentive awards in FY 2001 for increasing the number of children they placed from foster care into permanent adoptive homes. These recipients have reinvested their bonuses to help improve their respective adoption and child welfare programs. Americans also continue to welcome children from other countries into their homes through international adoptions. Last year, families in the United States adopted over 19,000 children from around the world.

Despite the progress we have made in increasing our adoption rate, we still have much work to do. More than 130,000 children, ranging from toddlers to teenagers, still remain in foster care awaiting adoption. While foster parents offer temporary essential care, the children for whom they care need the stability of a permanent family. It is often challenging to find families for older children and those children who have special needs. Yet they deserve a future with a nurturing family.

To help States promote adoption and support families who adopt, I signed a tax relief bill last year that permanently eases the financial burden on families that adopt children. And in January 2002, I signed into law a bill to extend and expand the Promoting Safe and Stable Families Program. Through this legislation, we are strengthening families by promoting adoption, offering post-adoptive services to families that adopt, and providing education and training vouchers to older adopted children and foster youth.

In July 2002, my Administration launched the AdoptUSKids national campaign to increase awareness about adoption and its role in helping all children reach their full potential. We have also created the first Federal adoption photo-listing web site devoted to children awaiting adoption and families who adopt, www.AdoptUSKids.org. During its first year, the web site will feature pictures and profiles of more than 6,500 children awaiting adoption, as well as a database of approved adoptive families. This unique web site will help to connect children from across the country with loving adoptive families, and it will also serve as a great resource for all adoptive families.

On November 23, dozens of communities will gather in courtrooms across the country to celebrate National Adoption Day. On this momentous day, thousands of adoptions will be finalized and celebrated. These efforts demonstrate our Nation's dedication to ensuring that every child can thrive in a secure, loving, and stable home.

Through adoption, Americans can forever change not only a child's life but also their own. By providing children in need with the opportunity to grow and succeed through adoption, we can help them become confident, compassionate, and successful members of society.

NOW, THEREFORE, I, GEORGE W. BUSH, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim November 2002 as National Adoption Month. I call on all Americans to observe this month with appropriate programs and activities to honor adoptive families, and to participate in efforts to find permanent homes for waiting children.

IN WITNESS WHEREOF, I have hereunto set my hand this first day of November, in the year of our Lord two thousand two, and of the Independence of the United States of America the two hundred and twenty-seventh.

GEORGE W. BUSH

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations

SHO #02-004

November 12, 2002

Dear State Health Official:

States now have the option of ensuring that needed prenatal care is available under SCHIP to benefit unborn children and uninsured low-income women. The purpose of this letter is to provide general information concerning this provision and guidance for amending your state plan to reflect the provision of prenatal care to unborn children under the State Children's Health Insurance Program (SCHIP) if your state wishes to take advantage of this option.

In the interest of providing necessary prenatal care and other health services to children, we promulgated a final rule on October 2 that revised the definition of "child" at 42 CFR 457.10 to clarify that "child" means an individual from conception up to age 19. This rule provides states with the option to consider an unborn child to be a targeted low-income child and therefore eligible for coverage under SCHIP, if other applicable state eligibility requirements are met. This permits states to provide vital health care services to promote healthy pregnancies and healthy children regardless of the mother's eligibility status. Moreover, under the new regulation states are able to provide eligibility to unborn children of low-income immigrants, which results in access to important prenatal care for these women. The final rule may be found at: http://www.access.gpo.gov/su_docs/fedreg/a021002c.html.

We emphasize that this final rule is not intended to modify current health insurance financial practices or alter the relationship between the pregnant mother and/or her unborn child and the physician. Therefore, states that usually pay for pregnancy and delivery services through a bundled payment or global fee method consistent with general industry practices may continue to do so. Services that are often paid for using these methods include prenatal care, labor and delivery (including pain management), and postpartum care.

Federal financial participation (FFP) is available for claims for pregnancy and delivery services including prenatal care, labor and delivery (including pain management). Global fees commonly used in reimbursing for obstetrical care cover all prenatal visits, delivery, and at least one postnatal visit. As a global fee benefits the program by guarding against problems associated with unbundling and upcoding, and the number of new eligibles under the rule are estimated to represent less than 5 percent of total pregnancies covered by Medicaid and SCHIP, states will not be required to distinguish cases that are eligible under this regulation from others by changing their current global fee payment methodology. In addition, FFP is available for capitation rates that reflect the use of bundled payments or global fees by managed care entities.

States that currently do not pay in this manner should explore the extent to which general practices will allow bundling of these services. FFP will not be available for post hospitalization postpartum care that is not included in the bundled or capitated payment.

In order to adopt this option and be eligible for funds under title XXI, states must submit a state plan amendment, which must be approved by the Secretary. States adopting this option will be able to amend their state plan by submitting the enclosed addendum to the state plan and budget form. The addendum sections correspond to the relevant sections in your current State Child Health Plan Template.

States that have implemented SCHIP through a Medicaid expansion and wish to extend coverage to unborn children may submit the same plan amendment as described above. The state may continue to cover children from birth through age 18 under its Medicaid expansion program.

To incorporate this provision into your state plan, the state, through the appropriate state official, should submit these pages electronically to both the Centers for Medicare & Medicaid Services (CMS) Central and Regional Offices. Once approved, these pages will be added to your current State Child Health Plan. Each state should also review its current approved state plan and amend additional sections simultaneously, if necessary (e.g., if a new benefit package is being adopted or if cost sharing is being modified just for this eligibility group, or if the state has not previously implemented a separate child health program).

We encourage states to consider this important new opportunity to provide prenatal care and other health services to unborn children and their mothers.

Questions or assistance may be provided by your Central or Regional Office Project Officer.

Sincerely,

/s/

Dennis G. Smith
Director

Enclosure

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

Lee Partridge
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Brent Ewig
Senior Director, Access Policy
Association of State and Territorial Health Officials

Jennifer King
Director, Health and Human Services Task Force
American Legislative Exchange Council

Trudi Matthews
Senior Health Policy Analyst
Council of State Governments

Jim Frogue
Acting Director, Health and Human Services Task Force
American Legislative Exchange Council

SCHIP Budget Plan Template

	Federal Fiscal Year Costs
Enhanced FMAP rate	
Benefit Costs	
Insurance payments	
Managed care	
per member/per month rate @ # of eligibles	
Fee for Service	
Total Benefit Costs	
(Offsetting beneficiary cost sharing payments)	
Net Benefit Costs	
Administration Costs	
Personnel	
General administration	
Contractors/Brokers (e.g., enrollment contractors)	
Claims Processing	
Outreach/marketing costs	
Other	
Total Administration Costs	
10% Administrative Cost Ceiling	
Federal Share (multiplied by enh-FMAP rate)	
State Share	
TOTAL PROGRAM COSTS	

Note: The Federal Fiscal Year (FFY) runs from October 1st through September 30th.

Draft Preprint- Addition of SCHIP Coverage for Prenatal Care and Associated Health Care Services to the State Child Health Plan

State/Territory:_____
(Name of State/Territory)

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

4.1.2.1 Age: _____ through birth

4.1.3.1 Income:
0 % of the FPL (and not eligible for Medicaid) through
_____% of the FPL

Effective Date: _____(date costs begin to be incurred)
Implementation Date: _____(dates services begin to be provided)

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.10. Please provide a 1-year projected budget for *all* targeted low-income children covered under the state plan using the attached financial form. Additionally, please provide the following:

- Total 1- year cost of adding prenatal coverage:
  _____
- Estimate of unborn children covered in year 1:
  _____

National Sanctity of Human Life Day, 2003

By the President of the United States of America
A Proclamation

January 14, 2003

Our nation was built on a promise of life and liberty for all citizens. Guided by a deep respect for human dignity, our Founding Fathers worked to secure these rights for future generations, and today we continue to seek to fulfill their promise in our laws and our society. On National Sanctity of Human Life Day, we reaffirm the value of human life and renew our dedication to ensuring that every American has access to life, liberty, and the pursuit of happiness.

As we seek to improve quality of life, overcome illness, and promote vital medical research, my Administration will continue to honor our country's founding ideals of equal dignity and equal rights for every American. Every child is a priority and a blessing, and I believe that all should be welcomed in life and protected by law. My Administration has championed compassionate alternatives to abortion, such as helping women in crisis through maternity group homes, encouraging adoption, promoting abstinence education, and passing laws requiring parental notification and waiting periods for minors.

The Born-Alive Infants Protection Act, which I signed into law in August 2002, is an important contribution to our efforts to care for human life. This important legislation helps protect the most vulnerable members of our society by ensuring that every infant born alive, including one who survives abortion, is considered a person and receives protection under Federal law. It helps achieve the promises of the Declaration of Independence for all, including those without the voice and power to defend their own rights.

Through ethical policies and the compassion of Americans, we will continue to build a culture that respects life. Faith-based and community organizations and individual citizens play a critical role in strengthening our neighborhoods and bringing care and comfort to those in need. By helping fellow citizens, these groups recognize the dignity of every human being and the possibilities of every life; and their important efforts are helping to build a more just and generous Nation. By working together to protect the weak, the imperfect, and the unwanted, we affirm a culture of hope and help ensure a brighter future for all.

NOW, THEREFORE, I, GEORGE W. BUSH, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim Sunday, January 19, 2003, as National Sanctity of Human Life Day. As we reflect upon the sanctity of human life, I call upon all Americans to recognize this day with appropriate ceremonies in our homes and places of worship, to rededicate ourselves to compassionate service, and to reaffirm our commitment to respecting the life and dignity of every human being.

IN WITNESS WHEREOF, I have hereunto set my hand this fourteenth day of January, in the year of our Lord two thousand three, and of the Independence of the United States of America the two hundred and twenty-seventh.

GEORGE W. BUSH ###

President Calls Participants of the 30th Annual March for Life on the National Mall

January 22, 2003

THE PRESIDENT: Well, thank you, Nellie. I want to thank you very much for including me in the celebration of life. I want to thank the good folks there on the Mall today. I'm calling you from St. Louis, Missouri. I know there are some from Missouri there and, like many others, you've made great sacrifices to come to Washington today. A lot of you have ridden buses all night long and I know you're braving the cold. And I admire your perseverance and I admire your devotion to the cause of life.

You all are gathered today on the National Mall, which is not far from the monument to Thomas Jefferson who, as you all know, is author of our Declaration of Independence. And the March for Life upholds the self-evident truth of that Declaration – that all are created equal, given the unalienable rights of life, and liberty, and the pursuit of happiness. And that principle of America needs defenders in every place and every generation.

In our time, respect for the right to life calls us to defend the sick and the dying, persons with disabilities and birth defects, and all who are weak and vulnerable. And this self-evident truth calls us to value and to protect the lives of innocent children waiting to be born. (Applause.)

You and I share a commitment to building a culture of life in America, and we're making progress. As the President, I have signed the Born Alive Infants Protection Act, opposed the destruction of embryos for stem cell research, and refused to spend taxpayer money on international programs that promote abortion overseas. (Applause.)

MS. GRAY: Thank you.

THE PRESIDENT: My administration is challenging the Oregon law that permits physician-assisted suicide. (Applause.)

MS. GRAY: Thank you.

THE PRESIDENT: We support abstinence education, and crisis pregnancy programs, and parental notification laws. We offer compassionate alternatives to abortion by promoting adoption and extending state health care coverage for unborn children.

My hope is that the United States Congress will pass a bill this year banning partial-birth abortion, which I will sign. (Applause.) Partial-birth abortion is an abhorrent procedure that offends human dignity. I also urge the Congress to ban all human cloning. We must not create life to destroy life. Human beings are not research material to be used in a cruel and reckless experiment. (Applause.) For 30 years, the March for Life has been sustained by constant prayer and abiding hope, that one day, every child will be born into a family that loves that child and a nation that protects that child. And when that day arrives, you will have the gratitude of millions – especially those who know the gift of life because you cared and you kept faith. May God bless you all and may God continue to bless America.

MS. GRAY: Thank you, Mr. President. ###

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The George W. Bush Library

FORM	SUBJECT/TITLE	PAGES	DATE	RESTRICTION(S)
Memorandum	Mexico City Policy - To: POTUS - From: Jay Lefkowitz	4	02/10/2003	P5;

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COLLECTION:
Staff Secretary, White House Office of the

SERIES:
Von Der Heydt, Thomas (Tommy) - Bush Record Policy Memos

FOLDER TITLE:
Pro-Life Legacy: A Timeline (2001 - 2008)

FRC ID:
13894

OA Num.:
14457

NARA Num.:
14246

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the 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 advise 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 record misfile defined in accordance with 44 U.S.C. 2201(3).

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This Document was withdrawn on 4/24/2012 by MAL

Statement by the President on the Partial-Birth Abortion Act of 2003

March 13, 2003

Partial-birth abortion is an abhorrent procedure that offends human dignity, and I commend the Senate for passing legislation to ban it. Today's action is an important step toward building a culture of life in America. I look forward to the House passing legislation and working with the Senate to resolve any differences so that I can sign legislation banning partial-birth abortion into law.

###

Statement on Banning Partial-Birth Abortions

June 4, 2003

I applaud the House for passing legislation banning partial-birth abortions. Passage of this important legislation is a shared priority that will help build a culture of life in America. I urge Congress to quickly resolve any differences and send me the final bill as soon as possible so that I can sign it into law.

###

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FORM	SUBJECT/TITLE	PAGES	DATE	RESTRICTION(S)
Memorandum	Mexico City Policy - To: POTUS - From: Jay Lefkowitz	3	08/22/2003	P5;

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This Document was withdrawn on 4/24/2012 by MAL

Memo to the Secretary of State Regarding Voluntary Population Planning

August 29, 2003

MEMORANDUM FOR THE SECRETARY OF STATE

SUBJECT: Assistance for Voluntary Population Planning

On March 28, 2001, I issued a memorandum for the Administrator of the United States Agency for International Development (USAID) directing that certain conditions be placed on assistance for family planning activities provided to foreign nongovernmental organizations by USAID.

Because family planning grants are awarded by the Department of State outside of USAID as well as through USAID, you are hereby directed to extend the requirements of the March 28, 2001, memorandum to all assistance for voluntary population planning furnished to foreign nongovernmental organizations and appropriated pursuant to the Foreign Assistance Act, whether such assistance is furnished by USAID or any other bureau, office, or component of the Department of State.

As set forth in the March 28, 2001, memorandum, this policy applies to certain assistance provided to foreign nongovernmental organizations. Such organizations do not include multilateral organizations that are associations of governments. This policy shall not apply to foreign assistance furnished pursuant to the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (Public Law 108-25).

The foregoing directive is issued consisent with the authority vested in me by the Constitution and laws of the United States of America, including sections 104 and 104A of the Foreign Assistance Act of 1961, as amended.

You are authorized and directed to publish this memorandum in the Federal Register.

Memorandum

Memorandum for the Secretary of State
SUBJECT: Assistance for Voluntary Population Planning

August 29, 2003

On March 28, 2001, I issued a memorandum for the Administrator of the United States Agency for International Development (USAID) directing that certain conditions be placed on assistance for family planning activities provided to foreign nongovernmental organizations by USAID.

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The foregoing directive is issued consistent with the authority vested in me by the Constitution and laws of the United States of America, including sections 104 and 104A of the Foreign Assistance Act of 1961, as amended.

You are authorized and directed to publish this memorandum in the Federal Register.

GEORGE W. BUSH

###

Statement by the President on the Partial-Birth Abortion Ban

October 2, 2003

I applaud the House for passing the ban on partial-birth abortion so soon after the Congressional conferees completed their work. Today's action is an important step that will help us continue to build a culture of life in America. I look forward to the Senate passing this legislation so that I can sign this very important bill into law.

###

OCT 8 - 2003

MEMORANDUM FOR THE PRESIDENT

SUBJECT: Enrolled Bill H.R. 1925 - Runaway, Homeless, and Missing Children Protection Act
Sponsors - Rep. Gingrey (R) GA and 11 cosponsors

Last Day for Action

October 14, 2003 – Tuesday

Purpose

(1) Reauthorizes and makes changes to the Runaway and Homeless Youth Act, under which food, shelter, clothing, and education services are provided to homeless and runaway youth; and (2) extends the authorization for the Missing Children's Assistance Act, which supports efforts to locate and recover missing and exploited children.

Agency Recommendations

Office of Management and Budget	Approval
Department of Health and Human Services (HHS)	Approval
Department of Justice	Approval
Department of State	No objection (Informally)
Department of the Treasury	No objection (Informally)
Interagency Council on the Homeless	No objection (Informally)
Office of National Drug Control Policy	No objection (Informally)
Department of Education	No comment (Informally)
Department of Housing and Urban Development	No comment (Informally)
Department of Labor	No comment (Informally)

Discussion

H.R. 1925 would reauthorize HHS programs under the Runaway and Homeless Youth Act and Justice Department programs under the Missing Children's Assistance Act. Major provisions of the enrolled bill are described below.

Runaway and Homeless Youth Act

The Runaway and Homeless Youth Act (RHYA) authorizes a number of programs and activities to assist runaway and homeless youth. In particular, the RHYA authorizes HHS to make grants to public and private entities for: (1) the Runaway and Homeless Youth Grant Program (renamed the "Basic Center Program" by H.R. 1925), which provides services to meet the immediate needs of runaway or otherwise homeless youth and their families; and (2) the Transitional Living Program, which provides longer-term shelter and services designed to promote a transition to self-sufficient living and to prevent long-term dependency on social services. The RHYA also authorizes grants for: (1) a national communication system to assist runaway and homeless youth in communicating with their families and with service providers; (2) technical assistance, training, and research; and (3) a sexual abuse prevention program.

The authorization for the RHYA expired at the end of FY 2003, but the programs are continuing to operate through available appropriations.

Authorizations of Appropriations. H.R. 1925 would authorize a total of $105 million in FY 2004 and such sums as may be necessary in each of FYs 2005 - 2008 for programs under the RHYA, excluding the sexual abuse prevention program. The FY 2004 Budget requested $88 million for these programs. The House- and Senate-passed appropriations bills provide $88 million and $90 million, respectively, for these programs. H.R. 1925 would authorize such sums as may be necessary in each of FYs 2004 - 2008 for the sexual abuse prevention program. The FY 2004 Budget requested and the House- and Senate-passed appropriations bills provide $15 million for this program.

Changes to the Basic Center Program. The Basic Center Program (BCP) provides emergency short-term shelter, food, clothing, counseling, and referrals for health care, education, and other community services to runaway and homeless youth and their families. The BCP seeks to reunite youth with their families, whenever possible, or to locate appropriate alternative safe placements. Under current law, applicants for Basic Center grants are required to operate centers that have a maximum capacity of 20 youth. H.R. 1925 would allow grants to be made to applicants with a higher capacity when that capacity is required for compliance with State or local licensing laws or regulations.

Under current law, a "homeless youth" for the purpose of the BCP is an individual who is not more than 21 years of age for whom it is not possible to live in a safe environment with a relative and who has no other safe, alternative living arrangement. As proposed by the Administration, H.R. 1925 would clarify that youth more than 18 years of age are ineligible for shelter in a Basic Center, to address safety concerns when older youth are housed overnight in the same facility with younger youth. Youth between the ages of 19 and 21 would remain eligible for all other services provided by Basic Centers.

H.R. 1925 also would require BCP grantees to coordinate with school district liaisons under the McKinney-Vento Homeless Assistance Act to ensure that runaway and homeless youth are provided information about the educational services available to them. In addition, H.R. 1925 would authorize the use of BCP funds to test runaway and homeless youth for sexually transmitted diseases, where the testing is requested by the youth.

Changes to the Transitional Living Program. The Transitional Living Program (TLP) provides grants to public and private organizations to support longer-term residential services and a range of other services. These services include counseling in basic life skills, educational advancement, job attainment, and physical and mental health care for homeless youth between the ages of 16 - 21 who have no other safe, alternative living arrangements. Under current law, a homeless youth accepted into the TLP is eligible for services for up to 540 days. H.R. 1925 would provide an exception for youth who have not reached 18 years of age at the end of the 540 days; if otherwise qualified for the program, such youth would be allowed to remain in the program for 720 days or until their 18th birthday, whichever occurs first.

Under current law, of the amount reserved from appropriated funds to carry out the BCP and the TLP, between 20 percent and 30 percent must be reserved to carry out the TLP. H.R. 1925 would incorporate the Administration's proposal to require that 45 percent and, under certain circumstances, up to 55 percent be reserved to carry out the TLP, to address increasing need for the TLP.

Under current law, RHYA funds may be used under the TLP to fund maternity group homes. H.R. 1925 would amend current law by explicitly authorizing the use of RHYA funds for this purpose. In addition, H.R. 1925 would define the term "maternity group home" as a community-based, adult-supervised transitional living arrangement for pregnant or parenting youth and their children in which such pregnant or parenting youth are required to learn parenting skills and other skills to promote their long-term economic independence.

In addition, H.R. 1925 would require enhanced coordination by TLP grantees with school district liaisons and with social service, law enforcement, vocational training, welfare, legal service, and health care programs.

Other Changes to the RHYA. Current law authorizes, on a temporary basis, demonstration authority for grants to provide services to youth in rural areas. H.R. 1925 would make this demonstration authority permanent. In addition, H.R. 1925 would require HHS to: (1) consult, as appropriate, with the Department of Housing and Urban Development to ensure coordination of programs and services for homeless youth; (2) report to Congress, in consultation with the U.S. Interagency Council on the Homeless, on promising strategies to end youth homelessness; and (3) conduct a study of the TLP and report to Congress on long-term housing outcomes for youth after exiting the program.

H.R. 1925 would prohibit RHYA funds from being used for a program of distributing sterile needles or syringes for the hypodermic injection of an illegal drug. If a grantee that receives any RHYA funds carries out a needle distribution program, it would have to account for all funds used for such program separately from any RHYA funds.

Missing Children's Assistance Act

The Missing Children's Assistance Act (MCAA) authorizes programs intended to address the needs of missing, abducted, abused, and sexually exploited individuals who are less than 18 years of age. Under the MCAA, Justice is required to make an annual grant to the National Center for Missing and Exploited Children (National Center), to be used for purposes including: (1) a national 24-hour toll-free hotline through which individuals may report information regarding the location of any missing child; and (2) training and technical assistance to law enforcement agencies in the prevention, investigation, and prosecution of cases involving missing and exploited children. The MCAA currently is authorized through FY 2005. Other MCAA programs include the Jimmy Ryce Law Enforcement Training Center Program, which provides training and technical assistance to law enforcement and prosecutors.

Authorizations of Appropriations. H.R. 1925 would authorize appropriations, for each of FYs 2004 - 2008, of $20 million for the National Center and such sums as may be necessary for the other MCAA programs and activities. The 2004 Budget requested $33 million for MCAA programs, of which $13.4 million was for the National Center and the Jimmy Ryce Program. The House-passed appropriations bill provides $37 million for MCAA programs, of which $14 million is set aside for the National Center. The Senate-reported appropriations bill provides $33 million for MCAA programs, of which $17 million is set aside for the National Center.

Conclusion and Recommendations

HHS recommends approval of H.R. 1925, which would "improve critical services to runaway and homeless youth and enhance our efforts to protect these vulnerable youths."

We join HHS and Justice in recommending approval of H.R. 1925, which passed the House by a vote of 404 - 14 and the Senate by unanimous consent.

SIGNED

Joshua B. Bolten
Director

Enclosures

LRD: K.Blank/dmw 10/8/03

Memo approved in draft by: Income Maintenance Branch (Cheesebrough); Justice Branch (Crowley); and OPD (Halaska).

###

For Immediate Release
Office of the Press Secretary
October 10, 2003

Statement on H.R. 1925

Statement by the Press Secretary

On Friday, October 10, 2003, the President signed into law:

H.R. 1925, the "Runaway, Homeless, and Missing Children Protection Act" which reauthorizes and makes changes to the Runaway and Homeless Youth Act, under which food, shelter, clothing, and education services are provided to homeless and runaway youth; and extends the authorization for the Missing Children's Assistance Act, which supports efforts to located and recover missing and exploited children;

H.R. 2826, which designates the facility of the United States Postal Service located at 1000 Avenida Sanchez Osorio in Carolina, Puerto Rico, as the "Roberto Clemente Walker Post Office Building; and

S. 570, which changes the eligibility requirements for students in nonprofit and public foreign veterinary schools and Canadian medical schools to qualify for certain financial assistance programs.

###

President Applauds Congress for Partial-Birth Abortion Bill

October 21, 2003

I applaud the Senate for joining the House in passing the ban on partial-birth abortion. This is very important legislation that will end an abhorrent practice and continue to build a culture of life in America. I look forward to signing it into law.

###

President Bush Signs Partial Birth Abortion Ban Act of 2003

The Ronald Reagan Building
Washington, D.C.

November 5, 2003

THE PRESIDENT: Thank you very much. Good afternoon. I'm pleased that all of you have joined us as the Partial Birth Abortion Ban Act of 2003 becomes the law of the land. (Applause.) For years, a terrible form of violence has been directed against children who are inches from birth, while the law looked the other way. Today, at last, the American people and our government have confronted the violence and come to the defense of the innocent child. (Applause.)

I want to thank you all for coming. Many of you have worked long and hard to see this bill come to fruition, and we thank you for your efforts.

AUDIENCE MEMBER: Thank you, Mr. President. (Applause.)

THE PRESIDENT: I see some members of my Cabinet have come. I appreciate the good work of the Attorney General, John Ashcroft. (Applause.) Secretary of the Department of Health and Human Services, Tommy Thompson, is here. Thank you, Tommy. (Applause.) There are a lot of members of the Senate and House here today, I want to thank you all for passing this important legislation. I'm glad you're here. (Applause.)

The primary Senate sponsor is with us, Senator Rick Santorum. (Applause.) Senator Orrin Hatch and Senator Mike DeWine helped, as well, in the Senate. Thank you all very much. (Applause.) Steve Chabot was the primary House sponsor, and Steve is with us. Thanks for coming, Steve. (Applause.) I'm thankful that our Speaker is with us today. Mr. Speaker, I appreciate you coming. (Applause.) The Majority Leader, Tom DeLay, as well. Thank you for coming, Tom. (Applause.)

I'd like to mention three other members of the House. Henry Hyde is with us today. Mr. Chairman, we appreciate you coming. (Applause.) Jim Oberstar is with us. Jim, thank you for being here, sir, I appreciate you coming. (Applause.) Bart Stupak, from Michigan, is with us, as well. Thanks for coming, Bart, glad you're here. (Applause.)

I appreciate His Eminence, Cardinal Egan, is with us today. Thank you very much, sir. (Applause.)

In passing this legislation, members of the House and Senate made a studied decision based upon compelling evidence. The best case against partial birth abortion is a simple description of what happens and to whom it happens. It involves the partial delivery of a live boy or girl, and a sudden, violent end of that life. Our nation owes its children a different and better welcome. (Applause.) The bill I am about to sign protecting innocent new life from this practice reflects the compassion and humanity of America.

In the course of the congressional debate, the facts became clear. Each year, thousands of partial birth abortions are committed. As Doctor C. Everett Koop, the pediatrician and former Surgeon General has pointed out, the majority of partial birth abortions are not required by medical emergency. As Congress has found, the practice is widely regarded within the medical profession as unnecessary, not only cruel to the child, but harmful to the mother, and a violation of medical ethics. (Applause.)

The facts about partial birth abortion are troubling and tragic, and no lawyer's brief can make them seem otherwise. (Applause.) By acting to prevent this practice, the elected branches of our government have affirmed a basic standard of humanity, the duty of the strong to protect the weak. The wide agreement amongst men and women on this issue, regardless of political party, shows that bitterness in political debate can be overcome by compassion and the power of conscience. And the executive branch will vigorously defend this law against any who would try to overturn it in the courts. (Applause.)

America stands for liberty, for the pursuit of happiness and for the unalienable right of life. And the most basic duty of government is to defend the life of the innocent. Every person, however frail or vulnerable, has a place and a purpose in this world. Every person has a special dignity. This right to life cannot be granted or denied by government, because it does not come from government, it comes from the Creator of life. (Applause.)

In the debate about the rights of the unborn, we are asked to broaden the circle of our moral concern. We're asked to live out our calling as Americans. We're asked to honor our own standards, announced on the day of our founding in the Declaration of Independence. We're asked by our convictions and tradition and compassion to build a culture of life, and make this a more just and welcoming society. And today, we welcome vulnerable children into the care and protection of Americans. (Applause.)

The late Pennsylvania Governor Robert Casey once said that: when we look to the unborn child, the real issue is not when life begins, but when love begins. (Applause.) This is the generous and merciful spirit of our country at its best. This spirit is reflected in the Partial Birth Abortion Ban Act of 2003, which I am now honored to sign into law. God bless. (Applause.)

(The bill is signed.) (Applause.) Thank you, all. (Applause.)

###

For Immediate Release
Office of the Press Secretary
November 7, 2003

National Adoption Month, 2003

By the President of the United States of America
A Proclamation

Every year, tens of thousands of American families answer the call to adopt a child. During National Adoption Month, we recognize America's adoptive and foster families. We also commit to helping all of our children, including those waiting in foster care, find safe, permanent, and loving homes.

On November 22, communities across the country will come together to celebrate National Adoption Day by finalizing the adoptions of over 3,000 children from foster care. On this day and all this month, we honor families that have opened their hearts and homes to a child.

The number of children who are adopted has increased in recent years. Still, thousands of children in our country -- many with special needs -- continue to wait in foster care for an adoptive family.

We are taking important steps to make adoption more commonplace and to protect the well-being of our children. We have eased the financial burden of adoption by nearly doubling the maximum adoption tax credit. We expanded the Promoting Safe and Stable Families Program, which encourages adoption at the local level and supports adoptive families with services that ease a child's transition into a new family and help to strengthen the family. The Department of Health and Human Services provides incentives to States that increase the number of children adopted from State-supervised foster care.

Last year, my Administration launched the first Federal adoption website, www.AdoptUSKids.org, which features pictures and profiles of children available for adoption. This site helps loving families connect with waiting children across the country. Already, more than 1,700 children featured on the site have been placed with adoptive families. This progress is testimony to the selfless spirit of American families.

NOW, THEREFORE, I, GEORGE W. BUSH, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim November 2003 as National Adoption Month. I call on all Americans to observe this month with appropriate programs and activities to honor adoptive families and to participate in efforts to find permanent homes for waiting children.

IN WITNESS WHEREOF, I have hereunto set my hand this seventh day of November, in the year of our Lord two thousand three, and of the Independence of the United States of America the two hundred and twenty-eighth.

GEORGE W. BUSH

# # #

For Immediate Release
Office of the Press Secretary
December 2, 2003

President Bush Signs the Adoption Promotion Act of 2003

Remarks by the President at the Signing of H.R. 3182, the Adoption Promotion Act of 2003
The Roosevelt Room

9:25 A.M. EST

THE PRESIDENT: Good to see you all. Thank you. Thanks. Please be seated. Hi, Mary. Thank you, Jim. Thanks for coming. Thank you all for coming. Gosh, we got a lot of great -- great families with us today. We're really proud you all are here. I want to thank you for coming to the Roosevelt Room. I'm delighted you're here.

The adoption of a boy or a girl is a moment of joy for a family, and it's an act of great generosity. When parents share their homes and all they have with a child, the child they adopt and love as their own, all their lives are transformed forever. Isn't that right?

MRS. MARTIN: Yes.

MR. MARTIN: Yes. (Laughter.)

THE PRESIDENT: In every young life there is a great need to belong. For the sake of our children, this nation has a responsibility to encourage adoption of children at all ages -- from infants to adolescents. The legislation I'm about to sign today sends a clear message: Our society is building a culture that values every life, and our government strongly supports adoption.

I appreciate Deputy Secretary Claude Allen, from the Department of Health and Human Services, for joining us. I want to thank three members of the Congress who have been instrumental in this legislation, and I appreciate their good, hard work. Senator Mary Landrieu, of the great state of Louisiana, is with us -- Jim Oberstar, of Minnesota, and Dave Camp, of Michigan. Thank you all for coming. I appreciate you taking time to come to herald this important piece of legislation. I'm honored you all are here.

Bruce Willis is not with us, but I do want to thank him for being the national spokesperson on foster care and adoption. His message is helpful. It's important to help spread the word about the joys of adoption, and Bruce has been mighty helpful in doing just that.

I want to thank the parents of adoptive children who are with us today -- the Martin Family; the Hendrix Family are with us, and the Morris Family; and the Schwarzwalder Family. I'm honored you all are here. I want to thank you for giving me a chance, and the members of Congress a chance, after the bill signing, to personally thank you for showing America the generosity of spirit that makes our country such a wonderful place. We're really glad you're here.

Thanks to the Congress, and thanks to the groups that work on behalf of foster children, and to moms and dads across America, these last few years have brought real progress in the cause of adoption. We're making progress here in America.

Six years ago, Congress provided new incentives to the states to promote foster care adoptions, and those incentives have worked. I suspect these members of Congress worked on that important legislation. In just five years, from 1998 to 2002, the states placed more than 230,000 children in adoptive homes -- about the same number that had been adopted in the previous 10 years. We're making some progress here in America. (Applause.)

In the same period, thirty-three states and the District of Columbia have at least doubled foster care adoptions. To further promote adoption, we increased the adoption tax credit in 2001 from $5,000 to $10,000. I want to thank the members for working on that important piece of legislation. I hope it helps families.

In 2002, my administration created a new website called adoptuskids.org, which has already helped to join nearly 2,000 children with adoptive parents. In other words, if you want to be a part of this movement of love in America, go to the website. And the website will help you understand how best to become an adoptive parent. Many more still await their chance and their home, and we are determined to help all children in America.

Today in America, more 126,000 foster children still need an adoptive family. And nearly half of these children are past the age of nine. Foster parents bring help and kindness at a crucial point in a child's life, yet foster care is by nature temporary. And the aim of the system, and the desire of every child is a permanent home. The bill I sign this morning will help bring that opportunity to many more children of all ages.

The Adoption Promotion Act of 2003 will continue all the current incentives that have created new momentum for the adoption process in our states. In addition, we will begin monitoring the adoptions of foster children age nine and older, and provide extra incentives for states to increase adoption of older children. This is a proven way to increase the placement of children from foster care to permanent homes, and each one of those homes will be richer for the addition of new family members.

Here's one example standing with me. It's what we call a good-sized American family. (Laughter.)

MRS. MARTIN: Amen.

MR. MARTIN: Yes.

THE PRESIDENT: Diana and Chris Martin, good, solid Americans, a good loving mom and dad, are with us with seven children -- four of them adopted at ages 6, 8, 10, and 11 years old. (Applause.) You were six.

MRS. MARTIN: That's right.

THE PRESIDENT: How old are you?

TERRANCE MARTIN: Seven.

THE PRESIDENT: Okay, seven. (Laughter.) I'll take it up with the fact-checker. (Laughter.) Children who, at one time, were 6, 8, 10 and 11. (Laughter.)

Chris says, "Besides having to add a whole new wing on the house," -- maybe the tax credit helps (laughter) -- "it can be emotionally trying. They have a sense of abandonment, and they came with the fear of bonding to you because they've been let down, and they're afraid." He also said, "It's been rewarding because you can see the love in their eyes when they finally realize they have a place, they have a home, and that I am their dad."

Adoptive parents are giving much, and they are gaining much. The future of many thousands of children depend on the willingness of caring parents to make that personal commitment. It would take less than 1 percent of the American population to provide a home to every child awaiting adoption. Welcoming a child into your home and calling that child your son or daughter is a major decision. It is never to be made lightly. Yet so many parents who have made that decision, count it among life's greatest and happiest turning points. And so I hope more Americans, after careful thought and prayer, will make the decision to adopt a boy or girl of their own.

The act of Congress strongly affirms our national commitment to adoption, and will encourage adoption in every part of our land. I want thank you all for coming. We're honored to be with such loving parents and great Americans. And now I'd like to ask the members of Congress to join me as I sign this important piece of legislation, and maybe this great family would like to join us, as well. Thanks for coming. (Applause.) Here, Mary, get in here. All right, is everybody ready?

AUDIENCE: Yes.

CHILD: Can I come in there, too?

THE PRESIDENT: You want to come in here? (Laughter.)

CHILDREN: Yes.

THE PRESIDENT: Sure, come on. All right. They won't ask her any questions. (Laughter.) You ready? (The bill is signed.) (Applause.)

END 9:34 A.M. EST

###

National Sanctity of Human Life Day, 2004

A Proclamation

January 16, 2004

As Americans, we are led by the power of our conscience and the history of our country to defend and promote the dignity and rights of all people. Each person, however frail or defenseless, has a place and a purpose in this world. On National Sanctity of Human Life Day, we celebrate the gift of life and our commitment to building a society of compassion and humanity.

Today, the principles of human dignity enshrined in the Declaration of Independence -- that all persons are created equal and possess the unalienable rights to life, liberty, and the pursuit of happiness -- continue to guide us. In November, I signed into law the Partial-Birth Abortion Ban Act of 2003, reaffirming our commitment to protecting innocent life and to a basic standard of humanity -- the duty of the strong to defend the weak. My Administration encourages adoption and supports abstinence education, crisis pregnancy programs, parental notification laws, and other measures to help us continue to build a culture of life. By working together, we will provide hope to the weakest among us and achieve a more compassionate and merciful world.

NOW, THEREFORE, I, GEORGE W. BUSH, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim Sunday, January 18, 2004, as National Sanctity of Human Life Day. I call upon all Americans to recognize this day with appropriate ceremonies in our homes and places of worship and to reaffirm our commitment to respecting the life and dignity of every human being.

IN WITNESS WHEREOF, I have hereunto set my hand this fifteenth day of January, in the year of our Lord two thousand four, and of the Independence of the United States of America the two hundred and twenty-eighth.

GEORGE W. BUSH

###

President Bush Calls "March for Life" Participants

Remarks by the President in Telephone Call to March for Life Participants

January 22, 2004

THE PRESIDENT: Well, thank you very much, Nellie. I appreciate your kind introduction, and thank you for including me in this celebration of life. I'm calling you today from Roswell, New Mexico. (Applause.) And it sounds like you've got some people who know where Roswell is here in the audience. (Applause.)

I know that good folks have gathered there on the Mall from every corner of America to take part in the 31st March For Life. And I want you to pass on my best to each one of them in person, please, and tell them how much I appreciate their devotion to such a noble cause. (Applause.)

You believe, as I do, that every person, however frail or vulnerable, is a blessing. (Applause.) Each of us has a special dignity, a place and purpose in this world. And in the Declaration of Independence, our founders stated this self-evident truth: The right to life does not come from government, it comes from the Creator of life. (Applause.)

During the past three years we've made real progress toward building a culture of life in America. As President, I've signed the Born-Alive Infants Protection Act. (Applause.) I have signed legislation supporting maternity group homes. (Applause.) Working with the Congress, we have refused to spend taxpayers' money on international programs that promote abortion overseas. (Applause.) We're opposed to the destruction of embryos for stem cell research. (Applause.) And last November, it was my honor to sign into law a ban on the brutal procedure of partial birth abortion. (Applause.)

Nellie, I want you to know that our administration is vigorously defending this law against those who would seek to overturn it in the courts. (Applause.) I also want you to know without your hard work and dedication to the cause of life, these achievements would not have been possible.

But we all know there is still more to do. Earlier this week, I proposed that we double federal funding for abstinence education programs. (Applause.) We will continue to support crisis pregnancy centers, adoption, parental notification laws, and the vital work of faith-based groups. (Applause.)

I strongly support the Unborn Victims of Violence Act, which the House Judiciary Committee approved yesterday. (Applause.) And now the entire Congress should act on this bill so I can sign it into law. (Applause.)

We'll also work with Congress to pass without delay a comprehensive and effective ban on human cloning. (Applause.) We can push the limits of medical science while maintaining the highest of ethical standards. Human life is a creation, not a commodity, and should not be used as research material for reckless experiments. (Applause.)

Above all, we must continue with civility and respect to remind our fellow citizens that all life is sacred and worthy of protection. (Applause.) I know as you return to your communities you will

redouble your efforts to change hearts and minds, one person at a time. (Applause.) And this is the way we will build a lasting culture of life, a compassionate society in which every child is born into a loving family and protected by law. (Applause.)

MS. GRAY: We pledge that to you, Mr. President.

THE PRESIDENT: Thank you, Nellie. I appreciate so very much the opportunity to speak to you and the assembled crowd. May God bless you all, and may He continue to bless America. (Applause.) Thank you very much. (Applause.)

###

Statement by the President on the Unborn Victims of Violence Act

February 26, 2004

I applaud the House for passing the Unborn Victims of Violence Act today by a strong bipartisan vote. We must continue to build a culture of life in our country, a compassionate society in which every child is born into a loving family and protected by law.

Pregnant women who have been harmed by violence, and their families, know that there are two victims -- the mother and the unborn child -- and both victims should be protected by federal law.

I urge the Senate to pass this bill so that I can sign it into law.

###

President Applauds Senate for Passing Unborn Victims of Violence Act

March 25, 2004

I applaud the Senate for passing the Unborn Victims of Violence Act today by a strong bipartisan vote. We must continue to build a culture of life in our country, a compassionate society in which every child is welcomed in life and protected by law.

Pregnant women who have been harmed by violence, and their families, know that there are two victims -- the mother and the unborn child -- and both victims should be protected by Federal law.

I look forward to signing this important legislation into law.

###

President Bush Signs Unborn Victims of Violence Act of 2004

Remarks by the President at Signing of the Unborn Victims of Violence Act of 2004
The East Room

April 1, 2004

THE PRESIDENT: Thank you for coming. Thank you all. Please be seated. Thanks for the warm welcome. (Laughter.) Welcome to the people's house, the White House. I'm pleased that you all could be here for the first bill signing ceremony of the year 2004.

The Unborn Victims of Violence Act provides that, under federal law, any person who causes death or injury to a child in the womb shall be charged with a separate offense, in addition to any charges relating to the mother. (Applause.) As of today, the law of our nation will acknowledge the plain fact that crimes of violence against a pregnant woman often have two victims. (Applause.) And therefore, in those cases, there are two offenses to be punished. Under this law, those who direct violence toward a pregnant woman will answer for the full extent of the harm they have done, and for all the crimes they have committed.

I appreciate members of the United States Congress who have joined us today. Majority Leader Bill Frist is with us from the Senate. Thank you for coming. Majority Leader Tom DeLay of the House of Representatives -- (applause.) Members from both political parties have joined us. I appreciate the members on stage here, House bill sponsor, Congresswoman Melissa Hart from Pennsylvania, is with us. (Applause.) Senate sponsor, Senator Mike DeWine from Ohio, is with us. (Applause.) And the Chairman of the Judiciary Committees, Senator Orrin Hatch and Congressman Jim Sensenbrenner, are with us, as well. (Applause.) Thank you all.

I appreciate those in attendance today from across the country who have worked hard to get this bill passed. I also want to thank Sharon Rocha and her husband, Ron Grantski, for joining us today. (Applause.)

This act of Congress addresses tragic losses such as Sharon and Ron have known. They have laid to rest their daughter, Laci, a beautiful young woman who was joyfully awaiting the arrival of a new son. They have also laid to rest that child, a boy named Conner, who was waiting to be born when his life, too, was taken. His little soul never saw light, but he was loved, and he is remembered. (Applause.) And his name is forever joined with that of his mom in this statute, which is also known as Laci and Conner's Law. (Applause.) All who knew Laci Peterson have mourned two deaths, and the law cannot look away and pretend there was just one.

Each of these families on this stage has lost a child, or a grandchild, or both. Carol and Buford Lyons, Tracy Marciniak-Seivers, Stephanie Alberts, Cynthia Warner -- I thank you all for your courage for coming today. (Applause.)

As these and the other families understand, any time an expectant mother is a victim of violence, two lives are in the balance, each deserving protection, and each deserving justice. If the crime is murder and the unborn child's life ends, justice demands a full accounting under the law.

Until today, the federal criminal code had been silent on the injury or death of a child in cases of

violence against a pregnant woman. This omission in the law has led to clear injustices. The death of an innocent unborn child has too often been treated as a detail in one crime, but not a crime in itself. Police and prosecutors had been to crime scenes and have shared the grief of families, but have so often been unable to seek justice for the full offense. The American people, as well, have learned of these cases, and they urged action. The swift bipartisan passage of this bill through Congress this year indicates a strong consensus that the suffering of two victims can never equal only one offense.

The moral concern of humanity extends to those unborn children who are harmed or killed in crimes against their mothers. And now, the protection of federal law extends to those children, as well. With this action, we widen the circle of compassion and inclusion in our society, and we reaffirm that the United States of America is building a culture of life. (Applause.)

It is now my honor to sign the Unborn Victims of Violence Act of 2004.

(The bill is signed.) (Applause.)

###

Statement on Partial Birth Abortion

June 1, 2004

Partial birth abortion is an abhorrent procedure that must be ended once and for all. The President strongly disagrees with today's California court ruling, which overturns the overwhelming bipartisan majority in Congress that voted to pass this important legislation. The President is committed to building a culture of life in America and the Administration will take every necessary step to defend this law in the courts.

###

For Immediate Release
Office of the Press Secretary
November 4, 2004

National Adoption Month, 2004

By the President of the United States of America
A Proclamation

By deciding to share their hearts and homes with a child, adoptive parents demonstrate great compassion and receive many blessings in return. During National Adoption Month, we recognize the generosity of adoptive and foster families who are providing hope and love, and we encourage the adoption of children of all ages.

In 2002, I signed the Promoting Safe and Stable Families legislation that supports families and promotes adoption, and last December I signed the Adoption Promotion Act of 2003 to increase incentives to adopt older children. We have raised the adoption tax credit to $10,000 per child and created the AdoptUSKids website that has joined thousands of children with adoptive parents. We are working hard to place more children from foster care to permanent homes. This year, on November 20, communities from all 50 States and the District of Columbia will celebrate National Adoption Day by finalizing the adoption of thousands of children by loving families. And each one of those families will be enriched by the addition of new members. By bringing care and hope into other lives, individuals can fill their own lives with greater purpose.

NOW, THEREFORE, I, GEORGE W. BUSH, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim November 2004 as National Adoption Month. I call on all Americans to observe this month with appropriate programs and activities to honor adoptive families and to participate in efforts to find permanent homes for waiting children.

IN WITNESS WHEREOF, I have hereunto set my hand this fourth day of November, in the year of our Lord two thousand four, and of the Independence of the United States of America the two hundred and twenty-ninth.

GEORGE W. BUSH

# # #

National Sanctity of Human Life Day, 2005

A Proclamation by the President of the United States of America

January 15, 2005

The Declaration of Independence proclaimed that all Americans are endowed by the Creator with the unalienable rights to life, liberty, and the pursuit of happiness. On National Sanctity of Human Life Day, we celebrate the sacred gift of life.

We have a responsibility in America to defend the life of the innocent and the powerless. Our Nation has made significant progress in recent years toward building a culture of life. Last year, I signed into law the Unborn Victims of Violence Act of 2004, which provides that any person who causes death or injury to a pregnant woman commits two separate offenses. I worked with members of both parties to ban the brutal practice of partial-birth abortion, and I signed the Born-Alive Infants Protection Act. Working with the Congress, my Administration has halted spending of taxpayers' money on international programs that promote abortions overseas. We continue to promote abstinence education, adoption programs, crisis pregnancy programs, and other efforts to help protect life.

My Administration remains committed to the steadfast belief in the dignity of every human being and the promise of every life. Across our country, we must continue to encourage our citizens to make ours a more just and welcoming society in which every child is born into a loving family and protected by law. We will work with decency and respect to change hearts and minds, one person at a time. In doing so, we will build a lasting culture of life and a more compassionate society.

NOW, THEREFORE, I, GEORGE W. BUSH, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim Sunday, January 16, 2005, as National Sanctity of Human Life Day. I call upon all Americans to recognize this day with appropriate ceremonies in our homes and places of worship and to reaffirm our commitment to respecting the life and dignity of every human being.

IN WITNESS WHEREOF, I have hereunto set my hand this fourteenth day of January, in the year of our Lord two thousand five, and of the Independence of the United States of America the two hundred and twenty-ninth.

GEORGE W. BUSH

###

President Bush Calls "March for Life" Participants

January 24, 2005

THE PRESIDENT: Nellie, thank you. Thanks a lot for inviting me to speak. I know it's chilly there in Washington, but weather hasn't stopped thousands of participants from marching for life for the past 32 years, and it did not this year, either. And so I'm honored to be a part of this tremendous witness that is taking place in our Nation's Capitol, and it's good to hear your voice again.

You know, we come from many backgrounds -- different backgrounds, but what unites us is our understanding that the essence of civilization is this: The strong have a duty to protect the weak. (Applause.)

I appreciate so very much your work toward building a culture of life-- (applause) -- a culture that will protect the most innocent among us and the voiceless. We are working to promote a culture of life, to promote compassion for women and their unborn babies. (Applause.) We know -- we know that in a culture that does not protect the most dependent, the handicapped, the elderly, the unloved, or simply inconvenient become increasingly vulnerable.

The America of our dreams, where every child is welcomed in law -- in life, and protected in law may still be some ways away, but even from the far side of the river, Nellie, we can see its glimmerings. (Applause.) We're making progress in Washington. I've been working with members of the Congress to pass good, solid legislation that protects the vulnerable and promotes the culture of life. I signed into law a ban on partial birth abortion. (Applause.) Infants who are born despite an attempted abortion are now protected by law. (Applause.) So are nurses and doctors who refused to be any part of an abortion. (Applause.) And prosecutors can now charge those who harm or kill a pregnant woman with harming or killing her unborn child. (Applause.)

We're also moving ahead in terms of medicine and research to make sure that the gifts of science are consistent with our highest values of freedom, equality, family, and human dignity. We will not sanction the creation of life only to destroy it. (Applause.)

What I'm saying is we're making progress, and this progress is a tribute to your perseverance and to the prayers of the people. I want to thank you, especially, for the civil way that you have engaged one of America's most contentious issues. I encourage you to take heart from our achievements, because a true culture of life cannot be sustained solely by changing laws. We need, most of all, to change hearts. (Applause.) And that is what we're doing, seeking common ground where possible, and persuading increasing numbers of our fellow citizens of the rightness of our cause.

This is the path to the culture of life that we seek for our country. And on its coldest days, and one of our coldest days, I encourage you to take warmth and comfort from our history which tells us that a movement that appeals to the noblest and most generous instincts of our fellow Americans -- and that is based on a sacred promise enshrined in our founding document that this movement will not fail. (Applause.)

And so on this day of compassion, where warm hearts are confronting the cold weather, I ask that God bless you for your dedication, and may God continue to bless our great country. And thank you for letting me share this moment with you, Nellie. (Applause.)

###

For Immediate Release
Office of the Press Secretary
March 17, 2005

President's Statement on Terri Schiavo

The case of Terri Schiavo raises complex issues. Yet in instances like this one, where there are serious questions and substantial doubts, our society, our laws, and our courts should have a presumption in favor of life. Those who live at the mercy of others deserve our special care and concern. It should be our goal as a nation to build a culture of life, where all Americans are valued, welcomed, and protected - and that culture of life must extend to individuals with disabilities.

# # #

Withdrawal Marker
The George W. Bush Library

FORM	SUBJECT/TITLE	PAGES	DATE	RESTRICTION(S)
Memorandum	Enrolled Bill S. 686 - To: POTUS - From: Joshua Bolten	3	03/20/2005	P5;

This marker identifies the original location of the withdrawn item listed above. For a complete list of items withdrawn from this folder, see the Withdrawal/Redaction Sheet at the front of the folder.

COLLECTION:
Staff Secretary, White House Office of the

SERIES:
Von Der Heydt, Thomas (Tommy) - Bush Record Policy Memos

FOLDER TITLE:
Pro-Life Legacy: A Timeline (2001 - 2008)

FRC ID:
13894

OA Num.:
14457

NARA Num.:
14246

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the 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 advise between the President and his advisors, or between such advisors [a)(5) of the PRA]
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For Immediate Release
Office of the Press Secretary
March 21, 2005

Statement on S. 686

Statement by the Press Secretary

On Monday, March 21, 2005, the President signed into law:

S. 686, which provides that the United States District Court for the Middle District of Florida shall have jurisdiction to hear, determine, and render judgment on a suit or claim by or on behalf of Theresa Marie Schiavo for the alleged violation of any right of Theresa Marie Schiavo under the Constitution or laws of the United States relating to the withholding or withdrawal of food, fluids, or medical treatment necessary to sustain her life; provides that any parent of Theresa Marie Schiavo shall have standing to bring a suit under the Act; and establishes other procedures for a suit under the Act.

# # #

For Immediate Release
Office of the Press Secretary
March 31, 2005

President Discusses Schiavo, WMD Commission Report

Room 450
Dwight D. Eisenhower Executive Office Building

11:31 A.M. EST

THE PRESIDENT: Today millions of Americans are saddened by the death of Terri Schiavo. Laura and I extend our condolences to Terri Schiavo's families. I appreciate the example of grace and dignity they have displayed at a difficult time. I urge all those who honor Terri Schiavo to continue to work to build a culture of life, where all Americans are welcomed and valued and protected, especially those who live at the mercy of others. The essence of civilization is that the strong have a duty to protect the weak. In cases where there are serious doubts and questions, the presumption should be in the favor of life.

The most solemn duty of the American President is to protect the American people. Since September the 11th, 2001, we've taken bold and vigorous steps to prevent further attacks and overcome emerging threats. We face a new and different kind of enemy. The threats today are unprecedented. The lives of our citizens are at stake. To protect them, we need the best intelligence possible, and we must stay ahead of constantly changing intelligence challenges.

So last year I issued an executive order creating an independent commission to look at America's intelligence capabilities, especially our intelligence about weapons of mass destruction. I asked two fine Americans to chair this commission, Judge Laurence Silberman and former Senator Chuck Robb. They have done an excellent job. I appreciate your service to our country.

I also want to thank the other members of the commission -- Senator John McCain, Rick Levin, Harry Rowen, Walt Slocombe, Bill Studeman, Judge Patricia Wald, Chuck Vest and Lloyd Cutler. I want to thank them for their hard work. They spent a lot of time on this project. I asked these distinguished individuals to give me an unvarnished look at our intelligence community, and they have delivered.

This morning the commission presented me with their recommendations, which are thoughtful and extremely significant. The central conclusion is one that I share: America's intelligence community needs fundamental change to enable us to successfully confront the threats of the 21st century.

My administration has taken steps consistent with the commission's recommendations. In February, I named John Negroponte the first Director of National Intelligence, a post that was created to help ensure that our intelligence community works as a single, unified enterprise. It's important for Congress to move quickly on John's confirmation, because he'll have a key role in the continued reform and restructuring of intelligence capabilities.

Today I've directed Homeland Secretary advisor Fran Townsend to oversee the interagency process, to review the commission's findings, and to ensure that concrete action is taken. The commission report delivers a sharp critique of the way intelligence has been collected and analyzed against some of the most different intelligence targets, especially Iraq.

To win the war on terror, we will correct what needs to be fixed, and build on what the commission calls solid intelligence successes. These include the uncovering of Libya's nuclear and missile programs. In Pakistan, our intelligence helped expose and shut down the world's most dangerous nuclear proliferation network. Where we have had success, the commission reports we have seen innovative collection techniques and a fusion of interagency intelligence capabilities. We must work to replicate these successes in other areas.

The men and women of our intelligence community work hard. And the sacrifices they have made have helped protect America, and our nation is grateful for their hard work. The work they're doing is critical. We need to prevent terrorists from getting their hands on the weapons of mass murder they would like to use against our citizens.

The work of our intelligence community is extremely difficult work. Every day, dangerous regimes are working to prevent us from uncovering their programs and their possible relationships with terrorists. And the work our intelligence men and women do is, by nature, secret, which is why the American people never hear about many of their successes. I'm proud of the efforts of our intelligence workers and I'm proud of their commitment to the security of our country, and the American people should be proud, too.

And that's why this report is important. It will enable these fine men and women to do their jobs in better fashion, to be able to more likely accomplish their mission, which is to protect the American people, and that's why I'm grateful to the commission for this hard work.

The President and his national security team must have intelligence that is timely and intelligence that is accurate. In their report today, the commission points out that America needs to know much more about the weapons programs and intentions of our most dangerous adversaries. They have given us useful and important guidance that will help us transform our intelligence capabilities for the needs of a dangerous new century.

In other words, we need to adjust. We need to understand the threats and adjust our capabilities to meet those threats. We will work to give our intelligence professionals the tools they need. Our collection and analysis of intelligence will never be perfect, but in an age where our margin for error is getting smaller, in an age in which we are at war, the consequences of underestimating a threat could be tens of thousands of innocent lives. And my administration will continue to make intelligence reforms that will allow us to identify threats before they fully emerge so we can take effective action to protect the American people.

I'm grateful for your hard work, and now the chairman of the commission and the co-chairman of the commission have agreed to answer your questions. Thank you, sir.

END 11:38 A.M. EST

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Released by request only

HHS News

U.S. Department of Health and Human Services

www.hhs.gov/news

FOR IMMEDIATE RELEASE
Friday, April 22, 2005

Contact: HHS Press Office
(202) 690-6343

STATEMENT BY MIKE LEAVITT
Secretary of Health and Human Services
Regarding Born-Alive Infant Protection

Shortly after I was confirmed as Secretary, I received several inquiries on whether the Department of Health and Human Services was planning to issue regulations to implement the Born-Alive Infants Protection Act of 2002. The Born-Alive Act, passed with overwhelming bipartisan support in Congress and signed into law by President Bush in August 2002, is a law that defines the term "individual," "person," "human being," or "child" as any infant who is born alive, at any stage of development. While that definition seems so self-evident, Congress had received testimony that some infants who had been born alive after unsuccessful abortions were left to die. Because the Born-Alive Act is self-implementing and applies to all federal statutes, rulings, and regulations, no regulations are necessary.

The Act reaffirms the legal principle that all infants born alive are entitled to the full protection of the law. That is a principle I will vigorously uphold as Secretary. As a matter of law and policy, the U.S. Department of Health and Human Services will investigate all circumstances where individuals and entities are reported to be withholding medical care from an infant born alive in potential violation of federal statutes for which we are responsible. We will also take proactive steps to educate state officials, health care providers, hospitals and child protection agencies about their obligations to born-alive infants under federal law.

We took the first of these educational steps today by notifying relevant entities that we aggressively enforce federal laws that protect born-alive infants. We issued clear guidance that withholding medical care from an infant born alive may constitute a violation of the federal Emergency Medical Treatment and Labor Act and the Medicare Conditions of Participation. We also notified state agencies that receive grants under the Child Abuse Prevention and Treatment Act that they must have procedures in place to respond to reports of medical neglect as it applies to born-alive infants.

Ours is a society that values and defends life. The Department of Health and Human Services will continue to seek ways to revere and protect the dignity of life.

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Note: All HHS press releases, fact sheets and other press materials are available at http://www.hhs.gov/news.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-05-26

DATE: April 22, 2005

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Interaction of the Emergency Medical Treatment and Labor Act (EMTALA) and the Born-Alive Infants Protection Act of 2002

Letter Summary

- The Born-Alive Infants Protection Act of 2002 (Pub. L. 107-207) adds to the United States Code a definition of the term "individual" to include every infant who is born alive, at any stage of development; it also adds a definition of the term "born alive."
- The Emergency Medical Treatment and Labor Act (EMTALA) provides certain rights to "any individual" who comes to an emergency department and "any individual" who comes to a hospital. In particular, hospitals must provide an appropriate medical screening examination to any individual who comes to an emergency department, and either stabilizing treatment or an appropriate transfer for an individual who comes to a hospital and who is determined to have an emergency medical condition.
- **Attachment:** The attached Guidance provides direction to regional office and state survey agency personnel on how to apply EMTALA in investigations when the Born-Alive Infants Protection Act is potentially implicated.

The purpose of this memorandum is to provide guidance to regional office (RO) and state survey agency (SA) personnel regarding the enforcement of the Emergency Medical Treatment and Labor Act (EMTALA) during investigations of hospitals where the Born-Alive Infants Protection Act could be potentially implicated. It has recently come to the agency's attention that there may be occasions where, in hospitals, an infant may be born alive within the meaning of the definition added to the U.S. Code by the Born-Alive Infants Protection Act, but where hospitals have failed to comply with the requirements of EMTALA.

Under the Born-Alive Infants Protection Act, such an infant is defined as an "individual." Since EMTALA provides protection to "individual[s]," RO and SA personnel conducting EMTALA investigations need to be aware of the interaction of both statutes in order to appropriately comply with their obligations to conduct EMTALA surveys. This memorandum provides guidance on the interaction of the two statutes.

Background

Congress enacted EMTALA to ensure public access to emergency services, regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when an individual comes to the emergency department and a request is made for examination or treatment for a medical condition, including active labor, regardless of an individual's ability to pay. In addition, when an individual comes to a hospital, and the hospital determines that the individual has an emergency medical condition, the hospital is required to provide either stabilizing treatment within its capabilities, or to effect an appropriate transfer. If a hospital is unable to stabilize an individual with an emergency medical condition within its capability, or if the individual requests, an appropriate transfer should be implemented.

To help promote consistent application of the regulations concerning the special responsibilities of Medicare-participating hospitals in emergency cases, the Centers for Medicare & Medicaid Services (CMS) has occasionally published regulations clarifying hospitals' responsibilities and obligations under EMTALA. Most recently, in September of 2003, CMS published such regulations. Shortly after those regulations became effective, we issued revised Interpretive Guidelines to implement those regulations. We also amended our State Operations Manual to incorporate the new regulations. From time to time, we also issue guidance to surveyors to use when conducting an investigation and assessing a hospital's compliance with EMTALA.

Effective Date: Immediately. Please orient surveyors and implement procedures to ensure that the information in this memorandum is operational within 60 days.

Training: This information should be distributed to all survey and certification staff, their managers, and the state/RO training coordinators.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

Attachment

Attachment

GUIDANCE ON THE INTERACTION OF THE BORN-ALIVE INFANTS PROTECTION ACT AND EMTALA

Summary of the Born-Alive Infants Protection Act

The Born-Alive Infants Protection Act, Pub. L. 107-207, amended title 1 of the United States Code by defining the terms "person," "human being," "child," and "individual." In particular, the statute instructs that,

> [i]n determining the meaning of any Act of Congress, or of any ruling, regulation, or interpretation of the various administrative bureaus and agencies of the United States, the words "person", "human being", "child", and "individual", shall include every infant member of the species homo sapiens who is born alive at any stage of development.
>
> 1 U.S.C. § 8(a).

The statute goes on to define the term "born alive" with respect to the species homo sapiens, as any member of that species expelled or extracted

> from his or her mother □ at any stage of development, who after such expulsion or extraction breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, cesarean section or induced abortion.
>
> 1 U.S.C. § 8(b).

Summary of the Emergency Medical Treatment and Labor Act (EMTALA)

The EMTALA statute is codified at section 1867 of the Social Security Act, 42 U.S.C. § 1395dd. Hospitals and physicians generally have three obligations under EMTALA. The first is commonly referred to as the screening requirement, and applies to any individual who comes to the emergency department of a hospital and for whom a request is made for examination or treatment for a medical condition. Such an individual is entitled to have a medical screening examination to determine whether or not an emergency medical condition exists. The second is commonly referred to as the stabilization requirement, and applies to any individual who comes to the hospital and whom the hospital determines has an emergency medical condition. Such an individual is entitled to stabilizing treatment within the capability of the hospital. The third obligation flows from the second, and also applies to any individual in a hospital with an

emergency medical condition. This obligation is sometimes known as the transfer requirement, and restricts the ability of the hospital to transfer that individual to another hospital unless the individual is stabilized. If the individual is not stabilized, they may only be transferred if the individual requests the transfer or if the medical benefits of the transfer outweigh the risks.

In addition to the basic requirements of EMTALA, the statute contains "whistleblower" protection. In particular, section 1867(i) of the Act prohibits a hospital from taking adverse action against an employee because the employee reports a violation of the section. EMTALA is enforced by penalties that can be imposed against the hospital in an amount up to $50,000 per violation ($25,000 per violation in the case of a hospital with less than 100 beds); hospitals that violate EMTALA also put their Medicare provider agreements at risk. A physician that violates EMTALA is subject to a penalty of $50,000 per violation and, if the violation is gross or flagrant, or repeated, to exclusion from the Medicare and Medicaid programs. In addition, EMTALA can be enforced by a private right of action brought in the U.S. District Courts by any individual harmed as a direct result of an EMTALA violation by a hospital.

The 2003 regulations included some modifications and clarifications to hospitals' responsibilities and obligations under EMTALA. For example, the regulations clarified the screening requirement and made clear that it applied to any individual who presented to an area of the hospital that met the definition of a "dedicated emergency department" and made a request for a medical screening examination. The regulation defined dedicated emergency department as the area of the hospital that met any one of three tests: that it is licensed by the state as an emergency department; that it held itself out to the public as providing emergency care; or that during the preceding calendar year, at least one-third of its outpatient visits were for the treatment of emergency medical conditions. The preamble to the regulation noted that it is possible that the labor and delivery department of a hospital could meet the definition of dedicated emergency department. (See 68 Fed. Reg. at 53229 (September 9, 2003)).

The regulation also clarified other circumstances in which the screening requirement may apply. For example, an individual who comes to certain locations on the hospital's campus, but not to the dedicated emergency department, is entitled to the protection of EMTALA in certain circumstances. In particular, if the individual comes to the hospital and makes request for examination or treatment for an emergency medical condition, then the screening requirement will apply. If the individual does not make a verbal request, but a prudent layperson observer would conclude, based on the person's appearance or behavior, that the person needed emergency examination or treatment, the screening requirement also applies.

In addition, the regulation also clarified the application of EMTALA with respect to inpatients. Prior to the issuance of the regulations, CMS had never made clear whether EMTALA applied to inpatients. With the new regulations, as codified at 42 C.F.R. § 489.24(d)(2), it is clear that EMTALA does not apply to inpatients, whether admitted after the individual has been admitted through the emergency department or whether the individual has been admitted for an elective procedure.

Notably, the regulations retained an earlier requirement that any individual (whether or not that

individual is a Medicare beneficiary) who comes to the hospital and who is determined to have an emergency medical condition is protected by both the stabilization requirement and the transfer requirement if the individual is not admitted. (See 42 C.F.R. § 489.24(d)(1)). The retention of this requirement meant that CMS continued to intend for hospitals to stabilize any individual (or to meet the applicable transfer requirements for any individual) who has not been admitted as an inpatient, but who is determined by the hospital to have an emergency medical condition. The preamble to the regulation also notes that it would be a violation of EMTALA to admit an individual to the hospital in a bad faith attempt to evade EMTALA obligations.

The preamble to the regulation also noted that even though EMTALA does not apply to inpatients, hospitals were still bound by the Medicare conditions of participation (CoPs) to provide appropriate care to inpatients. In particular, the preamble noted four CoPs that are potentially applicable when a hospital provides treatment for an admitted patient. For example, hospital governing bodies must ensure that the hospital medical staff has written policies and procedures for appraisal of inpatients who develop an acute medical condition while admitted. The preamble also notes the discharge planning CoP, which requires that hospitals have a discharge planning process that applies to all patients. Hospitals must also have an organized medical staff that is responsible to the hospital's governing body for the quality of medical care provided to patients. Finally, the hospital governing body must ensure that the hospital has an organization-wide quality assessment and performance improvement program to evaluate the provision of patient care. These CoPs are intended to protect patient health and safety, and to ensure that high quality medical care is provided to all patients. Failure to meet these CoPs could result in a finding of noncompliance at the condition level for the hospital and lead to termination of the hospital's Medicare provider agreement.

Interaction of the Born-Alive Infant Protection Act and EMTALA

With the definition of the terms "person" and "individual" codified at 1 U.S.C. § 8, it is clear that there may be some circumstances where EMTALA protections can attach to an infant who is born alive, as that term is defined in 1 U.S.C. § 8(b). For example, assume that a hospital's labor and delivery department meets the definition of a "dedicated emergency department" under the new regulations. If an infant were born alive (again, as that term is defined in 1 U.S.C. § 8(b)) in that dedicated emergency department, and a request were made on that infant's behalf for screening for a medical condition, (or if a prudent layperson would conclude, based on the infant's appearance or behavior, that the infant needed examination or treatment for an emergency medical condition and that a request would have been made for screening) the hospital and physician could be liable for violating EMTALA for failure to provide such a screening examination. This follows because the born-alive infant is a "person" and an "individual" under 1 U.S.C. § 8(a), and the screening requirement of EMTALA applies to "any individual" who comes to the emergency department.

Another example could occur were an infant to be born alive elsewhere on the hospital's campus (i.e., not in the hospital's dedicated emergency department) and a prudent layperson observer

concluded, based on the born-alive infant's appearance or behavior, that the born-alive infant were suffering from an emergency medical condition. In such a circumstance, the hospital and its medical staff would be required to perform a medical screening examination on that born-alive infant to determine whether or not an emergency medical condition existed. If the hospital or its medical staff determined that the born-alive infant were suffering from an emergency medical condition, there would then arise an obligation to admit the infant, or to comply with either the stabilization requirement or the transfer requirement, or risk a finding of an EMTALA violation. This follows because the born-alive infant is a "person" and an "individual," as described above, and the stabilization and transfer requirements of EMTALA apply to "any individual" who comes to the hospital.

Finally, a third example could occur if the hospital were to admit a born-alive infant. As noted above, EMTALA does not apply to inpatients. Were an infant born alive and then admitted to the hospital, EMTALA would not apply to protect the infant in most circumstances. However, the CoPs described above clearly would apply to the infant once he or she was admitted to the hospital as an inpatient. If a hospital were to violate those CoPs, it would put at risk its Medicare provider agreement.

Conduct of Investigations

EMTALA is a complaint-driven statute. If you receive a complaint that suggests that a born-alive infant has been denied a screening examination, stabilizing treatment, or an appropriate transfer, you should treat that complaint as potentially triggering an EMTALA investigation of the hospital. Note that it is not necessary to determine that the hospital acted with an improper motive in any failure to provide a screening examination, stabilizing treatment, or an appropriate transfer in order to conclude that an EMTALA violation has occurred. The Supreme Court of the United States has held that a finding of improper motive is not required to conclude that an EMTALA violation has occurred.

###

ACF Administration for Children and Families	U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Administration on Children, Youth and Families	
	1. Log No: ACYF-CB-PI-05-01	**2. Issuance Date: April 22, 2005**
	3. Originating Office: Children's Bureau	
	4. Key Words: CAPTA and the Born-Alive Infants Protection Act of 2002	

PROGRAM INSTRUCTION

TO: State and Territorial Agencies Administering or Supervising the Administration of the Child Abuse Prevention and Treatment Act (CAPTA) Program.

SUBJECT: Child Abuse Prevention and Treatment Act requirements and the Born Alive Infants Protection Act of 2002.

LEGAL AND RELATED REFERENCES: The Born-Alive Infants Protection Act of 2002, Public Law 107-207; and the Child Abuse Prevention and Treatment Act.

PURPOSE: The purpose of this Program Instruction (PI) is to provide instruction to States about the requirements of the Born-Alive Infants Protection Act that are applicable to the CAPTA State grant program.

BACKGROUND: The Born-Alive Infants Protection Act, Public Law 107-207, was enacted on August 5, 2002, and amends the United States Code to provide that, in determining the meaning of any Act of Congress, or of any ruling, regulation or interpretation of a federal administrative bureau or agency, the words "person," "human being," "child," and "individual" "shall include every infant member of the species homo sapiens who is born alive at any stage of development." (1 U.S.C. 8(a)). The Act also defines the term "born alive" to mean the complete expulsion or extraction, at any stage of development, of a member of the homo sapiens species from his or her mother who – regardless of whether the umbilical cord has been cut, or whether the expulsion or extraction occurs as a result of natural or induced labor, cesarean section, or induced abortion – after such expulsion or extraction, possesses certain indicia of life (1 U.S.C. 8 (b)). The text of the Act is attached.

The purpose of the Act was to reaffirm the legal principle that infants who are born alive, at any stage of development – including those born alive after failed abortions – are persons entitled to the protections of the law. See H.R. Rep. 107-186 at 3 and throughout (2001).

INSTRUCTION:

All references to a "child" or "children" in the definitions, provisions and assurances of the Child Abuse Prevention and Treatment Act, as amended, are to be read to include infants who are "born-alive" as that term is defined at 1 U.S.C. 8. States also must ensure that their State laws, procedures and practices with respect to child abuse and neglect conform to the requirements of CAPTA as its terms are interpreted in accordance with Public Law 107-207.

In particular, States must ensure that implementation of section 106(b)(2)(B) of CAPTA, which requires States to have procedures for responding to reports of medical neglect (including the withholding of medically indicated treatment from disabled infants with life-threatening conditions), applies to born-alive infants. This means that the State must provide the following with regard to born-alive infants:

X Coordination and consultation with individuals designated by and within health-care facilities with regard to responding to medical neglect (section 106(b)(2)(B)(i) of CAPTA);

X Prompt notification by the individuals designated within health-care facilities of cases of suspected medical neglect (including withholding of medically indicated treatment from disabled infants with life-threatening conditions) to child protective services (section 106(b)(2)(B)(ii) of CAPTA);

X At a minimum, *the authority* for State child protective services to pursue any legal remedies as may be necessary to provide medical care or treatment for a child when such care or treatment is necessary to prevent or remedy serious harm to the child (sections 106(b)(2)(A)(vi), 106(b)(2)(B), and 113(b) of CAPTA); and,

X The authority for State Child Protective Services to pursue, and the *actual pursuit* of, any legal remedies that may be necessary to prevent the withholding of medically indicated treatment from disabled infants with life-threatening conditions (section 106(b)(2)(B) and section 113(b) of CAPTA).

INQUIRIES TO: ACF Regional Offices.

/s/

Wade F. Horn, Ph.D.
Assistant Secretary for Children and Families

Attachment

Born-Alive Infants Protection Act of 2002: Public Law 107-207

SECTION 1. SHORT TITLE.

This Act may be cited as the ``Born-Alive Infants Protection Act of 2002''.

SEC. 2. DEFINITION OF BORN-ALIVE INFANT.

(a) In General.--Chapter 1 of title 1, United States Code, is amended by adding at the end the following:

Sec. 8. `Person', `human being', `child', and `individual' as including born-alive infant.

(a) In determining the meaning of any Act of Congress, or of any ruling, regulation, or interpretation of the various administrative bureaus and agencies of the United States, the words `person', `human being', `child', and `individual', shall include every infant member of the species homo sapiens who is born alive at any stage of development.

(b) As used in this section, the term `born alive', with respect to a member of the species homo sapiens, means the complete expulsion or extraction from his or her mother of that member, at any stage of development, who after such expulsion or extraction breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the umbilical cord has been cut, and regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, cesarean section, or induced abortion.

(c) Nothing in this section shall be construed to affirm, deny, expand, or contract any legal status or legal right applicable to any member of the species homo sapiens at any point prior to being born alive' as defined in this section.'

(b) Clerical Amendment.--The table of sections at the beginning of chapter 1 of title 1, United States Code, is amended by adding at the end the following new item:

8. `Person', `human being', `child', and `individual' as including born-alive infant.'

###

President's Statement on House Passing Child Interstate Abortion Notification Act

April 27, 2005

I commend the House for its bipartisan vote to protect the health and safety of minors by ensuring that state parental involvement laws are not circumvented. The parents of pregnant minors can provide counsel, guidance, and support to their children, and should be involved in these decisions. I urge the Senate to pass this important legislation and help continue to build a culture of life in America.

###

Withdrawal Marker
The George W. Bush Library

FORM	SUBJECT/TITLE	PAGES	DATE	RESTRICTION(S)
Memorandum	Bioethics Agenda - To: POTUS - From: Yuval Levin	5	05/12/2005	P5;

This marker identifies the original location of the withdrawn item listed above. For a complete list of items withdrawn from this folder, see the Withdrawal/Redaction Sheet at the front of the folder.

COLLECTION:
Staff Secretary, White House Office of the

SERIES:
Von Der Heydt, Thomas (Tommy) - Bush Record Policy Memos

FOLDER TITLE:
Pro-Life Legacy: A Timeline (2001 - 2008)

FRC ID:
13894

OA Num.:
14457

NARA Num.:
14246

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the 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 advise 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 record misfile defined in accordance with 44 U.S.C. 2201(3).

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b(1) National security classified information [(b)(1) of the FOIA]
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b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

This Document was withdrawn on 4/25/2012 by MAL

For Immediate Release
Office of the Press Secretary
November 2, 2005

National Adoption Month, 2005

A Proclamation by the President the of United States of America

All children deserve strong families with mothers and fathers who are there to protect and love them. Every year, thousands of Americans extend the gift of family to a child through adoption. During National Adoption Month, we recognize the compassion of adoptive and foster families and renew our pledge to finding loving and stable homes for children in need.

Many of our citizens have revealed the good heart of America by opening their homes to children through adoption. We are grateful to every family who provides a safe, nurturing environment for their adopted children. Last year, an estimated 51,000 children were adopted from our Nation's foster care system, and tens of thousands more were adopted through private agencies and from overseas. Today, more than 118,000 children remain in foster care in the United States awaiting adoption. On November 19, National Adoption Day, thousands of these children will celebrate the finalization of their adoptions and go to their new homes, secure in the love of families they can now call their own.

My Administration remains committed to encouraging adoption. This year, 24 States, the District of Columbia, and the Commonwealth of Puerto Rico were recognized through our Adoption Incentives Program for their efforts to enhance their adoption and child welfare programs. These efforts have contributed to an increase in adoptions from 28,000 per year in 1996 to an estimated 51,000 in 2004. In addition, the AdoptUSKids initiative, which includes public service announcements in English and Spanish and a website, www.AdoptUSKids.org, has helped place more than 5,000 children in permanent homes over the last 3 years.

As we observe National Adoption Month, we recognize the many caring families who have made a difference in a child's life through adoption. By giving these children the love, guidance, and support they need to grow, adoptive and foster families play a vital role in helping the next generation of Americans achieve their dreams.

NOW, THEREFORE, I, GEORGE W. BUSH, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim November 2005 as National Adoption Month. I call on all Americans to observe this month with appropriate programs and activities to honor adoptive families and to participate in efforts to find permanent homes for waiting children.

IN WITNESS WHEREOF, I have hereunto set my hand this second day of November, in the year of our Lord two thousand five, and of the Independence of the United States of America the two hundred and thirtieth.

GEORGE W. BUSH

# # #

National Sanctity of Human Life Day, 2006

A Proclamation by the President of the United States of America

January 20, 2006

Our Nation was founded on the belief that every human being has rights, dignity, and value. On National Sanctity of Human Life Day, we underscore our commitment to building a culture of life where all individuals are welcomed in life and protected in law.

America is making great strides in our efforts to protect human life. One of my first actions as President was to sign an order banning the use of taxpayer money on programs that promote abortion overseas. Over the past 5 years, I also have been proud to sign into law the Born-Alive Infants Protection Act, the Unborn Victims of Violence Act, and a ban on partial-birth abortion. In addition, my Administration continues to fund abstinence and adoption programs and numerous faith-based and community initiatives that support these efforts.

When we seek to advance science and improve our lives, we must always preserve human dignity and remember that human life is a gift from our Creator. We must not sanction the creation of life only to destroy it. America must pursue the tremendous possibilities of medicine and research and at the same time remain an ethical and compassionate society.

National Sanctity of Human Life Day is an opportunity to strengthen our resolve in creating a society where every life has meaning and our most vulnerable members are protected and defended including unborn children, the sick and dying, and persons with disabilities and birth defects. This is an ideal that appeals to the noblest and most generous instincts within us, and this is the America we will achieve by working together.

NOW, THEREFORE, I, GEORGE W. BUSH, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim Sunday, January 22, 2006, as National Sanctity of Human Life Day. I call upon all Americans to recognize this day with appropriate ceremonies and to reaffirm our commitment to respecting and defending the life and dignity of every human being.

IN WITNESS WHEREOF, I have hereunto set my hand this twentieth day of January, in the year of our Lord two thousand six, and of the Independence of the United States of America the two hundred and thirtieth.

GEORGE W. BUSH

###

President Calls "March for Life" Participants

January 23, 2006

THE PRESIDENT: Nellie, thank you very much. I appreciate the invitation to speak. I'm calling from Manhattan, Kansas. (Applause.) Sounds like you got some good folks from Kansas there. (Applause.) I want to thank everybody there -- if you're from Kansas, or anywhere else in our country, for your devotion to such a noble cause.

You believe, as I do, that every human life has value, that the strong have a duty to protect the weak, and that the self-evident truths of the Declaration of Independence apply to everyone, not just to those considered healthy or wanted or convenient. These principles call us to defend the sick and the dying, persons with disabilities and birth defects, all who are weak and vulnerable, especially unborn children. (Applause.)

We're making good progress in defending these principles, Nellie, and you and I are working together, along with others, to build what I've called a culture of life. One of my first acts as the President was to ban the use of taxpayer money on programs that promote abortion overseas. (Applause.) I want to thank you all for getting that ban on partial-birth abortion to my desk, a bill I was proud to sign -- (applause) -- and a law which we are going to defend -- and are defending -- vigorously in our courts. Because we acted, infants who are born despite an attempted abortion are now protected by law. Thanks to "Laci and Conner's Law," prosecutors can now charge those who harm or kill a pregnant woman with harming or killing her unborn child, as well. (Applause.)

We're vigorously promoting parental notification laws, adoption, teen abstinence, crisis pregnancy programs, and the vital work of our faith-based groups. We're sending a clear message to any woman facing a crisis pregnancy: We love you, we love your child, and we're here to help you.

There's more work to be done. The House has passed a bill to ensure that state parental involvement laws are not circumvented by those who take minors across state lines to have abortions. And the United States Senate needs to pass this bill so I can sign it into law. (Applause.)

We also must respect human life and dignity when advancing medical science, and we're making progress here, as well. Last month, I signed a pro-life bill supporting ethical treatment and research using stem cells from umbilical cord blood. I also renew my call for Congress to ban all forms of human cloning. Because human life is a gift from our Creator and should never be used as a means to an end, we will not sanction the creation of life only to destroy it.

By changing laws we can change our culture. And your persistence and prayers, Nellie, and the folks there with you, are making a real difference. We, of course, seek common ground where possible; we're working to persuade more of our fellow Americans of the rightness of our cause. And this is a cause that appeals to the conscience of our citizens, and is rooted in America's deepest principles -- and history tells us that with such a cause, we will prevail.

Again, Nellie, thank you for letting me come to speak to you. Tell everybody there that I ask for God's blessings on them and their families, and, of course, may God continue to bless our grand country. (Applause.)

###

President Appreciates Senate Passage of the Child Custody Protection Act

July 25, 2006

Transporting minors across state lines to bypass parental consent laws regarding abortion undermines state law and jeopardizes the lives of young women. To combat this dangerous practice, the Senate today passed the Child Custody Protection Act, which penalizes those who unlawfully attempt to circumvent parental notification requirements.

I appreciate the Senate's efforts to preserve the integrity of state law and protect our Nation's families. I look forward to the House and Senate resolving their differences in Conference and sending this legislation for my signature.

###

For Immediate Release
Office of the Press Secretary
October 30, 2006

National Adoption Month, 2006

A Proclamation by the President of the United States of America

During National Adoption Month, we encourage the adoption of young people in need, and we honor the adoptive and foster families who have offered children a loving and supportive home.

The best of America is reflected in the many citizens who have adopted children as their own. Mothers and fathers are the most important influences in a child's life, and children with caring, involved parents can better realize the full promise of America. Parents help their children thrive by encouraging them to aim high, work hard, and make good choices that will lead to healthy, satisfying lives. On November 18, loving families across America will celebrate National Adoption Day by finalizing their adoptions of children from foster care. This day will also raise awareness of the many children still waiting to be adopted and encourage more Americans to choose adoption.

My Administration is committed to helping place children with caring families. Through the Collaboration to AdoptUsKids project at adoptuskids.org, we are working to provide guidance and support for parents considering adoption. We are also offering tax credits to ease the financial burden on adoptive families, and we are providing funding to help strengthen State adoption services through the Adoption Incentives Program and the Promoting Safe and Stable Families Program. Together, these efforts can help connect children with loving families and help provide greater hope and opportunity for America's children.

During National Adoption Month, we pay tribute to the parents who have opened their hearts and homes and helped provide love and stability for young people. By caring for the youngest members of our society, these families are helping our children grow into successful adults and building the future of our country.

NOW, THEREFORE, I, GEORGE W. BUSH, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim November 2006 as National Adoption Month. I call upon all Americans to observe this month with appropriate programs and activities to honor adoptive families and to participate in efforts to find permanent homes for waiting children.

IN WITNESS WHEREOF, I have hereunto set my hand this thirtieth day of October, in the year of our Lord two thousand six, and of the Independence of the United States of America the two hundred and thirty-first.

GEORGE W. BUSH

# # #

National Sanctity of Human Life Day, 2007

A Proclamation by the President of the United States of America

January 19, 2007

America was founded on the principle that we are all endowed by our Creator with the right to life and that every individual has dignity and worth. National Sanctity of Human Life Day helps foster a culture of life and reinforces our commitment to building a compassionate society that respects the value of every human being.

Among the most basic duties of Government is to defend the unalienable right to life, and my Administration is committed to protecting our society's most vulnerable members. We are vigorously promoting parental notification laws, adoption, abstinence education, crisis pregnancy programs, and the vital work of faith-based groups. Through the "Born-Alive Infants Protection Act of 2002," the "Partial-Birth Abortion Ban Act of 2003," and the "Unborn Victims of Violence Act of 2004," we are helping to make our country a more hopeful place.

One of our society's challenges today is to harness the power of science to ease human suffering without sanctioning practices that violate the dignity of human life. With the right policies, we can continue to achieve scientific progress while living up to our ethical and moral responsibilities.

National Sanctity of Human Life Day serves as a reminder that we must value human life in all forms, not just those considered healthy, wanted, or convenient. Together, we can work toward a day when the dignity and humanity of every person is respected.

NOW, THEREFORE, I, GEORGE W. BUSH, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim Sunday, January 21, 2007, as National Sanctity of Human Life Day. I call upon all Americans to recognize this day with appropriate ceremonies and to underscore our commitment to respecting and protecting the life and dignity of every human being.

IN WITNESS WHEREOF, I have hereunto set my hand this eighteenth day of January, in the year of our Lord two thousand seven, and of the Independence of the United States of America the two hundred and thirty-first.

GEORGE W. BUSH

###

President Bush Calls March for Life Participants

January 22, 2007

THE PRESIDENT: Yes, Nellie, thank you. (Applause.) Thank you very much, Nellie. And I want to thank everybody there for taking part in today's March for Life. I appreciate so very much the devotion to such an honorable cause, and the good work everyone is doing to defend life.

And, Nellie, it's good to hear your voice again, and I thank you very much for giving me a chance to visit with you and the crowd that is assembled there on the Mall. (Applause.)

It is important for all Americans to remember that our Declaration of Independence states that every person has the right to life, liberty, and the pursuit of happiness. (Applause.) It also states that these rights come from our Creator, and that governments are formed to secure these rights for all their citizens. And we believe every human life has value, and we pray for the day when every child is welcome in life and protected into law. (Applause.)

Nellie, I want to thank you very much, and the members of Congress there who have worked hard to make progress toward this goal over the last six years. I want the folks assembled there to know that we're making progress. We promoted adoption, support parental notification laws, ended federal funding for abortions overseas, and are funding crisis pregnancy programs. (Applause.)

I had the privilege of signing legislation that extends legal protection to children who are born, despite abortion attempts, allows prosecutors to charge those who harm or kill a pregnant woman with harming or killing her unborn child, as well. (Applause.) I signed into law a ban on the cruel practice of partial-birth abortions, and we will vigorously defend that law in the courts.

Nellie, what I'm saying is, is that we're building a culture of life here. And I want to thank you and everybody assembled for helping.

We are a caring nation, and our values should also guide us on how we harness the gifts of science. New medical breakthroughs bring the hope of cures for terrible diseases and treatments that can improve the lives of millions. Our challenge is to make sure that science serves the cause of humanity instead of the other way around. (Applause.)

Last summer I vetoed a bill that would support the taking of innocent life in the hope of finding medical benefits for others, and I have made it clear to the Congress we must pursue medical advances in the name of life, not at the expense of it. (Applause.)

As we move forward, we've all got to remember that a true culture of life cannot be built by changing laws alone. We've all got to work hard to change hearts. We will find areas where we can agree and, at the same time, work to persuade more of our fellow citizens to join this great cause. The sanctity of life is written in the hearts of all men and women. And so I say, go forth with confidence that a cause rooted in human dignity and appealing to the best instincts of our citizens cannot fail.

Again, Nellie, thank you very much. I appreciate your dedication to this important cause. I send my thanks to all there on the Mall. I ask for God's blessings on your work, and that God continue to bless our country. (Applause.)

Thank you.

###

President Bush Pleased by Supreme Court's Decision to Uphold Partial-Birth Abortion Ban

April 18, 2007

I am pleased that the Supreme Court upheld a law that prohibits the abhorrent procedure of partial-birth abortion. Today's decision affirms that the Constitution does not stand in the way of the people's representatives enacting laws reflecting the compassion and humanity of America. The partial-birth abortion ban, which an overwhelming bipartisan majority in Congress passed and I signed into law, represents a commitment to building a culture of life in America.

The Supreme Court's decision is an affirmation of the progress we have made over the past six years in protecting human dignity and upholding the sanctity of life. We will continue to work for the day when every child is welcomed in life and protected in law.

###

of the fourth provision of the Church Amendments, 42 U.S.C. 300a–7(d), in order to discriminate against certain classes of patients, including illegal immigrants, drug and alcohol users, patients with disabilities or patients with HIV, or on the basis of race or sexual preference.

Response: Comments offered a number of hypothetical situations where individual health care workers might attempt to discriminate against individuals on a variety of grounds, using provider conscience as a pretext, and have suggested that the proposed regulation would permit such activity. Many of the described hypothetical situations are vague or lack substantial detail, but to the extent that the Comments suggest that the regulation permits unlawful discrimination, we disagree. It is important to emphasize that the health care provider conscience protection provisions have existed in law for many years, and that this regulation only implements these existing requirements. As a result, there is nothing in this regulation that newly permits the types of actions described in Comments. It is also important to emphasize that the health care conscience protection laws exist as one part of a number of federal laws that address discrimination on a variety of grounds, and that the actions described in the hypothetical situations that violate federal civil rights laws, continue to violate federal civil rights laws.

We do not believe there is a conflict between the operation of health care conscience protection laws and other federal laws. Congress has enacted a network of laws that govern different activities, and we believe proper meaning can be given to all of them. There are several federal civil rights laws intended to protect individuals from discrimination in programs receiving federal financial assistance or in public accommodations based on their individual characteristics (e.g., race, color, national origin, disability, age, sex and religion). In the former, the individuals protected by these laws typically are beneficiaries of, or applicants for, services and activities provided through federally funded programs. The health care conscience protection laws have a different purpose, protecting individual health care workers and entities from discrimination in connection with particular practices such as abortion, or from compulsion to perform health care activities that they find religiously or morally objectionable. As such, these two sets of laws are intended to protect different populations and on different grounds. On their face, there is no inherent inconsistency or conflict between these laws.

How various federal laws would apply to any particular situation depends largely on the facts of the situation. Thus, it is inappropriate to make definitive statements about legal outcomes in Response to the many scenarios raised in Comments. Entities subject to these laws are responsible for ensuring against illegal discrimination in providing health care services to the public, while also protecting the conscience rights of the health care workers who are affiliated with these entities. Because these laws do not on their face conflict, we believe it is possible in most situations for entities to act without violating any applicable federal laws. In many cases, for example, entities may accommodate health care worker conscience rights—while ensuring that all eligible patients are served, including members of federally protected classes—by managing the workforce to ensure sufficient coverage.

Many of the scenarios raised in Comments involved health care workers hypothetically discriminating against particular individuals on legally impermissible grounds (e.g., race or disability). To the extent these scenarios implied that the health care conscience protection laws protect workers who object to providing services based on an individual's federally protected characteristics, we disagree. We believe such actions are outside of the scope of the health care provider conscience protections. Those laws protect health care workers' conscience rights with respect to particular actions or activities, not with respect to an individual's characteristics that are protected by federal law. To the extent there are actual conflicts between any of the health care conscience protection laws and federal civil rights laws, an entity would be required to comply with federal civil rights requirements.

Where the federal health care conscience protection laws and the civil rights laws are both conditioned on the receipt of federal funding, application of rules of statutory construction require continued compliance with federal civil rights laws. The health care conscience protection laws would not be interpreted to impliedly repeal federal civil rights requirements. Moreover, given the strong national policies embodied in federal civil rights laws that protect individuals from unlawful discrimination based on their federally protected individual characteristics, and that ensure that federally supported programs are available to all without discrimination, we believe that federal civil rights protections prevail.

Comment: A number of Comments argued that the proposed regulation would limit patient access to basic reproductive health care services, including contraceptive services. Many Comments also asserted that the proposed regulation would disproportionately affect certain sub-populations, including low-income patients, minorities, the uninsured, patients in rural areas, the Medicaid population, or other medically underserved populations. Some Comments further warned of health consequences, such as an increase in unintended pregnancy, should the proposed rule be promulgated. Finally, several Comments expressed concern that the proposed rule would limit access to emergency procedures, such as emergency contraception for rape victims, surgery for ectopic pregnancies, and other services.

Response: The Department recognizes that access to health care services is a challenge facing the entire health care system, and that it is not a challenge restricted to the context of reproductive health services. In recent years, the Department has proposed or implemented several important initiatives aimed at increasing access to quality health care, including by providing health care services for the poor, elderly and disabled; increasing access to quality medical care through expansion of the federal Community Health Center program; proposing to support and encourage States' efforts to work with the private marketplace to help ensure affordable health insurance; and supporting the enactment of proven medical liability reforms that increase patient access to quality medical care. The Department supports continuing such efforts into the future in addressing barriers to affordable, quality health care.

We disagree that this regulation would create new limitations on health care access, including basic reproductive health care services, services provided by publicly funded clinics, and health care services provided in emergency situations. First, this regulation does not expand the scope of existing federal laws, some of which have been in place for many years, protecting health care entities from discrimination on the basis of provider conscience with respect to abortion and certain other services to which a provider may have religious or moral objections. The Department has a duty to enforce these laws applying to recipients of Department funds. Even absent the issuance of this final rule,

EMTALA for many years. Thus, we do not anticipate any actual conflict between EMTALA and this regulation.

Comment: Some Comments expressed concern that this rule could interfere with existing state laws that regulate contraceptive coverage mandates in insurance policies, access to emergency contraception, and access to birth control at pharmacies. Commenters were also concerned that this regulation would impact a State's ability to enforce these laws and upset the balance that state and local laws already strike between the religious freedom of health care providers and a patient's need to access health care services.

Response: As mentioned above, this rule was issued to help define the rights and responsibilities created by the existing federal health care provider conscience protection provisions, clarify the scope of the existing protections, require certain recipients of Department funds to certify compliance with these requirements, and define certain terms for the purposes of this rule. This rule does not change federal policy regarding the conscience rights of health care providers, or create new rights, but simply seeks to ensure that recipients of Department funds are aware of the existing conditions that apply to the receipt of these funds. As such, States should already be aware of these existing protections, and should ensure that they do not take actions that would violate these established federal protections. By accepting federal funds, States accept the conditions that the Congress has imposed on the receipt of those funds. In this case, Congress has seen fit to include broad conscience protections for health care entities that apply to a wide array of Department activities. As this rule implements existing law, if States wish to adopt or enforce policies that seek to ensure that patients have proper access to health care services, they would be expected to do so, but they should avoid policies that interfere with federally protected rights, or risk the loss of federal funds. While the Department is aware that some States may have laws that, if enforced, depending on the factual circumstances, might violate these federally protected rights, the Department is not aware of any particular instance where a State has done so in an inappropriate fashion. The Department's objective is to protect the conscience rights established in federal law, not to penalize States that adopt laws that, if enforced against an objecting individual or entity, could violate federal law. The Department is committed to working cooperatively with States to help ensure that they do not violate the federal protections.

Comment: Several Comments claimed that the proposed rule is covered under existing federal laws, which makes the new proposed rule unnecessary.

Response: The Department agrees that the provider conscience regulation's purpose is to implement existing federal laws by providing definitions to clarify the scope of those laws and to adopt certification mechanisms that will be used to increase awareness of, and compliance with, those laws. For reasons stated above, the Department disagrees that the rule is unnecessary.

Comment: Several Comments noted that the rule supports the First Amendment right of freedom of religion.

Response: The Department agrees. It is clear that Congress intended these statutes—the Church Amendment in particular—to further protect, in part, the First Amendment right to free exercise of one's religion in the context of healthcare provided by recipients of Departmental funds.

Comment: Commenters claimed that the rule, if promulgated, would violate the "constitutionally protected right to choose."

Response: We disagree. The Supreme Court has read the Constitution to include rights to privacy and bodily integrity broad enough to protect a woman's choice to procure an abortion. The case law on turning this interpretation of the Constitution does not create or identify a corresponding duty on the part of any provider to be involved in the procedure in any way. In contrast, many protections, including principles established in court cases [4] and ethical principles found in State and federal laws,[5] are in place to ensure that no such duty is imposed on providers. The regulations implementing the Church Amendments, PHS Act § 245, and the Weldon Amendment merely interpret these federal health care conscience protection provisions and encourage compliance.

Comment: Comments stated that Congress upheld the access-to-care rights of pregnant women in the Education Appropriations Act beginning in 1997. The Comments declared that the proposed rule would contradict 42 CFR 59.5(a)(5), which states women are to receive "neutral, factual information and nondirective counseling, and referral upon request," regarding prenatal care and delivery, as well as adoption and termination options.

Response: The Department is unsure which provision in the Education Appropriations Act the Commenter was referencing, and cannot respond except to say that we are unaware of any federal law that imposes a positive duty on doctors to provide services to which the provider objects.

This rule is consistent with 42 CFR 59.5 with respect to an individual provider's right to refuse to counsel or refer for abortion, as explained in the preamble to the final rule that promulgated that requirement:

> The ancillary suggestion, that the requirement to provide options counseling should not apply to employees of a grantee who object to providing such counseling on moral or religious grounds, is likewise rejected. In addition to the foregoing considerations, such a requirement is not necessary. Under 42 U.S.C. 300a–7(d), grantees may not require individual employees who have such objections to provide such counseling. However, in such cases the grantee must make other arrangements to ensure that the service is available to Title X clients who desire it. 65 FR 41270, 41274 (2000).

As is always the case, requirements and prohibitions contained in a regulation cannot be enforced in derogation of conflicting statutes. Thus, under section 245 of the Public Health Service Act and the Weldon Amendment, the Department cannot and does not enforce 42 CFR 59.5(a)(5) against an otherwise eligible grantee or applicant who objects to the requirement to counsel on or refer for abortion. See *Nat'l Family Planning & Reprod. Health Ass'n v. Gonzales*, 468 F.3d 826, 828 (DC Cir. 2006) ("* * * the government notes, and plaintiff doesn't contest, that in the event of conflict the regulation must yield to a valid statute.").

Comment: A number of Comments stated that the proposed rule is unnecessary in part because of the National Research Act, which created protection within biomedical and behavioral research organizations and formed a commission to ensure these rights are protected.

Response: The Department disagrees. The Department has identified several instances that suggest that providers, employers, and employees are unaware of the protections found in federal law. Hundreds of Comments have confirmed this lack of awareness. This rule is an

[4] "If [a] hospital's refusal to perform sterilization [or, by implication, abortion] infringes upon any constitutionally cognizable right to privacy, such infringement is outweighed by the need to protect the freedom of religion of denominational hospitals 'with religious or moral scruples against sterilizations and abortions.'" Taylor v. St. Vincent's Hospital, 523 F.2d 75, 77 (9th Cir. 1975) (citations omitted).

[5] See, e.g., S.D. Codified Laws § 36–11–70 (2003); Miss. Code Ann. § 41–107–5 (2004).

important step in ensuring knowledge of, and compliance with, the provider conscience provisions found in these statutes.

Comment: One Commenter argued that the regulation was needed and there are no court rulings, including *Roe* v. *Wade* and *Planned Parenthood* v. *Casey*, 505 U.S. 833 (1992), that compel an individual or institutional health care provider to participate in the provision of abortions, so the regulation does not contradict the cases.

Response: The Department agrees. Although these cases interpret the Constitution to include a right to abortion, they do not create an affirmative duty on the part of any provider to perform or participate in the provision of such an abortion.

Comment: A Commenter cited the Supreme Court case of *Griswold* v. *Connecticut*, 381 U.S. 479 (1965), that addressed the privacy of a married couple to engage in the use of birth control versus the State's law which declared contraception illegal.

Response: The Department notes that the Supreme Court in *Griswold* affirmed a married couple's right to use contraception as against a State law that prohibited such access. It did not impose upon any provider an affirmative duty to prescribe or dispense contraception.

Comment: One Commenter stated that *Shelton* v. *University of Medicine and Dentistry of New Jersey*, 223 F.3d 220 (3d Cir. 2000), clearly shows that in times of emergency professional ethical obligations to care for the sick and injured outweigh their conscience.

Response: The Department disagrees with this reading of *Shelton*. The sole issue in that case was "whether a state hospital reasonably accommodated the religious beliefs and practices of a staff nurse who refused to participate in what she believed to be abortions." *Shelton* v. *University of Med. & Dentistry*, *223 F.3d 220, 222* (3d Cir. 2000). Her employer offered her a lateral transfer, which she refused. The court held that this offer of a lateral transfer was a reasonable accommodation under the Civil Rights Act of 1964. The court said nothing of ethical obligations to care for the sick and injured outweighing conscience.

Comment: One Commenter argued that the rule does not make clear that the providers' religious objection has to be to the activity or procedure, not to the patient and stated that in a recent decision (*North Coast Women's Care Medical Group* v. *Benitez*, 44 Cal. 4th 1145 (2008)), the California Supreme Court ruled that doctors are barred from refusing medical care to homosexuals based on the doctors' religious beliefs about homosexuals.

Response: In *Benitez*, the California Supreme Court was interpreting State, not federal, law. The Court's analysis is inapplicable to this situation. Further, the Department believes the statutes and this rule are sufficiently clear as to applicability.

Comment: One Commenter suggested that the proposed rule violates a White House directive that executive departments and agencies submit all proposed rules by June 1, 2008, except in "extraordinary circumstances." The Commenter stated the Department should explain those extraordinary circumstances or withdraw its proposal.

Response: The memorandum issued by the Chief of Staff to the President was solely for purposes of management and coordination of the Executive Branch, conferred no rights on anyone outside the Executive Branch, did not create any legal requirements, and by its own terms authorized the exercise of discretion and exceptions to timing guidelines where appropriate. The Department has solicited and carefully evaluated public Comment as required by the Administrative Procedure Act. Nothing in applicable law precluded issuance of the proposed rule, just as nothing in applicable law precludes the issuance of this final rule.

Comment: Some Comments requested that the 30-day Comment period be extended.

Response: We decline to extend the 30-day Comment period. The purpose of extending the Comment period would be to provide additional opportunity to Comment on the proposed rule. We note that, as demonstrated by the volume of Comments received by the Department, Commenters had ample opportunity to submit Comments and did so. The Department received Comments discussing a wide range of issues, including potential impact of the proposed rule, from stakeholders including hospitals, health care providers, professional associations, trade groups, advocacy organizations, private citizens, and others. The Department has had sufficient opportunity to weigh the issues posed by public Comments, including the impact of the proposed rule and its interaction with State and federal laws, and has taken such Comments into account in issuing this final rule.

Comment: One Commenter stated that the interests protected in the regulation are only specific concerns of providers in particular situations or locations, and the only thing needed to remedy the conflict is to change the situation or location to accommodate the employee.

Response: The Department agrees that employers should strive for accommodation of religious beliefs, moral convictions, or convictions against involvement in abortions or sterilizations. However, the Department believes that regulations are necessary to ensure that employers opt to accommodate their employees' objections rather than to engage in intimidation or discrimination.

Comment: One Comment asserted that HHS's concern about the development of an environment in which individuals from diverse backgrounds are discouraged from entering health care professions contrasts with the accreditation requirements of The Liaison Committee on Medical Education (LCME) and The Accreditation Council for Graduate Medical Education (ACGME). That is, these organizations have standards that are "designed to ensure that the education of physicians provides an environment that embraces a diversity of views and values for both health care providers and patients."

Response: The Department disagrees. Although the requirements are certainly useful as future physicians are educated, the Department thinks it would be uncontroversial to suggest that over time, as physicians and other professionals are trained and begin practicing medicine, their attitudes and demeanor may change. Thus, these regulations are needed to protect against coercion and discrimination across the span of a professional's education and career.

Comment: One Commenter claimed that the regulation would require the American Medical Association to rewrite its code of ethics.

Response: As noted before, this regulation simply enforces federal law. The American Medical Association code of ethics—which, in any event, does not appear to conflict with federal law—is not binding law, so it may not matter if there is a conflict. Insofar as problems may arise as a result of conflict between any code of ethics and federal law, the proper solution is to rewrite the relevant code of ethics.

Comment: One Commenter recommended that the Department set up a process by which providers ensure patients receive care from another provider when they have objections to the requested procedure.

Response: While the Department suspects that such referrals may be how many providers will handle these types of situations, it declines to impose such a requirement in the rule, since such a requirement would constitute "making arrangements for", "referring for", or

"assisting in the performance" of an abortion or other objectionable procedure in violation of the health care provider conscience protection statutes.

III. Legal Authority

On the basis of the following statutory authority, the Secretary promulgates these regulations, requiring certification of compliance with anti-discrimination statutes.

5 U.S.C. 301 empowers the head of an Executive department to prescribe regulations "for the government of his department, the conduct of its employees, the distribution and performance of its business, and the custody, use, and preservation of its records, papers, and property."

The Church Amendments, 42 U.S.C. 300a–7 (2000), prohibit recipients of Department funding under the PHS Act and several other statutes from discriminating against employees and others who participate in health service programs or research activities funded in whole or part by the Department who refuse to perform certain medical services, including sterilization, abortion, or research activities because of religious or moral beliefs. Specifically, section 300a–7(c)(1)(A) and (B) provides that recipients may not discriminate in the employment of or the extension of staff privileges to any health care professional because he refused, because of his religious beliefs or moral convictions, to perform or assist in the performance of any sterilization or abortion procedures. Section 300a–7(d) provides that no individual shall be required to perform or assist in the performance of any health service program or research activity funded in whole or part by the Department contrary to his religious beliefs or moral convictions.[4]

PHS Act § 245, 42 U.S.C. 238n (1996), prohibits the Federal government and any State or local government that receives federal financial assistance from discriminating against any health care entity (including both individual and institutional providers) on the basis that, among other things, the entity refuses to [1] receive training in abortion; [2] provide abortion training; [3] perform abortions; [4] provide referral for such abortions; and [5] provide referrals for abortion training. 42 U.S.C. 238n(a).

The Weldon Amendment, Consolidated Appropriations Act, 2008, Public Law 110–161, § 508(d), 121 Stat. 1844, 2209 (2008), prohibits a federal agency or program, or any State or local government from receiving Department funds if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

These statutory provisions require that the Department and recipients of Department funds refrain from discriminating against institutional and individual health care entities for their participation or refusal to participate in certain medical services or research activities funded by the federal government. The Department has authority to promulgate regulations to enforce these prohibitions. Finally, the Department also has the legal authority to require that recipients certify their compliance with these proposed requirements and to require their sub-recipients to likewise certify their compliance with these proposed requirements.

We respond to the Comment on the Department's legal authority to promulgate these regulations in section H (General Comments) of the Comments section above.

IV. Section-by-Section Description of the Final Rule

Section 88.1 Purpose

Proposed Rule: In the proposed rule, the "Purpose" section set forth the objective that this final rule provides for the implementation and enforcement of federal nondiscrimination statutes protecting the conscience rights of health care entities. It also states that the statutory provisions and regulations contained in this Part are to be interpreted and implemented broadly to effectuate these protections.

The Department received no Comments on this section.

Final Rule: The Department adopts this provision as recommended in the proposed rule without modification.

Section 88.2 Definitions

Assist in the Performance

Proposed Rule: The Department, in considering how to interpret the term "assist in the performance," sought to provide broad protection for individuals. At the same time, the Department sought to guard against potential abuses of these protections by limiting the definition of "assist in the performance" to only those individuals who have a reasonable connection to the procedure, health service or health service program, or research activity to which they object.

Therefore, the Department proposed to interpret this term broadly, as encompassing individuals who are members of the workforce of the Department-funded entity performing the objectionable procedure. When applying the term "assist in the performance" to members of an entity's workforce, the Department proposed that the term be limited to participation in any activity with a reasonable connection to the objectionable procedure, including referrals, training, and other arrangements for the procedure, health service, or research activity. For example, an operating room nurse would assist in the performance of surgical procedures; an employee whose task it is to clean the instruments used in a particular procedure would also be considered to assist in the performance of the particular procedure under the proposed rule.

The Department responds to Comments on the proposed definition of this term above.

[4] Section 300a–7(c)(1) provides that "[a]n entity which receives a grant, contract, loan, or loan guarantee under the [Act] * * * may [A] discriminate in the employment, promotion, or termination of employment of any physician or other health care personnel, or [B] * * * in the extension of staff or other privileges to any physician or other health care personnel * * * because he refused to perform or assist in the performance of * * * [an] abortion" on the grounds that doing so "would be contrary to his religious beliefs or moral convictions." 42 U.S.C. 300a–7(c)(1). Section 300a–7(c)(2) provides that "[a]n entity which receives * * * a grant or contract for biomedical or behavioral research under any program administered by [HHS]" may discriminate in the employment of or the extension of staff privileges to any health care professional "because he refused to perform or assist in the performance of" "any lawful health service" based on religious belief or moral conviction. 42 U.S.C. 300a–7(c)(2). Section 300a–7(d) provides that "[n]o individual [may] be required to perform or assist in the performance of any part of a health service program * * * funded in whole or in part under a program administered by the Secretary of Health and Human Services" if doing so "would be contrary to his religious beliefs or moral convictions." 42 U.S.C. 300a–7(d). Section 300a–7(e) provides that "[n]o entity that receives funding under the PHS Act from denying admission to, or otherwise discriminating against, "any applicant [including for internships and residencies] for training or study because of the applicant's reluctance * * * to counsel, suggest, recommend, assist, or in any way participate in the performance of abortion * * * contrary to or consistent with the applicant's religious beliefs or moral convictions." 42 U.S.C. 300a–7(e). In addition, section 300a–7(b) provides in part that "[t]he receipt of any grant, contract, loan, or loan guarantee under the [PHS Act] * * * by any individual or entity does not authorize any court or any public official or other public authority to require" (1) the individual to perform or assist in an abortion if it would be contrary to his/her religious beliefs or moral convictions; or (2) the entity to make its facilities available for abortions, if the performance of abortions in the facilities is prohibited by the entity on the basis of religious beliefs or moral convictions, or provide personnel for the performance of abortions if it would be contrary to the religious beliefs or moral convictions of such personnel. 42 U.S.C. 300a–7(b).

Final Rule: The Department adopts the above definition as proposed.

Health Care Entity/Entity

Proposed Rule: While both PHS Act § 245 and the Weldon Amendment provide examples of specific types of protected individuals and health care organizations, neither statute provides an exhaustive list of such health care entities. PHS Act § 245 defines "health care entity" as "includ[ing] an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions." As a matter of statutory construction as well as long-standing Departmental interpretation, the definition of "health care entity" in PHS Act § 245 also encompasses institutional entities, such as hospitals and other entities. The Weldon Amendment defines the term "health care entity" as "includ[ing] an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan." The Church Amendment does not define the term "entity," and does not use the term "health care entity."

In keeping with the definitions in PHS Act § 245 and the Weldon Amendment, the Department proposed to define "health care entity" to include the specifically mentioned types of individuals and organizations from the two statutes, as well as other types of entities referenced in the Church Amendments.

The Department responds to Comments on the proposed definition of this term above.

Final Rule: The Department adopts the proposed definition without modification. It is important to note that the Department does not intend for this to be a comprehensive list of relevant types of individuals and organizations for purposes of the regulation, but merely a list of examples.

Health Service/Health Service Program

Proposed Rule: One of the provisions in the Church Amendments uses the term "health service," another uses the term "health service program." The Church Amendments do not define those terms, nor does the Public Health Service Act define "health service program." In developing an appropriate definition for "health service program," the proposed rule looked at the Social Security Act. Section 1128B(f)(1) of the Social Security Act, 42 U.S.C. 1320a–7b(f)(1), defines a similar term, "federal health care program", as "any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government."

Building on this broad definition, it was proposed that the term "health service program" should be understood to include an activity related in any way to providing medicine, health care, or any other service related to health or wellness, including programs where the Department provides care directly (*e.g.*, Indian Health Service); programs where grants pay for the provision of health services (*e.g.*, Administration for Children and Families' programs such as the Unaccompanied Refugee Minor and the Division of Unaccompanied Children Services programs and HRSA programs such as community health centers); programs where the Department reimburses another entity that provides care (*e.g.*, Medicare); and health benefit programs where federal funds are used to provide access to health coverage (*e.g.*, SCHIP, Medicaid, and Medicare Advantage).

The Department responds to Comments on the proposed definition of this term above.

Final Rule: Upon further reflection, the Department has determined that the meaning of the term "health service" is self-evident, and so we do not adopt a definition for "health service" in this final rule.

Final Rule: The Department adopts the above definition without modification.

Individual

Proposed Rule: For the purposes of the new proposed part, the proposed rule defined "individual" to mean a member of the workforce [see definition of "workforce" below] of an entity or health care entity. One conscience clause of the Church Amendments, 42 U.S.C. 300a–7(d), provides that "[n]o individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health, Education and Welfare [Secretary of Health and Human Services] if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions." (Emphasis added.)

The Department responds to Comments on the proposed definition of this term above.

Final Rule: The Department adopts the above definition as proposed.

Instrument

Proposed Rule: The proposed rule uses the term "instrument" to mean the variety of means by which the Department conveys funding and resources to organizations, including: grants, cooperative agreements, contracts, grants under a contract, and memoranda of understanding. The proposed definition of "instrument" was intended to include all means by which the Department conveys funding and resources.

No Comments were received on the definition of this term.

Final Rule: The Department adopts the above definition without modification.

Recipient

Proposed Rule: The proposed rule defined this term to mean any entity that receives Department funds directly.

The Department responds to Comments on the proposed definition of this term above.

Final Rule: The Department adopts this definition as proposed.

Sub-recipient

Proposed Rule: The proposed rule defined this term to mean any entity that receives Department funds indirectly through a recipient or sub-recipient.

The Department responds to Comments on the proposed definition of this term above.

Final Rule: The Department adopts this definition as proposed.

Workforce

Proposed Rule: In the proposed rule we defined the term "workforce" as including employees, volunteers, trainees, and other persons whose conduct, in the performance of work for an entity, is under the control or authority of such entity, whether or not they are paid by the Department-funded entity. The definition was drawn from the "Administrative Data Standards and Related Requirements" rules implementing the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR parts 160, 162, and 164 (2008) at 45 CFR 160.103. In keeping with this definition, persons and organizations under contract with an entity, if they are under the control or authority of the entity, would be considered members of the entity's workforce.

The Department responds to Comments on the proposed definition of this term above.

Final Rule: In response to public Comments on this issue, we have provided an exclusive definition of the

term "workforce" by changing "includes" to "means" in the definition. In defining both "individual" and "workforce," the Department promulgates definitions that provide a reasonable scope for the natural persons protected by 42 U.S.C. 300a–7(d) and the corresponding provisions of these regulations. By limiting the scope of persons protected by these regulations to those who are under the control or authority of an entity that implements a health service program or research activity funded in whole or in part under a program administered by the Department, we provide the bright line necessary for Department-funded entities subject to the applicable Church Amendment provisions to set policies or otherwise take steps to secure conscience protections within the workplace and, thus, to comply with the Church Amendment and these regulations.

As indicated in the proposed rule—and consistent with the scope of the Church Amendments, which include physicians and other health care providers that have privileges with an entity receiving funding from the Department—we intended the concept of "workforce" to include physicians and other health care providers who have privileges at the entity funded by the Department. After publication of the proposed rule, it came to the Department's attention that the language of the "workforce" definition may not be clear on this issue. Accordingly, to ensure clarity on this point, we are revising the definition of "workforce" by adding at the end "or health care providers holding privileges with the entity".

Section 88.3 Applicability

Proposed Rule: The "Applicability" section of the proposed rule directs individuals and entities receiving funds from the Department to the appropriate sections of proposed section 88.4 that set forth the relevant requirements, drawn from the three statutes that form the basis of this regulation, that are applicable to them and also directed to the provisions regarding certifications that the various recipients of federal monies must provide.

Final Rule: In this final rule, we have included a technical correction in section 88.3 clarifying that educational institutions, teaching hospitals, and programs for the training of health care professionals or health care workers shall comply with section 88.4(c)(2), which prohibits discrimination against or denial of admission to applicants "because of reluctance or willingness to counsel, suggest, recommend, assist, or in any way participate in the performance of abortions or sterilizations contrary to or consistent with the applicant's religious beliefs or moral convictions" in accordance with PHS Act § 245, 42 U.S.C. 300a–7(e). Apart from this change, we have adopted this provision as recommended in the proposed rule.

Section 88.4 Requirements and Prohibitions

Proposed Rule: The "Requirements and Prohibitions" section in the proposed rule explains the obligations that the Church Amendments, PHS Act § 245, and the Weldon Amendment impose on entities which receive funding from the Department, depending on the type of entity and the program or statute under which the funding is received. These provisions are taken from the relevant statutory language and make up the elements of the certification provided by the entities. The proposed rule states that we intend for the requirements and prohibitions to be interpreted using the definitions contained in section 88.2.

Final Rule: The final rule adopts this provision without change.

Section 88.5 Written Certification of Compliance

Proposed Rule: In the "Written Certification of Compliance" section of the proposed rule, the Department proposed to require certain recipients and sub-recipients of Department funds to certify compliance with the Church Amendments, PHS Act § 245, and the Weldon Amendment, as applicable, and to provide for the affected recipients and sub-recipients requirements for collecting, maintaining, and submitting written certifications.

We are concerned that there is a lack of knowledge on the part of States, local governments, and the health care industry of the rights of health care entities created by, and the corresponding obligations imposed on the recipients of certain federal funding by, the nondiscrimination provisions. Under the proposed rule, recipients of federal funds would be required to submit their certifications directly to the Department as part of the instrument or in a separate writing signed by the recipients' officer or other person authorized to bind the recipient. They would also be required to collect and maintain certifications by sub-recipients who receive Department funds through them.

The proposed regulation would require that entities certify in writing that they will operate in compliance with the Church Amendments, PHS Act § 245, and the Weldon Amendment as applicable. Certification provides a demonstrable way of ensuring that the recipients of such funding know of, and attest that they will comply with, the applicable nondiscrimination provisions. Sub-recipients of federal funds—entities that will receive federal funds indirectly through another entity (a recipient or other sub-recipient)—would be required to provide certification as set out in the "Sub-recipient" subsection of the "Certification of Compliance" section, and submit them to the recipients through which they receive Department funds for maintenance. Although it would be collected and maintained by the recipient, this certification by sub-recipients would be a certification addressed to the Department, not to the recipients collecting the certification. Recipients would be expected to comply with requirements for retention of and access to records set forth in 45 CFR 74.53.

While all recipients and sub-recipients of Department funds are required to comply with the Church Amendments, PHS Act § 245, and the Weldon Amendment, as applicable, section 88.5(a), as proposed, would contain several important exceptions to the proposed requirement to provide the written certification, including individual physicians, physician offices, other health care practitioners, and other participants in Part B of the Medicare program; (2) physicians, physician offices, or other health care practitioners participating in Part C of the Medicare program, when such individuals or organizations are sub-recipients of Department funds through a Medicare Advantage plan; and (3) sub-recipients of State Medicaid programs (*i.e.*, any entity that is paid for services by the State Medicaid program).

While other providers participating in the Medicare program as well as State Medicaid programs would be required to submit written certification of compliance to the Department, the large number of entities included in the categories of providers listed above (e.g., individual physicians, physician offices, other health care practitioners, and sub-recipients of State Medicaid programs) would have posed significant implementation hurdles for Departmental components and programs. Furthermore, the Department believed that, due primarily to their generally smaller size, the excepted categories of recipients and sub-recipients of Department funds in the above categories would be less likely to encounter the types of issues sought to be addressed in this regulation.

However, we noted in the proposed rule that excepted providers may become subject to the proposed written certification requirement by receiving Department funds under a separate agency or program. For example, under the proposed rule, a physician office participating in Medicare Part B may become subject to the proposed written certification requirement by receiving Department funds to conduct clinical research. We noted, however, that the State Medicaid programs would be responsible for ensuring the compliance of their sub-recipients as part of ensuring that the State Medicaid program is operated consistent with applicable nondiscrimination provisions.

Final Rule: Partly in Response to suggestions received in Response to a solicitation of public Comment on this issue (see the Department Responses to the Comments on the proposed certification requirement above), HHS has determined to make further exceptions to the certification requirements in section 88.5 in the final rule. Exceptions from the written certification requirement are included for Departmental grant programs whose purpose is unrelated to health care provision, including economic assistance, and which do not involve medical research or the involvement of health care providers, and which are unlikely to involve referral for provision of health care. These programs often involve funding to States and other governments for non-health care purposes, and/or cash assistance or vouchers, rather than direct services by a funded entity, to individuals. These programs are unlikely to involve Department funds being used for medical research, the participation of health care providers or referral to health care providers. As a consequence, these programs are also unlikely to encounter the circumstances contemplated by this regulation, and therefore the assurance of compliance represented by a certification is not considered necessary by the Department for such programs. Programs excepted under this provision include certain current programs administered by the Administration for Children and Families, including Low-Income Home Energy Assistance Program, Assets for Independence, the Child Care and Development Fund, Job Opportunities for Low-Income Individuals, Mentoring Children of Prisoners, and programs overseen by the Office of Child Support Enforcement, as well as certain current programs administered by the Administration on Aging. Finally, an exception to the written certification requirement of section 88.5 has been included for Indian Tribes and Tribal Organizations when contracting with the Indian Health Service under the Indian Self-Determination and Education Assistance Act.

As stated in the proposed rule, individual Department components have been tasked with determining how best to implement the written certification requirements set out in this regulation in a way that ensures efficient program operation. To this end, Department components have been given discretion to phase in the written certification requirement by no later than the beginning of the next federal fiscal year following the effective date of the regulation.

Finally, we have reorganized the wording of the written certifications in section 88.5 for purposes of clarity and to more closely track the language of the health care conscience protection laws. Recipients are expected to comply with the records retention and access requirements in 45 CFR 74.53, 45 CFR 92.42, 45 CFR 96.30, and any other applicable requirements.

Section 88.6 Complaint Handling and Investigating

Proposed Rule: This section did not appear in the proposed rule.

Final Rule: We have included a new section 88.6 to clarify, as was stated in the preamble to the proposed rule, that the HHS Office for Civil Rights (OCR) has been designated to receive complaints of discrimination and coercion based on the health care conscience protection statutes and this regulation. OCR will coordinate handling of complaints with the staff of the Departmental programs from which the entity, with respect to which a complaint has been filed, receives funding (*i.e.*, Department funding component).

IV. Analysis of Economic Impacts

Executive Order 12866—Regulatory Planning and Review

HHS has examined the economic implications of this final rule as required by Executive Order 12866. Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity). Executive Order 12866 classifies a rule as significant if it meets any one of a number of specified conditions, including: having an annual effect on the economy of $100 million, adversely affecting a sector of the economy in a material way, adversely affecting competition, or adversely affecting jobs. A regulation is also considered a significant regulatory action if it raises novel legal or policy issues. HHS has determined that, although this final rule is not economically significant, it is a significant regulatory action as defined by Executive Order 12866.

Comment: One Comment stated that HHS did not provide an adequate cost-benefit analysis as required by E.O. 12866. The Comment pointed out that the Department concluded that the rule is a significant regulatory action but did not undertake a more formal analysis.

Response: HHS disagrees. Our conclusion, based on the analysis of impacts of the proposed rule, was that the rule was not economically significant. Therefore, the assessment of potential costs and benefits provided was sufficient to meet the requirements of the Executive Order.

Comment: Two Comments stated HHS's analysis was inadequate in that it did not consider the costs of additional health care or other impacts on patients and employers because various definitions had been broadened. Another Comment stated that HHS did not asses the effects on public health resulting from a decrease in access to care.

Response: HHS disagrees. As stated previously, the Department does not agree that the interpretation of the terms used in this rule have been broadened or that the scope of the laws were expanded. Nor does HHS agree that this rule would cause changes in staffing or other processes beyond those changes entities have already incurred in order to comply with existing statutes. This final rule does not limit patient access to health care, but rather implements existing federal laws. Thus, we have not changed our analysis in Response to this Comment.

An underlying assumption of this regulation is that the health care industry, including entities receiving Department funds, will benefit from more diverse and inclusive workforces by informing health care workers of their rights and fostering an environment in which individuals from many different faiths and philosophical backgrounds are encouraged to participate. As a result, we cannot accurately account for all of the regulation's future benefits, but the Department is confident that the future benefits will exceed the costs of complying with the regulation.

Comment: One Comment suggested that the number of affected entities suggests that the benefits will not exceed the costs of complying with the regulation. The Commenter provided no clarification and no data to support this statement.

Response: The Department has not revised its analysis in Response to this Comment.

The statutes mandating the requirements for protecting health care workers as discussed in this rule have been in effect for a number of years. Therefore, the regulatory burden associated with this rule is largely associated with the incremental costs of certifying to the Federal government and the cost of collecting and maintaining records of certification statements from sub-recipients. We estimate the universe and number of entities that would be required to certify to be 571,047 (see Table I). This estimate has been revised from the proposal to reflect new exceptions to the certification requirement for recipients of ACF, AOA, and IHS funds. We do not distinguish between recipients and sub-recipients of HHS funding. Each entity could be a recipient, a sub-recipient, or both.

TABLE—AFFECTED ENTITIES

Health care entity	Number of entities
Hospitals (less than 100 beds)[7]	2,409
Hospitals (100–200 beds)[7]	1,129
Hospitals (200–500 beds)[7]	1,160
Hospitals (more than 500 beds)[7]	244
Nursing Homes (less than 50 beds)[8]	2,388
Nursing Homes (50–99 beds)[8]	5,819
Nursing Homes (99–199 beds)[8]	6,877
Nursing Homes (more than 200 beds)[8]	1,037
Physicians Offices[9]	284,200
Offices of Other Health Care Practitioners[9][10]	115,378
Outpatient Care Centers[11][12]	26,001
Medical and Diagnostic Laboratories[13]	11,856
Home Health Care Services[13]	20,184
Pharmacies (chain and independent)[13]	58,109
Dental Schools[13]	58
Medical Schools (Allopathic)[13]	125
Medical Schools (Osteopathic)[13]	20
Nursing Schools (Licensed practical)[14]	1,138
Nursing Schools (Baccalaureate)[21]	650
Nursing Schools (Associate degree)[23]	985
Nursing Schools (Diploma)[23]	78
Occupational Therapy Schools[17]	142
Optometry Schools[17]	17
Pharmacy Schools[17]	92
Podiatry Schools[17]	7
Public Health Schools[17]	37
Residency Programs (accredited)[18]	8,494
Health Insurance Carriers and 3rd-Party Administrators[18]	4,578
Grant awards[17]	63,741
Contractors[18]	4,245
State and territorial governments	57
Total	571,347

The Department envisions three sub-categories of potential costs for recipients and sub-recipients of Department funds: (1) Direct costs associated with the act of certification; (2) Direct costs associated with collecting and maintaining certifications made by sub-recipients; and (3) Indirect costs associated with certification.

In the analysis to the proposed rule, we explained that indirect costs associated with the certification requirement might include costs for such actions as staffing/scheduling changes and internal reviews to assess compliance. We further explained that there is insufficient data to estimate the number of funding recipients not

[7] Health, United States, 2007. U.S. Dept. of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. Nov. 2007.

[8] Nursing Home Data Compendium, 2007 edition. U.S. Dept. of Health and Human Services, Centers for Medicaid and Medicare Services.

[9] See HIPAA Administrative Simplification NPRM: Modification to Medical Data Code Set Standards To Adopt ICD–10–CM and ICD–10–PCS; Proposed Rule, 73 FR 49796–49872, August 22, 2008.

[10] From the NAICS Code 6213—Office of Other Health Care Practitioners (including Chiropractors, Optometrists, non-Physician Mental Health Practitioners, Physical Occupational and Speech Therapists, Podiatrists, and all other Miscellaneous Health Care Practitioners.

[11] From the NAICS Code 6214—Outpatient Care Centers (including Family Planning Centers, Outpatient Mental Health and Substance Abuse Centers, Other Outpatient Care Centers, HMO Medical Centers, Kidney Dialysis Centers, Freestanding Ambulatory Surgical and Emergency Centers, and all Other Outpatient Care Centers.

[12] 2005 NCPA-Pfizer Digest: Total Prescription Sales Increase At Nation's Independent Pharmacies. National Community Pharmacist Association Press Release, May 12, 2005.

[13] Dental Education At A Glance, 2004. American Dental Education Association. Available at: http://www.adea.org/GPR/Documents/2004_Data/Ed_At_A_Glance.pdf.

[14] National Center for Health Workforce Analysis. U.S. Health Workforce Personal Factbook. U.S. Dept. of Health and Human Services, Health Resources and Services Administration.

[15] Number of Accredited Programs by Academic Year (7/1/2007–6/30/2008). Accreditation Council for Graduate Medical Education. Available at: http://www.acgme.org/adspublicReports/accredited_programs.asp.

[16] U.S. Department of Labor, Bureau of Labor Statistics, National Occupational Employment and Wage Estimates, May 2007.

[17] IHS Grants Statistics, 2007. Available at http://www.ihs.gov/grantsnet.

[18] General Services Administration (estimated).

currently compliant with the Church Amendments, PHS Act § 245, or the Weldon Amendment. We received no Comments indicating that there were any funding recipients not currently compliant. Therefore, we continue to assume that, because together these three federal statutes have been in existence for many years, the incremental indirect costs of certification will be minimal for Department funding recipients.

Comment: Four Commenters argued against our administrative cost estimates associated with the certification process. These Comments stated that the analysis of the proposed rule did not sufficiently account for the cost of collecting, maintaining, and submitting written certifications. However, the Comments provided no new information or data.

Response: HHS disagrees. In determining the costs associated with collecting and maintaining the certification, we reviewed the analysis and regulatory costs associated with or conducted for several other similar certification requirements for HHS programs. The Comments did not provide any new information or data nor did they suggest any activities for which we did not already account in the analysis. Thus, we have not changed the analysis in Response to these Comments.

The direct cost of certification is the cost of reviewing the certification language, reviewing relevant entity policies and procedures, and reviewing files before signing. We estimate that each of the 571,947 entities will spend an average of 30 minutes on these activities. Although some entities may need to sign a certification statement more than once, we assume that the entity will only carefully review the language, procedures and their files before signing the initial statement each year. We assume the cost of signing subsequent statements to be small. Some existing HHS certification forms specify the certification statement should be signed by the CEO, CFO, direct owner, or Chairman of the Board. According to Bureau of Labor Statistics wage data, the mean hourly wage for occupation code 11–1011, Chief Executives, is $72.77. We estimate the loaded rate to be $145.54. Thus, the cost associated with the act of certification is $41.6 million (571,947 × .5 × $145.54).

The direct cost of collecting and maintaining certifications made by sub-recipients is estimated as the labor cost. We assume that each of the 63,741 grant awardees and 4,245 contractors doing business with HHS have at least one sub-recipient. We also assume that, on average, each grant awardee and contractor will spend one hour collecting and maintaining certifications made by sub-recipients. The mean hourly wage for office and administrative support occupations, occupation code 43–0000, is $15.00, or $30 loaded. Thus the cost of collecting and maintaining records is estimated to be $2 million (67,986 entities × 1 hour × $30).

Comment: One Comment suggested the analysis should consider the legal fees likely to flow from litigation over the proposed regulations.

Response: HHS disagrees. In assessing the costs and benefits of regulations, the government assumes compliance. Thus, the amount of litigation is assumed to be minimal and very difficult to predict.

The total quantifiable costs of the regulation are estimated to be $43.6 million each year.

Congressional Review Act

The Congressional Review Act defines a "major rule" as "any rule that the Administrator of the Office of Information and Regulatory Affairs [OIRA] of the Office of Management and Budget finds has resulted in or is likely to result in—[A] an annual effect on the economy of $100,000,000 or more; [B] a major increase in costs or prices for consumers, individual industries, federal, State, or local government agencies, or geographic regions; or [C] significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic and export markets." 5 U.S.C. 804(2). Based on OMB's review of the rule under Executive Order 12866, the Administrator of OIRA has determined that this rule is not a major rule for purposes of the Congressional Review Act. This finding of the Administrator is not subject to judicial review. 5 U.S.C. 805.

Regulatory Flexibility Act

HHS has examined the economic implications of this final rule as required by the Regulatory Flexibility Act (5 U.S.C. 601–612). If a rule has a significant economic impact on a substantial number of small entities, the Regulatory Flexibility Act requires agencies to analyze regulatory options that would lessen the economic effect of the rule on small entities. This will not impose significant costs on small entities. Therefore, the Secretary certifies that this rule will not result in a significant impact on a substantial number of small entities.

Comment: One Comment suggested HHS should assess the impact on small entities who will incur costs to hire new staff and make staffing changes to accommodate objections by workforce members.

Response: HHS acknowledges that there may be indirect costs associated with the certification requirement including costs for such actions as staffing/scheduling changes and internal reviews to assess compliance. As stated in the proposed rule, there continues to be insufficient data to estimate the number of funding recipients not currently compliant with the Church Amendments, PHS Act § 245, or the Weldon Amendment. Because together these three federal statutes have been in existence for many years, we expect the incremental and indirect costs of certification to be minimal for Department funding recipients. HHS received no Comments on this assumption. Therefore, we continue to conclude that these indirect costs of certification will be minimal.

Unfunded Mandates Reform Act of 1995

Title II of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) requires cost-benefit and other analyses before any rulemaking if the rule would include a "Federal mandate that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100,000,000 or more (adjusted annually for inflation) in any 1 year." The current inflation-adjusted statutory threshold is about $115 million. HHS has determined that this final rule would not constitute a significant rule under the Unfunded Mandates Reform Act.

Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct requirement costs on state and local governments, preempts State law, or otherwise has federalism implications.

All three statutes implemented through this regulation—the Church Amendments, PHS Act § 245, and the Weldon Amendment—impose restrictions on States, local governments, and public entities receiving funds from the Department, including under certain Department-implemented statutes. Insofar as these regulations impact State and local governments in addition to those impacts caused by the statutory provisions, they do so only to the extent that States and local governments are required to submit certifications of compliance with the statutes and this

regulation, as applicable. Since we expect the recipients of Department funds to comply with existing federal law, we anticipate the impact on States and local governments of the certification requirement to be negligible.

The Department received Comments from a number of States, State officials, or components of State governments on the proposed rule. The Department considered those Comments in finalizing the rule.

Assessment of Federal Regulation and Policies on Families

Section 654 of the Treasury and General Government Appropriations Act of 1999 requires federal departments and agencies to determine whether a proposed policy or regulation could affect family well-being. If the determination is affirmative, then the Department or agency must prepare an impact assessment to address criteria specified in the law.

Comment: Several Comments disagreed with the Department's assertion in the proposed rule that the regulation will not have an impact on family well-being. Another Commentor stated that the Treasury and General Government Appropriations Act of 1999 requires the Department to determine if the proposed rule would affect family well-being. The Commentor stated that if family well-being is affected, the Department must provide an impact assessment of these effects. The Commentor also stated that the proposed rule does not adequately address the impact on family well-being.

Response: The Department disagrees. This final rule defines certain key terms, ensures that recipients of Department funds know about their legal obligations under existing federal health care provider conscience protection provisions, and requires written certification by certain recipients that they will comply with such provisions, as applicable. As stated above, the rule does not expand the scope of existing federal health care conscience protection laws, nor does it create new barriers to health care access that might have an impact on family well-being. The Department finds that this rule does not affect family well-being within the meaning of section 654 of the Treasury and General Government Appropriations Act, 1999, enacted as part of the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (Pub. L. 105–277, 112 Stat. 2681).

V. Paperwork Reduction Act of 1995

HHS received Comments on the burden associated with the written certification requirements contained in sections 88.5(a), (c) and (d) of this final rule and are therefore soliciting Comments on the information collection requirements associated with this rule, consistent with the Paperwork Reduction Act of 1995.

To obtain or retain federal funding for various activities, the Department requires the certification of all recipients and sub-recipients of Department funding. The certification and associated documents are necessary to ensure that recipients and sub-recipients of federal funds comply with federal anti-discrimination law.

Likely respondents to this certification requirement include all entities required to certify as estimated in the EO 12866 analysis listed above, which provides a high estimate of 571,947 recipients and sub-recipients. As outlined above, it will take an estimated 30 minutes for each recipient and sub-recipient to review the relevant language and provide the relevant certifications as well as, in the case of recipients, to collect and maintain certifications by sub-recipients, as applicable. The Department therefore estimates the annual aggregate burden to collect the information to be as follows:

The Department is seeking public Comments on the proposed data collection associated with this final rule through a 60-day Federal Register notice. Interested persons are invited to send Comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

This final rule becomes effective 30 days after publication. However, affected parties do not have to comply with the information collection requirements in the final rule until the Department of Health and Human Services publishes in the Federal Register the control numbers assigned by the Office of Management and Budget (OMB). Publication of the control numbers notifies the public that OMB has approved these information collection requirements under the Paperwork Reduction Act of 1995.

List of Subjects in 45 CFR Part 88

Abortion, Civil rights, Colleges and universities, Employment, Government contracts, Government employees, Grant programs, Grants administration, Health care, Health insurance, Health professions, Hospitals, Insurance companies, Laboratories, Medicaid, Medical and dental schools, Medical research, Medicare, Mental health programs, Nursing homes, Public health, Religious discrimination, Religious liberties, Reporting and recordkeeping requirements, Rights of conscience, Scientists, State and local governments, Sterilization, Students.

■ Therefore, under the Church Amendments, 42 U.S.C. 300a–7, Public Health Service Act § 245, 42 U.S.C. 238n, the Weldon Amendment, Consolidated Appropriations Act, 2008, Public Law 110–161, Div. G, § 508(d), 121 Stat. 1844, 2209, and 5 U.S.C. 301, and for the reasons set forth in the preamble, the Department of Health and Human Services is amending 45 CFR Subtitle A, Subchapter A by adding Part 88 to read as follows:

PART 88—ENSURING THAT DEPARTMENT OF HEALTH AND HUMAN SERVICES FUNDS DO NOT SUPPORT COERCIVE OR DISCRIMINATORY POLICIES OR PRACTICES

Sec.
88.1 Purpose.
88.2 Definitions.
88.3 Applicability.
88.4 Requirements and prohibitions.
88.5 Written certification of compliance.
88.6 Complaint handling and investigation.

Authority: 42 U.S.C. 300a–7, 42 U.S.C. 238n, Public Law 110–161, Div. G, § 508(d), 121 Stat. 1844, 2209, 31, 42 U.S.C. 1395w–22(j)(3)(B), 42 U.S.C. 1396u–2(b)(3), and 5 U.S.C. 301.

§ 88.1 Purpose.

The purpose of this Part is to provide for the implementation and enforcement of the Church Amendments, 42 U.S.C. 300a–7, section 245 of the Public Health Service Act, 42 U.S.C. 238n, and the Weldon Amendment, Consolidated Appropriations Act, 2008, Public Law 110–161, Div. G, § 508(d), 121 Stat. 1844, 2209 (collectively referred to as the federal healthcare conscience protection statutes). These statutory provisions protect the rights of health care entities/entities, both individuals and institutions, to refuse to perform health care services and research activities to which they may object for religious, moral, ethical, or other

reasons. Consistent with this objective to protect the conscience rights of health care entities/entities, the provisions in the Church Amendments, section 245 of the Public Health Service Act and the Weldon Amendment, and the implementing regulations contained in this Part are to be interpreted and implemented broadly to effectuate their protective purposes.

§ 88.2 Definitions.

For the purposes of this part:

Assist in the Performance means to participate in any activity with a reasonable connection to a procedure, health service or health service program, or research activity, so long as the individual involved is a part of the workforce of a Department-funded entity. This includes counseling, referral, training, and other arrangements for the procedure, health service, or research activity.

Entity includes an individual physician or other health care professional, health care personnel, a participant in a program of training in the health professions, an applicant for training or study in the health professions, a post graduate physician training program, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, laboratory or any other kind of health care organization or facility. It may also include components of State or local governments.

Health Care Entity includes an individual physician or other health care professional, health care personnel, a participant in a program of training in the health professions, an applicant for training or study in the health professions, a post graduate physician training program, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, laboratory or any other kind of health care organization or facility. It may also include components of State or local governments.

Health Service Program includes any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded, in whole or in part, by the Department. It may also include components of State or local governments.

Individual means a member of the workforce of an entity/health care entity.

Instrument is the means by which federal funds are conveyed to a recipient, and includes grants, cooperative agreements, contracts, grants under a contract, memoranda of understanding, and any other funding or employment instrument or contract.

Recipient means an organization or individual receiving funds directly from the Department or component of the Department to carry out a project or program. The term includes State and local governments, public and private institutions of higher education, public and private hospitals, commercial organizations, and other quasi-public and private nonprofit organizations such as, but not limited to, community action agencies, research institutes, educational associations, and health centers. The term may include foreign or international organizations (such as agencies of the United Nations) which are recipients, sub-recipients, or contractors or subcontractors of recipients or sub-recipients at the discretion of the Department awarding agency.

Sub-recipient means an organization or individual receiving funds indirectly from the Department or component of the Department through a recipient or another sub-recipient to carry out a project or program. The term includes State and local governments, public and private institutions of higher education, public and private hospitals, commercial organizations, and other quasi-public and private nonprofit organizations such as, but not limited to, community action agencies, research institutes, educational associations, and health centers. The term may include foreign or international organizations (such as agencies of the United Nations) which are recipients, sub-recipients, or contractors or subcontractors of recipients or sub-recipients at the discretion of the Department awarding agency.

Workforce means employees, volunteers, trainees, contractors, and other persons whose conduct, in the performance of work for a Department-funded entity, is under the control or authority of such entity, whether or not they are paid by the Department-funded entity, or health care providers holding privileges with the entity.

§ 88.3 Applicability.

(a) The Department of Health and Human Services is required to comply with sections §§ 88.4(a), (b)(1), and (d)(1) of this part.

(b) Any State or local government that receives federal funds appropriated through the appropriations act for the Department of Health and Human Services is required to comply with §§ 88.4(b)(1) and 88.5 of this part.

(c) Any entity that receives federal funds appropriated through the appropriations act for the Department of Health and Human Services to implement any part of any federal program is required to comply with §§ 88.4(b)(2) and 88.5 of this part.

(d) Any State or local government that receives federal financial assistance is required to comply with §§ 88.4(a) and 88.5 of this part.

(e) Any State or local government, any part of any State or local government, or any other public entity must comply with § 88.4(e) of this part.

(f)(1) Any entity, including a State or local government, that receives a grant, contract, loan, or loan guarantee under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Assistance and Bill of Rights Act of 2000, must comply with §§ 88.4(c)(1) and 88.5 of this part.

(2) In addition to complying with the provisions set forth in § 88.4(c)(1) of this part, any such entity that is an educational institution, teaching hospital, or program for the training of health care professionals or health care workers shall also comply with § 88.4(c)(2) of this part.

(g)(1) Any entity, including a State or local government, that carries out any part of any health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services must comply with §§ 88.4(d)(1) and 88.5 of this part.

(2) In addition to complying with the provisions set forth in (g)(1) of this section, any such entity that receives grants or contracts for biomedical or behavioral research under any program administered by the Secretary of Health and Human Services shall also comply with §§ 88.4(d)(2) of this part.

§ 88.4 Requirements and prohibitions.

(a) Entities to whom this paragraph (a) applies shall not:

(1) Subject any institutional or individual health care entity to discrimination for refusing:

(i) To undergo training in the performance of abortions, or to require, provide, refer for, or make arrangements for training in the performance of abortions;

(ii) To perform, refer for, or make other arrangements for, abortions; or

(iii) To refer for abortions;

(2) Subject any institutional or individual health care entity to discrimination for attending or having attended a post-graduate physician training program, or any other program of training in the health professions, that does not or did not require attendees to perform induced abortions or require, provide, or refer for training

in the performance of induced abortions, or make arrangements for the provision of such training;

(3) For the purposes of granting a legal status to a health care entity (including a license or certificate), or providing such entity with financial assistance, services or benefits, fail to deem accredited any postgraduate physician training program that would be accredited but for the accrediting agency's reliance upon an accreditation standard or standards that require an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether such standard provides exceptions or exemptions;

(b)(1) Any entity to whom this paragraph (b)(1) applies shall not subject any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for, abortion.

(2) Entities to whom this paragraph (b)(2) applies shall not subject any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortion, as part of the federal program for which it receives funding.

(c) Entities to whom this paragraph (c) applies shall not:

(1) Discriminate against any physician or other health care professional in the employment, promotion, termination, or extension of staff or other privileges because he performed or assisted in the performance, or refused to perform or assist in the performance of a lawful sterilization procedure or abortion on the grounds that doing so would be contrary to his religious beliefs or moral convictions, or because of his religious beliefs or moral convictions concerning abortions or sterilization procedures themselves;

(2) Discriminate against or deny admission to any applicant for training or study because of reluctance or willingness to counsel, suggest, recommend, assist, or in any way participate in the performance of abortions or sterilizations contrary to or consistent with the applicant's religious beliefs or moral convictions.

(d) Entities to whom this paragraph (d) applies shall not:

(1) Require any individual to perform or assist in the performance of any part of a health service program or research activity funded by the Department if such service or activity would be contrary to his religious beliefs or moral convictions.

(2) Discriminate in the employment, promotion, termination, or the extension of staff or other privileges to any physician or other health care personnel because he performed, assisted in the performance, refused to perform, or refused to assist in the performance of any lawful health service or research activity on the grounds that his performance or assistance in performance of such service or activity would be contrary to his religious beliefs or moral convictions, or because of the religious beliefs or moral convictions concerning such activity themselves.

(e) Entities to whom this paragraph (e) applies shall not, on the basis that the individual or entity has received a grant, contract, loan, or loan guarantee under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Assistance and Bill of Rights Act of 2000, require:

(1) Such individual to perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions, or

(2) Such entity to:

(i) Make its facilities available for the performance of any sterilization procedure or abortion if the performance of such procedure or abortion in such facilities is prohibited by the entity on the basis of religious beliefs or moral convictions, or

(ii) provide any personnel for the performance or assistance in the performance of any sterilization procedure or abortion if the performance or assistance in the performance of such procedure or abortion by such personnel would be contrary to the religious beliefs or moral convictions of such personnel.

§88.5 Written certification of compliance.

(a) *Certification Requirement.* Except as provided in paragraph (e) of this section, recipients shall include the written certifications as set forth in paragraph (c)(4) of this section in the application for the grant, cooperative agreement, contract, grant under a contract, memorandum of understanding or other funding or employment instrument or contract, as applicable. Except as provided in paragraph (e) of this section, sub-recipients must provide the Certification of Compliance as set out in paragraph (d)(3) of this section, submitted as part of the sub-recipient's original agreement with the recipient in the execution of its grant, cooperative agreement, contract, grant under a contract, memorandum of understanding or other funding instrument or contract, or in a separate writing, signed by the sub-recipient's officer or other person authorized to bind the sub-recipient. All certifications shall be addressed directly to the Department; recipients are required to submit their certifications directly to the Department. Recipients and sub-recipients shall be required to be in full compliance with all applicable certification requirements by no later than the beginning of the federal fiscal year following the effective date of this regulation.

(b) *Notification of Certification Requirement.* The Department shall notify recipients of funding of the certification requirement at the time of award through the Request for Proposal, Request for Agreement, Provider Agreement, contract, guidance, or other public announcement of the availability of funding. Recipients shall not construe anything in this paragraph to mean that an entity or organization is in any way exempt from providing the certification in the event the Department should fail to provide notification.

(c) *Certification by recipients.* (1) Except as provided in paragraph (e) of this section, all recipients through any instrument must provide the Certification of Compliance as set out in paragraph (c)(4) of this section, submitted as part of the recipient's application for the grant, cooperative agreement, contract, grant under a contract, memorandum of understanding or other funding instrument or contract or in a separate writing signed by the recipients' officer or other person authorized to bind the recipient.

(2) Recipients must file with the Department a renewed certification upon any renewal, extension, amendment, or modification of the grant, cooperative agreement, contract, grant under a contract, memorandum of understanding or other funding or employment instrument or contract that extends the term of such instrument or adds additional funds to it. Recipients that are already recipients as of the effective date of this regulation must file a certification upon any extension, amendment, or modification of the grant, cooperative agreement, contract, grant under a contract, memorandum of understanding or other funding instrument or contract that extends the term of such instrument or adds additional funds to it.

(3) Recipients shall require certifications and re-certifications by all sub-recipients that receive funding through their association with the

recipient. Recipients shall require these certifications and re-certifications as often as recipients are required to sign or amend the instrument, for as long as the relationship between the recipient and the sub-recipient lasts. Recipients shall collect and maintain sub-recipient certifications for as long as the relationship between the recipient and the sub-recipient lasts, and for a reasonable time after the relationship ends, for the purpose of investigations, litigation, or other purposes.

(4) Except as provided in paragraph (e) of this section, all recipients shall provide the following certification:

"As the duly authorized representative of the recipient I certify that the recipient of funds made available through this [instrument] will not [check all that are appropriate]:

__[if recipient is a state or local government receiving federal funds appropriated through the appropriations act for the U.S. Department of Health and Human Services] subject any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for, abortion.

__[if recipient is an entity receiving federal funds appropriated through the appropriations act for the U.S. Department of Health and Human Services to implement any part of any federal program] subject any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortion as part of the federal program for which it receives funding.

__[if recipient is a State or local government that receives federal financial assistance]

(1) Subject any institutional or individual health care entity to discrimination for refusing: (a) To undergo training in the performance of abortions, or to require, provide, refer for, or make arrangements for training in the performance of abortions; (b) to perform, refer for, or make other arrangements for, abortions; or (c) to refer for abortions.

(2) subject any institutional or individual health care entity to discrimination for attending or having attended a post-graduate physician training program, or any other program of training in the health professions, that does not or did not require attendees to perform induced abortions or require, provide, or refer for training in the performance of induced abortions, or make arrangements for the provision of such training.

(3) for the purposes of granting a legal status to a health care entity (including a license or certificate), or providing such entity with financial assistance, services or benefits, fail to deem accredited any postgraduate physician training program that would be accredited but for the accrediting agency's reliance upon an accreditation standard or standards that require an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether such standard provides exceptions or exemptions.

__[if recipient is a State or local government, any part of any State or local government, or any other public entity] on the basis that the individual or entity has received a grant, contract, loan, or loan guarantee under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Assistance and Bill of Rights Act of 2000, require such individual to perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions, or such entity to make its facilities available for the performance of any sterilization procedure or abortion if the performance of such procedure or abortion in such facilities is prohibited by the entity on the basis of religious beliefs or moral convictions, or provide any personnel for the performance or assistance in the performance of any sterilization procedure or abortion if the performance or assistance in the performance of such procedure or abortion by such personnel would be contrary to the religious beliefs or moral convictions of such personnel.

__[if recipient is any entity (including a state or local government) that receives a grant, contract, loan, or loan guarantee under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Assistance and Bill of Rights Act of 2000] discriminate against any physician or other health care professional in the employment, promotion, termination, or extension of staff or other privileges because he performed or assisted in the performance, or refused to perform or assist in the performance of a lawful sterilization procedure or abortion on the grounds that doing so would be contrary to his religious beliefs or moral convictions, or because of his religious beliefs or moral convictions concerning abortions or sterilization procedures themselves.

__[if recipient is any entity (including a state or local government) that receives a grant, contract, loan, or loan guarantee under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Assistance and Bill of Rights Act of 2000 that is an educational institution, teaching hospital, or program for the training of health care professionals or health care workers] discriminate against or deny admission to any applicant for training or study because of reluctance or willingness to counsel, suggest, recommend, assist, or in any way participate in the performance of abortions or sterilizations contrary to or consistent with the applicant's religious beliefs or moral convictions.

__[if recipient is an entity, including a State or local government, that carries out any part of any health service program or research activity funded in whole or in part under a program administered by the U.S. Secretary of Health and Human Services] require any individual to perform or assist in the performance of any part of a health service program or research activity funded by the U.S. Department of Health and Human Services if such service or activity would be contrary to his religious beliefs or moral convictions.

__[if recipient is an entity that receives grants or contracts for biomedical or behavioral research under any program administered by the U.S. Secretary of Health and Human Services] discriminate in the employment, promotion, termination, or the extension of staff or other privileges to any physician or other health care personnel because he performed, assisted in the performance, refused to perform, or refused to assist in the performance of any lawful health service or research activity on the grounds that his performance or assistance in performance of such service or activity would be contrary to his religious beliefs or moral convictions, or because of the religious beliefs or moral convictions concerning such activity themselves."

__[All recipients] I further certify that the recipient acknowledges that any violation of these certifications may result in termination by the Department of any grant, cooperative agreement, contract, grant under a contract, memorandum of understanding or other funding or employment instrument or contract prior to the end of its term and recovery of appropriated funds expended prior to termination, and may be used as such at the Department's discretion. I further certify that, except as provided in 45 CFR 88.5(e), the recipient will include this certification requirement in any [instrument] to a sub-recipient of funds made available under this instrument, and will require, except as provided in 45 CFR 88.5(e), such sub-recipient to provide the same certification that the recipient organization or entity provided. I further certify the recipient organization will collect and maintain sub-recipient certifications for as long as the relationship between the recipient and the sub-recipient lasts, and for a reasonable time after the relationship ends, for the purpose of investigations, litigation, or other purposes."

(d) *Certification by Sub-recipients.* (1) Except as provided in paragraph (e) of this section, organizations or entities that are sub-recipients of the organization or entity providing the Initial Certification of Compliance must submit to the recipient for maintenance by the recipient through which the sub-recipient receives Department funds Certification of Compliance as set out in paragraph (d)(3) of this section, as part of the grant, cooperative agreement,

contract, grant under a contract, memorandum of understanding or other funding instrument or contract between the recipient and the sub-recipient or in a separate writing signed by the sub-recipients' officer or other person authorized to bind the sub-recipient.

[2] Except as provided in paragraph [e] of this section, sub-recipients of funds shall renew certification to the recipient through which it receives Department funds upon any renewal, extension, amendment, or modification of the grant, cooperative agreement, contract, grant under a contract, memorandum of understanding or other funding or employment instrument or contract that extends the term of such instrument or adds additional funds to it. Sub-recipients shall submit such renewals to the recipient entities through which they receive Department funding. Entities that are already sub-recipients as of the effective date of this regulation must certify upon any extension, amendment, or modification of the grant, cooperative agreement, contract, grant under a contract, memorandum of understanding or other funding instrument or contract that extends the term of such instrument or adds additional funds to it, and shall submit such certifications to the recipient entity through which they receive Department funding.

[3] Except as provided in paragraph [e] of this section, all sub-recipients of Department funds shall provide the following certification:

"As the duly authorized representative of the sub-recipient I certify that the sub-recipient of funds made available through this [instrument] will not [check all that are appropriate]:

__[if sub-recipient is a State or local government receiving federal funds appropriated through the appropriations act for the U.S. Department of Health and Human Services] subject any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for, abortion.

__[if sub-recipient is an entity receiving federal funds appropriated through the appropriations act for the U.S. Department of Health and Human Services to implement any part of any federal program] subject any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortion as part of the federal program for which it receives funding.

__[if sub-recipient is a State or local government that receives federal financial assistance]

[1] Subject any institutional or individual health care entity to discrimination for refusing: (a) To undergo training in the performance of abortions, or to require, provide, refer for, or make arrangements for training in the performance of abortions; (b) to perform, refer for, or make other arrangements for, abortions; or (c) to refer for abortions.

[2] subject any institutional or individual health care entity to discrimination for attending or having attended a post-graduate physician training program, or any other program of training in the health professions, that does not or did not require attendees to perform induced abortions or require, provide, or refer for training in the performance of induced abortions, or make arrangements for the provision of such training.

[3] for the purposes of granting a legal status to a health care entity (including a license or certificate), or providing such entity with financial assistance, services or benefits, the recipient will not fail to deem accredited any postgraduate physician training program that would be accredited but for the accrediting agency's reliance upon an accreditation standard or standards that require an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether such standard provides exceptions or exemptions.

__[if sub-recipient is a State or local government, any part of any State or local government, or any other public entity] on the basis that the individual or entity has received a grant, contract, loan, or loan guarantee under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Assistance and Bill of Rights Act of 2000, require such individual to perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions, or such entity to make its facilities available for the performance of any sterilization procedure or abortion if the performance of such procedure or abortion in such facilities is prohibited by the entity on the basis of religious beliefs or moral convictions, or provide any personnel for the performance or assistance in the performance of any sterilization procedure or abortion if the performance or assistance in the performance of such procedure or abortion by such personnel would be contrary to the religious beliefs or moral convictions of such personnel.

__[if sub-recipient is an entity (including a state or local government) that receives these funds through a recipient which received them through a grant, contract, loan, or loan guarantee under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Assistance and Bill of Rights Act of 2000] discriminate against any physician or other health care professional in the employment, promotion, termination, or extension of staff or other privileges because he performed or assisted in the performance, or refused to perform or assist in the performance of a lawful sterilization procedure or abortion on the grounds that doing so would be contrary to his religious beliefs or moral convictions, or because of his religious beliefs or moral convictions concerning abortions or sterilization procedures themselves.

__[if sub-recipient is any entity (including a State or local government) that receives these funds through a recipient which received them through a grant, contract, loan, or loan guarantee under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Assistance and Bill of Rights Act of 2000 that is an educational institution, teaching hospital, or program for the training of health care professionals or health care workers] discriminate against or deny admission to any applicant for training or study because of reluctance or willingness to counsel, suggest, recommend, assist, or in any way participate in the performance of abortions or sterilizations contrary to or consistent with the applicant's religious beliefs or moral convictions.

__[if sub-recipient is an entity (including a State or local government) that carries out any part of any health service program or research activity funded in whole or in part under a program administered by the U.S. Secretary of Health and Human Services] requires any individual to perform or assist in the performance of any part of a health service program or research activity funded by the U.S. Department of Health & Human Services if such service or activity would be contrary to his religious beliefs or moral convictions.

__[if sub-recipient is an entity that these funds through a recipient which received them through receives grants or contracts for biomedical or behavioral research under any program administered by the U.S. Secretary of Health and Human Services] discriminate in the employment, promotion, termination, or the extension of staff or other privileges to any physician or other health care personnel because he performed, assisted in the performance, refused to perform, or refused to assist in the performance of any lawful health service or research activity on the grounds that his performance or assistance in performance of such service or activity would be contrary to his religious beliefs or moral convictions, or because of the religious beliefs or moral convictions concerning such activity themselves."

[All sub-recipients] I further certify that the sub-recipient acknowledges that these certifications by the sub-recipient of funds are certifications made directly to the Department and that any violation of these certifications may result in termination by the Department of the recipient's grant, cooperative agreement, contract, grant

under a contract, memorandum of understanding or other funding or employment instrument or contract prior to the end of its term and recovery of appropriated funds expended prior to termination, and may be used as such at the Department's discretion. I further certify that the sub-recipient will submit all certifications to the recipient entity through which it received Department funds."

(e) *Exceptions.* Provided that such individuals or organizations are not recipients or sub-recipients of Department funds through another instrument, program, or mechanism, other than those set forth in paragraph (a)(1) through (a)(5) of this section, the following individuals or organizations shall not be required to comply with the written certification requirements set forth in this section:

(1) A physician, as defined in 42 U.S.C. 1395(r), physician office, or other health care practitioner participating in Part B of the Medicare program;

(2) A physician, as defined in 42 U.S.C. 1395(r), physician office, or other health care practitioner which participates in Part C of the Medicare program, when such individuals or organizations are sub-recipients of Department funds through a Medicare Advantage plan;

(3) A sub-recipient of Department funds through a State Medicaid program;

(4) A recipient or sub-recipient of Department funds awarded under certain grant programs currently administered by the Administration for Children and Families, whose purpose is either solely financial assistance unrelated to health care or which is otherwise unrelated to health care provision, and which, in addition, does not involve—

(i) Medical or behavioral research;

(ii) The involvement of health care providers;

(iii) Any significant likelihood of referral for the provision of health care; and

(5) A recipient or sub-recipient of Department funds awarded under certain grant programs currently administered by the Administration on Aging, whose purpose is either solely financial assistance unrelated to health care or which is otherwise unrelated to health care provision, and which, in addition, does not involve—

(i) Medical or behavioral research;

(ii) The involvement of health care providers;

(iii) Any significant likelihood of referral for the provision of health care; and

(6) Indian Tribes and Tribal Organizations when contracting with the Indian Health Service under the Indian Self-Determination and Education Assistance Act.

§88.6 Complaint handling and investigating.

The Office for Civil Rights (OCR) of the Department of Health and Human Services has been designated to receive complaints of discrimination and coercion based on the health care conscience protection statutes and this regulation. OCR will coordinate handling of complaints with the staff of the Departmental programs from which the entity, with respect to which a complaint has been filed, receives funding (i.e., Department funding component).

Dated: December 5, 2008.

Michael O. Leavitt,

Secretary.

[FR Doc. E8–30134 Filed 12–18–08; 8:45 am]

BILLING CODE 4150–38–P

Letter to Congressional Leaders on Pro-Life Issues

May 3, 2007

TBD, 2007

Dear Madame Speaker / Minority Leader Boehner / Reid / McConnell:

I am concerned that this year Congress may consider legislation that could substantially change Federal policy on abortion, and allow taxpayer dollars to be used for the destruction of human life. I am writing to make sure there is no misunderstanding of my views on these important issues.

Our nation was founded on the belief that every human being has rights, dignity, and matchless value. Every child should be welcomed into life and protected in law. The advancement of science and medicine need not conflict with the ethical imperative to cherish and protect every life. In fact, advances in science have made it possible to see life developing at earlier stages and underscore Americans' obligation to protect helpless and innocent life from destruction, whether it is in the womb or elsewhere. These issues are deeply emotional and are made even more complicated when the American taxpayer is asked to fund efforts that end human life.

As you know, current law prohibits federal funding for abortion, both domestically and internationally, except in cases of rape, incest, or where the life of the mother is endangered. Recent legislative practice has ensured that taxpayer funds do not underwrite organizations that perform or promote abortion as a method of family planning. Current U.S. law protects human embryos. The standing pattern is that appropriate conscience protections must be in place for health care entities, and that taxpayer dollars may not be used in coercive or involuntary family planning programs.

I urge that these and other existing, important protections be respected and continued. I believe it is the most basic duty of Government to guard the innocent. With that in mind, I will veto any legislation that weakens current Federal policies and laws on abortion, or that encourages the destruction of human life at any stage.

Sincerely,

George W. Bush

THE WHITE HOUSE

WASHINGTON

May 3, 2007

Dear Madam Speaker:

I am concerned that this year the Congress may consider legislation that could substantially change Federal policies and laws on abortion, and allow taxpayer dollars to be used for the destruction of human life. I am writing to make sure that there is no misunderstanding of my views on these important issues.

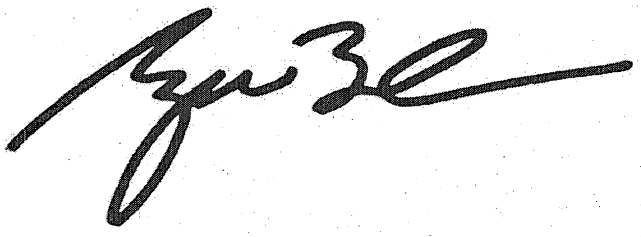
Our Nation was founded on the belief that every human being has rights, dignity, and matchless value. Every child should be welcomed into life and protected in law. The advancement of science and medicine need not conflict with the ethical imperative to cherish and protect every life. In fact, advances in science have made it possible to see life developing at earlier stages and underscore Americans' obligation to protect helpless and innocent life from destruction, whether it is in the womb or elsewhere. These issues are deeply emotional and are made even more complicated when the American taxpayer is asked to fund efforts that end human life.

As you know, current law prohibits Federal funding for abortion, both domestically and internationally, except in cases of rape, incest, or where the life of the mother is endangered. Recent legislative practice has ensured that taxpayer funds do not underwrite organizations that perform or promote abortion as a method of family planning. Current U.S. law protects human embryos. The standing pattern is that appropriate conscience protections must be in place for health care entities, and that taxpayer dollars may not be used in coercive or involuntary family planning programs.

to the Speaker of the House and
Majority Leader of Senate by WH Leg Affairs 5-5-07 E

I urge that these and other existing, important protections be respected and continued. I believe it is the most basic duty of Government to guard the innocent. With that in mind, I will veto any legislation that weakens current Federal policies and laws on abortion, or that encourages the destruction of human life at any stage.

Sincerely,



The Honorable Nancy Pelosi
Speaker of the
House of Representatives
Washington, D.C. 20515

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For Immediate Release
Office of the Press Secretary
October 31, 2007

National Adoption Month, 2007

A Proclamation By the President of the United States of America

During National Adoption Month, we recognize the adoptive and foster families who have shared their homes and hearts with children in need, and we encourage more Americans to consider adopting young people of all ages.

Families who adopt show the generous spirit of our Nation. Every child desires a permanent home, and when parents adopt a child to love as their own, lives are forever changed. For parents, the decision to adopt a child is among life's greatest and happiest turning points. On November 17, families across the country will celebrate National Adoption Day by finalizing their adoptions, and each one of these homes will be richer for the addition of new family members.

My Administration is committed to promoting adoption of children of all ages. We are working to bring together more children with loving, adoptive parents through the Collaboration to AdoptUsKids at adoptuskids.org and by providing States with financial assistance through the Adoption Incentives Program. The Promoting Safe and Stable Families Program helps improve care and services to children and families and ensure more young people in America have a caring, secure, and permanent home. Together, these efforts are building a brighter future for our youth.

During National Adoption Month, we honor adoptive and foster parents as they raise children of conviction and character. By accepting the gift of these children, parents are helping shape lives and contributing to the strength of our great Nation.

NOW, THEREFORE, I, GEORGE W. BUSH, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim November 2007 as National Adoption Month. I call upon all Americans to observe this month with appropriate programs and activities to honor adoptive families and to participate in efforts to find permanent homes for waiting children.

IN WITNESS WHEREOF, I have hereunto set my hand this thirty-first day of October, in the year of our Lord two thousand seven, and of the Independence of the United States of America the two hundred and thirty-second.

GEORGE W. BUSH

# # #

THE WHITE HOUSE

WASHINGTON

November 15, 2007

ACTION

President sgd per WH Executive Clerk AGS 11/16

MEMORANDUM FOR THE PRESIDENT

THROUGH: THE EXECUTIVE CLERK

FROM: STEVE HADLEY

SUBJECT: Ratification of the Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption

Purpose

To ratify the Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption, signed on March 31, 1994.

Background

The United States participated actively in the negotiation and adoption of the Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption, and signed the Convention on March 31, 1994. The Convention provides a framework for the adoption of children habitually resident in one Contracting State by persons habitually resident in another Contracting State. It establishes procedures to be followed in such adoption cases and mandates safeguards to protect the best interests of the children at issue. The Convention also provides for the recognition in all other Contracting States of adoptions that fall within its scope.

The Senate gave its advice and consent to ratification of the Convention on September 20, 2000, and implementing legislation for the Convention (the Intercountry Adoption Act of 2000) was signed into law on October 6, 2000, by President Clinton. The State Department has promulgated the necessary regulations and taken other actions necessary to implement the Convention. With

cc: Vice President
Chief of Staff
Assistant to the Vice President for National Security Affairs

your signature, the United States will be in a position to deposit its instrument of ratification with the Government of the Netherlands, the designated depositary.

The Domestic Policy Council has requested that you sign the instrument of ratification by the morning of November 16 (prior to your afternoon remarks on National Adoption Day).

Concurrence: NSC/Legal

RECOMMENDATION

That you sign the instrument of ratification of the Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption at Tab A.

Prepared by: Chris Camponovo
Reviewed by: Mike Kozak

Attachments
Tab A Instrument of Ratification (in duplicate)
Tab B Incoming Correspondence

GEORGE W. BUSH

President of the United States of America

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETING:

CONSIDERING THAT:

The Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption was adopted at the Seventeenth Session of the Hague Conference on Private International Law at The Hague on May 29, 1993, and was signed on behalf of the United States of America on March 31, 1994; and

The Senate of the United States of America by its resolution of September 20, 2000, two-thirds of the Senators present concurring therein, gave its advice and consent to ratification of the Convention subject to the following declarations:

(1) NON-SELF EXECUTING CONVENTION. -- The United States declares that the provisions of Articles 1 through 39 of the Convention are not self-executing.

(2) PERFORMANCE OF REQUIRED FUNCTIONS. -- The United States declares, pursuant to Article 22(2), that in the United States the Central Authority functions under Articles 15-21 may also be performed by bodies or persons meeting the requirements of Articles 22(2)(a) and (b). Such bodies or persons will be subject to federal law and regulations implementing the Convention as well as state licensing and other laws and regulations applicable to providers of adoption services. The performance of Central Authority functions by such approved adoption service providers would be subject to the supervision of the competent federal and state authorities in the United States.

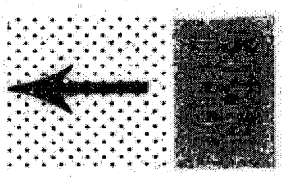
NOW, THEREFORE, I, George W. Bush, President of the United States of America, ratify and confirm the said Convention, subject to the aforesaid declarations.

IN TESTIMONY WHEREOF, I have signed this instrument of ratification and caused the Seal of the United States of America to be affixed.

DONE at the city of Washington

our Lord two thousand

Independence of the United States of America the two hundred thirty-second.



By the President:

By the Secretary of State:

7725

S/ES 200718281

United States Department of State

Washington, D.C. 20520

www.state.gov

November 2, 2007

UNCLASSIFIED

MEMORANDUM FOR JOHN I. PRAY, JR., BRIG GEN, USAF
DEPUTY EXECUTIVE SECRETARY
NATIONAL SECURITY COUNCIL

SUBJECT: Ratification of the Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption

Attached for signature by the President is the instrument of ratification, in duplicate, of the Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption, adopted at the Seventeenth Session of the Hague Conference on Private International Law at The Hague on May 29, 1993, and signed by the United States on March 31, 1994.

The Convention provides a framework for the adoption of children habitually resident in one Contracting State by persons habitually resident in another Contracting State. It establishes procedures to be followed in such adoption cases and mandates safeguards to protect the best interests of the children at issue. The Convention also provides for the recognition in all other Contracting States of adoptions that fall within its scope.

The United States participated actively in the negotiation and adoption of the Convention.

The Senate gave its advice and consent to ratification of the Convention on September 20, 2000. The resolution of advice and consent is subject to six declarations. The Senate resolution calls for two of the declarations to be included in the instrument of ratification to be signed by the President. Four of the declarations are of a domestic nature and, like similar declarations to other treaties, are not included in the instrument to be signed by the President.

The Department of State is the designated Central Authority for the United States under Article 6 of the Convention.

Implementing legislation for the Convention was signed on October 6, 2000 (P.L. 106-279), by then President Clinton, and the necessary regulations have been promulgated. The State Department has also designated two accrediting entities and will be prepared to announce before the U.S. effective date of the Convention the accreditation or approval of more than 38 adoption service providers. Thus, upon ratification by the President, the United States will be in a position to deposit its instrument of ratification with the Government of the Netherlands, the designated depositary.

The Convention entered into force internationally on May 1, 1995. The Convention will enter into force for the United States on the first day of the month following the expiration of three months after the deposit of its instrument of ratification.

Daniel B. Smith
Executive Secretary

Attachment:
Instrument of Ratification (in duplicate).

105TH CONGRESS
2d Session

SENATE

TREATY DOC.
105–51

CONVENTION ON PROTECTION OF CHILDREN AND CO-OPERATION IN RESPECT OF INTERCOUNTRY ADOPTION

MESSAGE

FROM

THE PRESIDENT OF THE UNITED STATES

TRANSMITTING

CONVENTION ON PROTECTION OF CHILDREN AND CO-OPERATION IN RESPECT OF INTERCOUNTRY ADOPTION, ADOPTED AND OPENED FOR SIGNATURE AT THE CONCLUSION OF THE SEVENTEENTH SESSION OF THE HAGUE CONFERENCE ON PRIVATE INTERNATIONAL LAW ON MAY 29, 1993

JUNE 11, 1998.—Convention was read the first time and, together with the accompanying papers, referred to the Committee on Foreign Relations and ordered to be printed for the use of the Senate

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U.S. GOVERNMENT PRINTING OFFICE
69-118 WASHINGTON : 1998

106TH CONGRESS, 2d Session | SENATE | EXEC. RPT. 106-14

CONVENTION ON PROTECTION OF CHILDREN AND CO-OPERATION IN RESPECT OF INTERCOUNTRY ADOPTION

APRIL 27, 2000.—Ordered to be printed

Mr. HELMS, from the Committee on Foreign Relations, submitted the following

REPORT

[To accompany Treaty Doc. 105-51]

The Committee on Foreign Relations, to which was referred the Convention on Protection of Children And Co-operation in Respect of Intercountry Adoption, adopted and opened for signature at the conclusion of the Seventeenth Session of The Hague Conference on Private International Law on May 29, 1993 (Treaty Doc. 105-51), having considered the same, reports favorably thereon, with six declarations, and recommends that the Senate give its advice and consent to the ratification thereof as set forth in this report and the accompanying resolution of ratification.

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I. PURPOSE

The Convention on Protection of Children And Co-operation in Respect of Intercountry Adoption (hereinafter, the "Hague Convention" or "Hague Convention on Intercountry Adoption") is intended to protect the rights of, and prevent abuses against, children, birth families, and adoptive parents involved in adoptions (or prospective adoptions) subject to the Convention, and to ensure that such adoptions are in the children's best interests. It is also intended to im-

79-118

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FORM	SUBJECT/TITLE	PAGES	DATE	RESTRICTION(S)
Talking Points	Press Points	1	N.D.	P5;

This marker identifies the original location of the withdrawn item listed above. For a complete list of items withdrawn from this folder, see the Withdrawal/Redaction Sheet at the front of the folder.

COLLECTION:
Staff Secretary, White House Office of the

SERIES:
Von Der Heydt, Thomas (Tommy) - Bush Record Policy Memos

FOLDER TITLE:
Pro-Life Legacy: A Timeline (2001 - 2008)

FRC ID:
13894

OA Num.:
14457

NARA Num.:
14246

RESTRICTION CODES

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This Document was withdrawn on 4/25/2012 by MAL

For Immediate Release
Office of the Press Secretary
November 16, 2007

President Bush and Mrs. Bush Mark National Adoption Day

East Room

2:22 P.M. EST

MRS. BUSH: Welcome to the White House. Thank you for coming today to celebrate National Adoption Day. Today is a chance to thank both the parents who give children life -- and the parents who give children love.

Every year in the United States, more than 150,000 children are welcomed into adoptive families. Some of these children come from foster care. Others are adopted by relatives. These children are born into many different communities across our country, and in many different countries around the world. All of these children share one destination: the waiting arms of loving parents.

Adoption is a hopeful act. It recognizes that every child has limitless potential for success, and limitless capacity for love. It's an act that's brought joy to millions of American families -- including ours. President Bush and I are the proud adoptive aunt and uncle of a niece and nephew.

As a mom and a teacher -- and from the young people I've met across the United States -- I know how important it is for children to grow up in positive, healthy homes. All children need love and support. And children with special needs, and children in foster care, are especially hungry for the love and stability that permanent families provide.

National Adoption Day reminds people across the United States of the more than 500,000 children who are in foster care. These children wait an average of three years in the system before finding families -- and many may never find families at all. According to a national survey, four out of every 10 Americans has considered adoption. If just one out of every 500 Americans adopted from the foster care system, every child in foster care would have a home.

Across our country, many people are working to raise awareness of adoption, and to make the process of adoption easier for parents and children. They take boys and girls who want to be sons and daughters, men and women who want to be moms and dads, and bring them together as families. These adoption advocates include judges, attorneys, child welfare workers, federal officials -- and many of the people in this room. I'm proud that one of them is my husband. Ladies and gentlemen, President George W. Bush. (Applause.)

THE PRESIDENT: Nice line of work when you get introduced by your wife. (Laughter.) Laura and I are sure glad you're here. I want to welcome members of the Congress, senators and members of the House. Thank you all for coming. You're kind to take time to join our honored guests. We're really glad you're here in the White House. And we're pleased to join you on National Adoption Day. We offer a special welcome to the youngsters who have joined us. We're glad you all are here. You've just got to know this is the people's house. And I know you took time off from school to be here today. (Laughter.) And I thank you for making such a difficult sacrifice. (Laughter.)

I thank the members of the National Adoption Day Coalition who have joined us. Few missions in life are more rewarding than uniting loving children with moms and dads for the very first time. Each of you has known this blessing. That's got to make you feel good in your soul. You've shared it with others, and in so doing, you've strengthened what is the very foundation of our country, and that is the American family. I want to thank you for being part of something that is so remarkable and so special.

It is fitting that we celebrate this day in a room honoring George Washington, or as some like to say, the original "George W." (Laughter and applause.) There he is. He raised four children who were not his by birth. He cared for them, provided for them, and he offered them advice -- even when they didn't want it.

(Laughter.) When one of his boys went off to college, Washington did what many parents do -- he checked up on him. And in 1798, he sent the young man a letter. It said: "I have, with much surprise, been informed of your devoting much time to a certain young lady." And he went on to advise that "your application to books is not [what] it ought to be." Well, some parents here today may be able to relate to this. It's probably hard to believe, but there was even a time when my Dad -- (laughter) -- felt compelled to write such a letter. (Laughter.)

Since Washington's time, this house has known many leaders who understood that not every family is defined by biology. A true family is defined by love. Around the corner, for example, is a portrait of a proud adopted son named Gerald R. Ford. A few steps away is the portrait of a proud adoptive father named Ronald Reagan. Close by is a proud grandfather of two adopted grandchildren, George H. W. Bush. And here in this room are children who have strengthened families, and enriched communities, and warmed hearts. You are the living reminders that adoptions are stories of celebration, stories of hope, and stories of love.

National Adoption Day also reminds us that not every child finds this happy ending. Each year, more than 100,000 foster children await adoption, and too many children will not find a permanent home. And so on this National Adoption Day, we remind our fellow citizens there's still plenty of acts of love to be done. Many people have worked with courts, and foster homes, and social workers to change that -- and our government has tried to help.

That's why I'm so proud members of Congress are here. We have joined with community- and faith-based organizations to raise public awareness of foster children awaiting adoption. And we worked with the Congress to assist families to overcome financial barriers to adopting children. Nothing is more vital to this country's future than helping young people find the love, stability, and support from families.

There's a man here, I told him -- I warned him I was going to talk about him, and that's a fellow named Tom Wollack. I want my fellow citizens who may be listening to hear this story: Tom has much to be proud of. He served our country in Vietnam, he's a New York City fire fighter. By the way, nothing finer than being a New York City fire fighter. He rushed to the scene of the World Trade Center on September the 11th, 2001. While others were leaving, he's a bunch of them that went in.

Yet at the top of his list of achievements are his seven children. Three were foster children that Tom later adopted. They're here -- two college and one soon-to-be college attendee. They were born to parents struggling with drug addiction. Today they are deeply loved members of the Wollack family. He calls his family his foundation -- and that foundation is here today, right here in the White House. We want to thank you for coming. I thank you for being a loving soul and truing -- showing our nation the true meaning of "family." Thank you, Tom.

Each of the families here has shown the world the depth and wonder of the human heart. And because of people like you, this Thanksgiving holiday will be particularly special for thousands of families in thousands of homes. Many children will be giving thanks for being part of a family they never thought they would have. Many parents will look across the table at children who once were strangers and who are now priceless treasures in their lives.

To the parents here today, please know how grateful we are that you have taken children in need of a hopeful start in life and made them your own. And to the young people here today, always remember that you are special not only because of what your parents have given you, but because of the love and joy you have given them. So thankful that the parents and children here today have found the gift of one another. And I am encourage our citizens across the land to explore adoption, look into the joys of adoption, and provide love for somebody who needs it.

I want to thank you all for coming. May God bless you and your families. May God bless our country. And now I'd ask the talented Rodney Atkins to come up here and perform some songs for us to celebrate this special day. God bless you.

END 2:33 P.M. EST ###

National Sanctity of Human Life Day, 2008

A Proclamation by the President of the United States of America

January 18, 2008

On National Sanctity of Human Life Day, we recognize that each life has inherent dignity and matchless value, and we reaffirm our steadfast determination to defend the weakest and most vulnerable members of our society.

America was founded on the belief that all men are created equal and have an inalienable right to life, liberty, and the pursuit of happiness, and our country remains committed to upholding that founding principle. Since taking office, I have signed legislation to help protect life at all stages, and my Administration will continue to encourage adoption, fund abstinence education and crisis pregnancy programs, and support faith-based groups. Today, as our society searches for new ways to ease human suffering, we must pursue the possibilities of science in a manner that respects the sacred gift of life and upholds our moral values.

Our Nation has made progress in its efforts to protect human life, and we will strive to change hearts and minds with compassion and decency. On National Sanctity of Human Life Day and throughout the year, we help strengthen the culture of life in America and work for the day when every child is welcomed in life and protected in law.

NOW, THEREFORE, I, GEORGE W. BUSH, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim Sunday, January 20, 2008, as National Sanctity of Human Life Day. I call upon all Americans to recognize this day with appropriate ceremonies and to underscore our commitment to respecting and protecting the life and dignity of every human being.

IN WITNESS WHEREOF, I have hereunto set my hand this eighteenth day of January, in the year of our Lord two thousand eight, and of the Independence of the United States of America the two hundred and thirty-second.

GEORGE W. BUSH

###

President Bush Speaks to March for Life Rally Participants

East Room

January 22, 2008

THE PRESIDENT: Nellie, good to be with you -- we're fellow West Texans who care deeply about the value of human life. Other members of the board of directors for the March for Life, leaders of the pro-life community, and all those who are here with us for the march, it's good to have you here and welcome to the White House. (Applause.)

As I look out at you, I'll see some folks who have been traveling all night to get here -- (laughter) -- you're slightly bleary-eyed. (Laughter.) I'll see others who are getting ready for a day out in the cold. But mostly I see faces that shine with a love for life. (Applause.)

I see people with a deep conviction that even the most vulnerable member of the human family is a child of God. You're here because you know that all life deserves to be protected. And as you begin your march, I'm proud to be standing with you. (Applause.)

Thirty-five years ago today the United States Supreme Court declared and decided that under the law an unborn child is not considered a person. But we know many things about the unborn. Biology confirms that from the start each unborn child is a separate individual with his or her own genetic code. Babies can now survive outside the mother's womb at younger and younger ages. And the fingers and toes and beating hearts that we can see on an unborn child's ultrasound come with something that we cannot see: a soul. (Applause.)

Today we're heartened -- we're heartened by the news that the number of abortions is declining. But the most recent data reports that more than one in five pregnancies end in an abortion. America is better than this, so we will continue to work for a culture of life where a woman with an unplanned pregnancy knows there are caring people who will support her; where a pregnant teen can carry her child and complete her education; where the dignity of both the mother and child is honored and cherished.

We aspire to build a society where each one of us is welcomed in life and protected in law. We haven't arrived, but we are making progress. Here in Washington we passed good laws that promote adoption and extend legal protection to children who are born despite abortion attempts. We came together to ban the cruel practice of partial birth abortion. (Applause.) And in the past year we have prevented that landmark law from being rolled back.

We've seen the dramatic breakthroughs in stem cell research that it is possible to advance medical science while respecting the sanctity of life. (Applause.) Building a culture of life requires more than law; it requires changing hearts. And as we reach out to others and find common ground, we can see the glimmerings of a new America on a far shore. This America is rooted in our belief that in a civilized society, the strong protect the weak. This America is nurtured by people like you, who speak up for the weak and the innocent. This America is the destiny of a people whose founding document speaks of the right to life that is a gift of our Creator, not a grant of the state. (Applause.)

My friends, the time is short and your march is soon. (Laughter.) As you give voice to the voiceless I ask you to take comfort from this: The hearts of the American people are good. (Applause.) Their minds are open to persuasion. And our history shows that a cause rooted in human dignity and appealing to the best instincts of the American people cannot fail. So take heart. (Applause.)

Take heart, be strong, and go forth. May God bless you. (Applause.)

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FORM	SUBJECT/TITLE	PAGES	DATE	RESTRICTION(S)
Memorandum	Proposed Regulatory Changes to HHS's Title X Family Planning Program - To: POTUS - From: Karl Zinsmeister	3	02/05/2008	P5;

This marker identifies the original location of the withdrawn item listed above. For a complete list of items withdrawn from this folder, see the Withdrawal/Redaction Sheet at the front of the folder.

COLLECTION:
Staff Secretary, White House Office of the

SERIES:
Von Der Heydt, Thomas (Tommy) - Bush Record Policy Memos

FOLDER TITLE:
Pro-Life Legacy: A Timeline (2001 - 2008)

FRC ID:
13894

OA Num.:
14457

NARA Num.:
14246

RESTRICTION CODES

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This Document was withdrawn on 4/25/2012 by MAL

state law. For that reason, this proposed action:

- Is not a "significant regulatory action" subject to review by the Office of Management and Budget under Executive Order 12866 (58 FR 51735, October 4, 1993);
- Does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- Is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- Does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- Does not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- Is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);
- Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);
- Is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the CAA; and
- Does not provide EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, February 16, 1994).

In addition, this proposed rule, pertaining to the Philadelphia County RACT under the 8-hour ozone NAAQS, does not have tribal implications as specified by Executive Order 13175 (65 FR 67249, November 9, 2000), because the SIP is not approved to apply in Indian country located in the state, and EPA notes that it will not impose substantial direct costs on tribal governments or preempt tribal law.

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Nitrogen dioxide, Ozone, Reporting and recordkeeping requirements, Volatile organic compounds.

Authority: 42 U.S.C. 7401 *et seq.*

Dated: August 18, 2008.

William T. Wisniewski,

Acting Regional Administrator, Region III.

[FR Doc. E8–19753 Filed 8–25–08; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 88

RIN 0991–AB48

Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices In Violation of Federal Law

AGENCY: Office of the Secretary, HHS.

ACTION: Proposed rule.

SUMMARY: The Department of Health and Human Services proposes to promulgate regulations to ensure that Department funds do not support morally coercive or discriminatory practices or policies in violation of federal law, pursuant to the Church Amendments (42 U.S.C. 300a–7), Public Health Service (PHS) Act § 245 (42 U.S.C. 238n), and the Weldon Amendment (Consolidated Appropriations Act, 2008, Pub. L. 110–161, § 508(d), 121 Stat. 1844, 2209). This notice of proposed rulemaking proposes to define certain key terms. Furthermore, in order to ensure that recipients of Department funds know about their legal obligations under these nondiscrimination provisions, the Department proposes to require written certification by certain recipients that they will comply with all three statutes, as applicable.

DATES: Submit written or electronic comment on the regulations proposed by this document by September 25, 2008.

ADDRESSES: In commenting, please refer to "Provider Conscience Regulation". Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.Regulations.gov* or via e-mail to *consciencecomment@hhs.gov.* To submit electronic comments to *http://www.Regulations.gov*, go to the Web site and click on the link "Comment or Submission" and enter the keywords "provider conscience". (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address only: Office of Public Health and Science, Department of Health and Human Services, *Attention:* Brenda Destro, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Room 728E, Washington, DC 20201.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address only: Office of Public Health and Science, Department of Health and Human Services, Attention: Brenda Destro, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Room 728E, Washington, DC 20201.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to the following address: Room 728E, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201. (Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal Government Identification, commenters are encouraged to leave their comments in the mail drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain proof of filing by stamping in and retaining and extra copy of the documents being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submitting Comments: We welcome comments from the public on all issues set forth in this proposed rule to assist us in fully considering issues and developing policies. For all comments submitted, you should specify the subject as "Provider Conscience Regulation".

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.Regulations.gov.* Click on the link "Comment or Submission" on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of

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FORM	SUBJECT/TITLE	PAGES	DATE	RESTRICTION(S)
Memorandum	Memo to the President Regarding Pro-Life Policies - To: POTUS - From: Karl Zinsmeister	3	05/02/2007	P5;

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b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

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arrangements for the provision of such training. In addition, PHS Act § 245 requires that, in determining whether to grant legal status to a health care entity (including a State's determination of whether to issue a license or certificate such as a medical license), the federal government and any State or local government receiving federal financial assistance deem accredited any post-graduate physician training program that otherwise would be accredited but for the reliance on an accrediting standard that requires an entity: (1) To perform induced abortions; or (2) to require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training.

Weldon Amendment [Consolidated Appropriations Act, 2008, Public Law No. 110–161, Div. G, § 508(d), 121 Stat. 1844, 2209 (Dec. 26, 2007)]

The Weldon Amendment, originally adopted as section 508(d) of the Labor–HHS Division (Division F) of the 2005 Consolidated Appropriations Act, Public Law 108–447 (Dec. 8, 2004), has been readopted (or incorporated by reference) in each subsequent HHS appropriations act. Title V of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2006, Public Law 109–149, § 508(d), 119 Stat. 2833, 2879–80; Revised Continuing Appropriations Resolution of 2007, Public Law 110–5, § 2, 121 Stat. 8, 9; Consolidated Appropriations Act, 2008, Public Law No. 110–161, Div. G, § 508(d), 121 Stat. 1844, 2209. The Weldon Amendment provides that "[n]one of the funds made available under this Act [making appropriations for the Departments of Labor, Health and Human Services, and Education] may be made available to a federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions." It also defines "health care entity" to include "an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan."

The Laws in the Courts

The federal courts have recognized the breadth and importance of statutory and other conscience protections for health care professionals and workers. Shortly after its passage, a federal appellate court decision characterized the importance of conscience protections contained in the Church Amendments. Faced with the question of a denominational hospital's right to refuse to perform sterilization procedures, the Ninth Circuit affirmed a lower court decision protecting the hospital's right to refuse to perform sterilizations and abortions on religious or moral grounds: "If [a] hospital's refusal to perform sterilization [or, by implication, abortion] infringes upon any constitutionally cognizable right to privacy, such infringement is outweighed by the need to protect the freedom of religion of denominational hospitals 'with religious or moral scruples against sterilizations and abortions.'" *Taylor* v. *St. Vincent's Hospital*, 523 F.2d 75, 77 (9th Cir. 1975) (citations omitted).

The Problem

There appears to be an attitude toward the health care professions that health care professionals and institutions should be required to provide or assist in the provision of medicine or procedures to which they object, or else risk being subjected to discrimination. Reflecting this attitude, in some instances the standards of professional organizations have been used to define the exercise of conscience to be unprofessional, forcing health care professionals to choose between their capacity to practice in good standing and their right of conscience.[1]

Despite the fact that several conscience statutes protecting health care entities from discrimination have been in existence for decades, the Department is concerned that the public and many health care providers are largely uninformed of the protections afforded to individuals and institutions under these provisions. This lack of knowledge within the health professions can be detrimental to conscience and other rights, particularly for individuals and entities with moral objections to abortion and other medical procedures.

The Department's Response

In general, the Department is concerned that the development of an environment in the health care field that is intolerant of individual conscience, certain religious beliefs, ethnic and cultural traditions, and moral convictions may discourage individuals from diverse backgrounds from entering health care professions. Such developments also promote the mistaken beliefs that rights of conscience and self-determination extend to all persons, except health care providers. Additionally, religious and faith-based organizations have a long tradition of providing medical care in the United States, and they continue to do so today—some of these are among the largest providers of health care in this nation. A trend that isolates and excludes some among various religious, cultural, and/or ethnic groups from participating in the delivery of health care is especially troublesome when considering current and anticipated shortages of health care professionals in many medical disciplines facing the country.

The Department also notes that, while many recipients of Department funds currently must certify compliance with federal nondiscrimination laws, federal conscience protections are not mentioned in existing forms. For example, Form PHS–5161–1, required as part of Public Health Service grant applications, requires applicants to certify compliance with all federal nondiscrimination laws, including laws prohibiting discrimination on the basis of race, color, national origin, religion, sex, handicap, age, drug abuse, and alcohol abuse or alcoholism. The Department seeks to raise awareness of federal conscience laws by specifically including reference to the nondiscrimination provisions contained in the Church Amendments, PHS Act § 245, and the Weldon Amendment in certifications currently required of most existing and potential recipients of Department funds.

Toward these ends, the Department has concluded that regulations and related efforts are necessary, in order to (1) educate the public and health care providers on the obligations imposed, and protections afforded, by federal law; (2) work with State and local governments and other recipients of funds from the Department to ensure compliance with the nondiscrimination requirements embodied in the Church Amendments, PHS Act § 245, and the Weldon Amendment; (3) when such compliance efforts prove unsuccessful, enforce these nondiscrimination laws through the various Department mechanisms, to ensure that Department funds do not support morally coercive or discriminatory practices or policies in violation of federal law; and (4) otherwise take an active role in promoting open communication within the healthcare industry, and between providers and patients, fostering a more

[1] "HHS Secretary Calls on Certification Group to Protect Conscience Rights," March 14, 2008. Available at *http://www.hhs.gov/news/press/2008pres/03/20080314a.html*.

inclusive, tolerant environment in the health care industry than may currently exist.

This regulation does not limit patient access to health care, but rather protects any individual health care provider or institution from being compelled to participate in, or from being punished for refusal to participate in, a service that, for example, violates their conscience.

These proposed actions are consistent with the Administration's current efforts to ensure that community and faith-based organizations are able to participate in federal programs on a level playing field with other organizations.

II. Summary of the Proposed Rule

This proposed rule sets out, and provides further definition of, the rights and responsibilities created by the federal nondiscrimination provisions. It clarifies the scope of nondiscrimination protections to applicable members of the Department's workforce, as well as and health care entities and members of the workforces of entities receiving Department funds. This proposed rule would also require certain recipients of Department funds to certify compliance with these requirements. In order to ensure proper enforcement, this proposed rule would define certain terms for the purposes of this proposed regulation.

The Office for Civil Rights of the Department of Health and Human Services has been designated to receive complaints of discrimination based on the nondiscrimination statutes and this proposed regulation. It will coordinate handling of complaints with the staff of the Departmental programs from which the entity with respect to whom a complaint has been filed receives funding. Enforcement of the requirements set forth in this proposed regulation will be conducted through the usual and ordinary program mechanisms. Compliance with the requirements proposed herein would likely be examined as part of any broader compliance review conducted by Department staff. If the Department becomes aware that a State or local government or an entity may be in violation of the requirements or prohibitions proposed herein, the Department would work with such government or entity to assist such government or entity to come into compliance with such requirements or prohibitions. If, despite the Department's assistance, compliance is not achieved, the Department will consider all legal options, including termination of funding, return of funds paid out in violation of nondiscrimination provisions under 45 CFR 74, and other measures.

III. Statutory Authority

On the basis of the above-mentioned statutory authority, the Secretary proposes to promulgate these regulations, requiring certification of compliance with the anti-discrimination statutes.

The statutory provisions discussed above require that the Department and recipients of Department funds (including State and local governments) refrain from discriminating against institutional and individual health care entities for their participation or refusal to participate in certain medical procedures or services, including certain health services, or research activities funded in whole or in part by the Federal Government. The Department has authority to promulgate regulations to enforce these prohibitions. Finally, the Department also has the legal authority to require that recipients certify their compliance with these proposed requirements and to require their sub-recipients to likewise certify their compliance with these proposed requirements. In addition, 5 U.S.C. 301 empowers the head of an Executive department to prescribe regulations "for the government of his department, the conduct of its employees, the distribution and performance of its business, and the custody, use, and preservation of its records, papers, and property."

IV. Provisions of the Proposed Rule

Section 88.1 Purpose

The "Purpose" section of the regulation sets forth the objective that the proposed regulation would, when finalized, provide for the implementation and enforcement of federal nondiscrimination statutes protecting the conscience rights of health care entities. It also states that the statutory provisions and regulations contained in this Part are to be interpreted and implemented broadly to effectuate these protections.

Section 88.2 Definitions

Assist in the Performance: The Department, in considering how to interpret the term "assist in the performance," seeks to provide broad protection for individuals' consciences. The Department seeks to avoid judging whether a particular action is genuinely offensive to an individual. At the same time, the Department wishes to guard against potential abuses of these protections by limiting the definition of "assist in performance" only to those actors who have a reasonable connection to the procedure, health service or health service program, or research activity to which they object.

Therefore, the Department proposes to interpret this term broadly, as encompassing individuals who are members of the workforce of the Department-funded entity performing the objectionable procedure. When applying the term "assist in the performance" to members of an entity's workforce, the Department proposes to include participation in any activity with a reasonable connection to the objectionable procedure, including referrals, training, and other arrangements for offending procedures. For example, an operating room nurse would assist in the performance of surgical procedures, and an employee whose task it is to clean the instruments used in a particular procedure would be considered to assist in the performance of the particular procedure.

Health Care Entity/Entity: While both PHS Act § 245 and the Weldon Amendment provide examples of specific types of protected individuals and health care organizations, neither statute provides an exhaustive list of such health care entities. PHS Act § 245 defines "health care entity" as "includ[ing] an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions." As the Department has previously indicated, the definition of "health care entity" in PHS Act § 245 also encompasses institutional entities, such as hospitals and other entities.[2] The Weldon Amendment defines the term "health care entity" as "includ[ing] an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan." The Church Amendment does not define the term "entity," and does not use the term "health care entity."

In keeping with the definitions in PHS Act § 245 and the Weldon Amendment, the Department proposes to define "health care entity" to include the specifically mentioned organizations from the two statutes, as well as other types of entities referenced in the Church Amendments. It is important to note that the Department does not intend for this to be a comprehensive list of relevant organizations for

[2] See Letter from Secretary Tommy G. Thompson to Hon. W.F. Tauzin, September 24, 2002.

purposes of the regulation, but merely a list of examples.

Health Service/Health Service Program: One of the provisions in the Church Amendments uses the term "health service," another uses the term, "health service program." Neither define the terms, nor does the PHS Act define "health service program." In developing an appropriate definition for "health service program," we have looked at the Social Security Act. Section 1128B(f)(1) of the Social Security Act, 42 U.S.C. 1320a–7b(f)(1), defines a similar term, "federal health care program", as "any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government."

Building on this broad definition, we propose that the term "health service program" should be understood to include an activity related in any way to providing medicine, health care, or any other service related to health or wellness, including programs where the Department provides care directly (e.g., Indian Health Service); programs where grants pay for the provision of health services (e.g., Administration for Children and Families programs such as the Unaccompanied Refugee Minor and the Division of Unaccompanied Children Services programs and HRSA programs such as community health centers); programs where the Department reimburses another entity that provides care (e.g., Medicare); and health insurance programs where federal funds are used to provide access to health coverage (e.g., SCHIP, Medicaid, and Medicare Advantage). Similarly, we propose that the term "health service" means any service so provided.

Individual: For the purposes of this part, the Department proposes to define "individual" to mean a member of the workforce (see definition of "workforce" below) of an entity or health care entity. One conscience clause of the Church Amendments, 42 U.S.C. 300a–7(d), provides that "[n]o *individual* shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health, Education and Welfare [Secretary of Health and Human Services] if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions (emphasis added)."

Instrument: We propose to use "instrument" to mean the variety of means by which the Department conveys funding and resources to organizations, including: grants, cooperative agreements, contracts, grants under a contract, and memoranda of understanding. The definition of "instrument" is intended to include all means by which the Department conveys funding and resources.

Recipient: This term is used to encompass any entity that receives Department funds directly.

Sub-recipient: This term is used to encompass any entity that receives Department funds indirectly through a recipient or sub-recipient.

Workforce: We propose to define "workforce" as including employees, volunteers, trainees, and other persons whose conduct, in the performance of work for an entity, is under the control or authority of such entity, whether or not they are paid by the Department-funded entity. The definition is drawn from the "Administrative Data Standards and Related Requirements" rules implementing Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160, 162, and 164 (2006) at 45 CFR 160.103. In keeping with this definition, persons and organizations under contract with an entity, if they are under the control or authority of the entity, would be considered members of the entity's workforce.

In defining both "individual" and "workforce," the Department proposes definitions that provide a reasonable scope for the natural persons protected by 42 U.S.C. 300a–7(d) and the corresponding provisions of these regulations. By limiting the scope of persons protected by these regulations to those who are under the control or authority of an entity that implements a health service program or research activity funded in whole or in part under a program administered by the Department, we propose to provide the bright line necessary for Department-funded entities subject to the applicable Church Amendment provisions to set policies or otherwise take steps to secure conscience protections within the workplace and, thus, to comply with the Church Amendment and these regulations.

Section 88.3 Applicability

The proposed "Applicability" section of the regulation outlines the certifications various entities must provide in order to receive Department funds. This section would direct entities to the appropriate sections that contain the relevant requirements from the three statutes that form the basis of this regulation.

Section 88.4 Requirements and Prohibitions

The "Requirements and Prohibitions" section explains the obligations that the Church Amendments, PHS Act § 245, and the Weldon Amendment impose on entities which receive funding from the Department. These provisions are taken from the relevant statutory language and make up the elements of the certification provided by the entities. We intend for the proposed requirements and prohibitions to be interpreted using the definitions proposed in section 88.2.

Section 88.5 Written Certification of Compliance

In the "Written Certification of Compliance" section of the regulation, the Department seeks to require certain recipients and sub-recipients of Department funds to certify compliance with the Church Amendments, PHS Act § 245, and the Weldon Amendment, as applicable, and to provide for the affected recipients and sub-recipients requirements for collecting, maintaining, and submitting written certifications.

We are concerned that there is a lack of knowledge on the part of States, local governments, and the health care industry of the rights of health care entities created by, and the corresponding obligations imposed on the recipients of certain federal funding by, the non-discrimination provisions. Under this proposed rule, recipients of federal funds would be required to submit their certifications directly to the Department as part of the instrument or in a separate writing signed by the recipients' officer or other person authorized to bind the recipient. They would also be required to collect and maintain certifications by sub-recipients who receive Department funds through them.

The proposed regulation requires that entities certify in writing that they will operate in compliance with the Church Amendments, PHS Act § 245, and the Weldon Amendment as applicable. Certification provides a demonstrable way of ensuring that the recipients of such funding know of, and attest that they will comply with, the applicable nondiscrimination provisions. Sub-recipients of federal funds—entities that will receive federal funds indirectly through another entity (a recipient or other sub-recipient)—are required to provide certification as set out in the "Sub-recipient" subsection of the "Certification of Compliance" section, and submit them to the recipients

through which they receive Department funds for maintenance.

Although it is collected and maintained by the recipient, this certification by sub-recipients is a certification addressed to the Department, not to the recipients collecting the certification. Recipients are expected to comply with requirements for retention of and access to records set forth in 45 CFR 74.53.

While all recipients and sub-recipients of Department funds are required to comply with the Church Amendments, PHS Act § 245, and the Weldon Amendment, as applicable, section 88.5(e) contains three important exceptions from the requirement to provide the written certification: (1) Physicians, physician offices, and other health care practitioners participating in Part B of the Medicare program; (2) physicians, physician offices, or other health care practitioners which participates in Part B of the Medicare program, when such individuals or organizations are sub-recipients of Department funds through a Medicare Advantage plan; and (3) sub-recipients of state Medicaid programs (i.e., any entity that is paid for services by the state Medicaid program). While other providers participating in the Medicare program as well as state Medicaid programs would be required to submit written certification of compliance to the Department, the large number of entities included in these three categories poses significant implementation hurdles for Departmental components and programs. Furthermore, the Department believes that, due primarily to their generally smaller size, the excepted categories of recipients and sub-recipients of Department funds are less likely to encounter the types of issues sought to be addressed in this regulation. However, excepted providers may become subject to the written certification requirement by nature of their receiving Department funds under a separate agency or program. For example, a physician office participating in Medicare Part B may become subject to the written certification requirement by receiving Department funds to conduct clinical research. We note, however, that the State Medicaid programs are responsible for ensuring the compliance of their sub-recipients as part of ensuring that the State Medicaid program is operated consistently with applicable nondiscrimination provisions. The Department is considering whether other recipients of Department funds from programs that do not involve the provision of health care should also be excepted from the certification requirement and we seek comment on this issue.

When finalized, individual Department components will be tasked with determining how best to implement the written certification requirements set out in this regulation in a way that ensures efficient program operation. To this end, Department components will be given discretion to phase in the written certification requirement by no later than the beginning of the next federal fiscal year following the effective date of the regulation.

V. Request for Comment

The Department, in order to craft its final rule to best reflect the environment within the health care field, seeks comment on this Proposed Rule. In particular, the Department seeks the following:

- Comment on all issues raised by the proposed regulation.
- Information with regard to general knowledge or lack thereof of the protections established by these nondiscrimination provisions, including any facts, surveys, audits, reports, or any other evidence of knowledge or lack of knowledge on these matters in the general public, as well as within the healthcare industry and educational institutions.
- In the past, there has been some confusion about whether the receipt of federal funds permitted public officials to require entities to provide abortions or perform sterilizations. The debate was resolved, and statutory provisions like section (b) of the Church Amendments [42 U.S.C. 300a–7(b)] were promulgated to protect entities from public authorities who would claim that the receipt of federal funds creates a legal obligation for the entity to provide abortions or sterilization procedures. The Department seeks information, including any facts, surveys, audits, or reports on whether this remains an issue, that is, do public authorities continue to claim that the receipt of federal funds is sufficient basis for entities to be required to provide abortions or perform sterilizations? If so, how should the Department address this problem?
- Comment on whether written certification of compliance with nondiscrimination provisions should contain language specifying that the certification is a material prerequisite to the payment of Department funds.
- The Department also seeks comment on what constitutes the most effective methods of educating recipients of Department funds, their employees, and participants of the protections against discrimination found in the Church Amendments, PHS Act § 245, and the Weldon Amendment. What is the best method for communicating to the public the protections afforded by these statutes, and any regulation implementing them?
  - One option is to require the physical posting of notices of nondiscrimination protections in conspicuous places within the buildings of recipients of funds, and on applications to educational programs that are recipients of funds. Have notices been effective educational tools with respect to individuals' rights under federal law?
  - Another option is to require inclusion of nondiscrimination protections in notice of applications for training, residency, and educational programs.
  - Another option is requiring notice of nondiscrimination protections on websites and in employee/volunteer handbooks of recipients.

  The Department seeks further comment on this matter—both on the merit of the options mentioned, and on any other means of educating the public with respect to the nondiscrimination protections under federal law.
- Comment on whether there are recipients of Department funds that should be excepted from the proposed certification requirement, for example because the program under which such recipients receive Department funds is unrelated to the provision of health care or medical research.

VI. Impact Analysis

Executive Order 12866—Regulatory Planning and Review

HHS has examined the economic implications of this proposed rule as required by Executive Order 12866. Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity). Executive Order 12866 classifies a rule as significant if it meets any one of a number of specified conditions, including: having an annual effect on the economy of $100 million, adversely affecting a sector of the economy in a material way, adversely affecting competition, or adversely affecting jobs. A regulation is also considered a significant regulatory action if it raises novel legal or policy issues. HHS has

determined that this proposed rule is a significant regulatory action as defined by Executive Order 12866.

An underlying assumption of this regulation is that the health care industry, including entities receiving Department funds, will benefit from more diverse and inclusive workforces by informing health care workers of their rights and fostering an environment in which individuals and organizations from many different faiths, cultures, and philosophical backgrounds are encouraged to participate. As a result, we cannot accurately account for all of the regulation's future benefits, but the Department believes the future benefits will exceed the costs of complying with the regulation.

The statutes mandating the requirements for protecting health care entities and individuals in the health care industry as discussed in this rule have been in effect for a number of years and the proposed regulations are consistent with prior Departmental interpretations of these nondiscrimination statutes;[3] therefore, the regulatory burden associated with this rule, if finalized, is largely associated with the incremental costs of a recipient certifying compliance to the federal government and the cost of collecting and maintaining records of certification statements from sub-recipients. We estimate the universe and number of entities that would be required to certify to be, at most, 584,294 (see Table I). We do not distinguish between recipients and sub-recipients of HHS funding. Each entity could be a recipient, a sub-recipient, or both. In accordance with subsection 88.5(e) below, physicians, physician offices, and other health care practitioners participating in Medicare Part B or who are sub-recipients assisting in the implementation of a State Medicaid program are not subject to the written certification requirement; however, a high estimate of the number of physician offices and offices of other health care practitioners who may be required to certify as recipients or sub-recipients of Department funds through other programs, instruments, or mechanisms is included.

TABLE I—AFFECTED ENTITIES

Health care entity	Number of entities
Hospitals (less than 100 beds)[1]	2,403
Hospitals (100–200 beds)[4]	1,129
Hospitals (200–500 beds)[4]	1,160
Hospitals (more than 500 beds)[4]	244
Nursing Homes (less than 50 beds)[2]	2,388
Nursing Homes (50–99 beds)[5]	5,819
Nursing Homes (99–199 beds)[5]	6,877
Nursing Homes (more than 200 beds)[5]	1,037
Physicians Offices[3]	234,200
Offices of Other Health CarePractitioners[6 4]	115,378
Outpatient Care Centers[6 5]	26,901
Medical and Diagnostic Laboratories[6]	11,856
Home Health Care Services[6]	20,184
Pharmacies (chain and independent)[6]	58,109
Dental Schools[7]	56
Medical Schools (Allopathic)[4]	125
Medical Schools (Osteopathic)[4]	20
Nursing Schools (Licensed practical)[8]	1,138
Nursing Schools (Baccalaureate)[11]	550
Nursing Schools (Associate degree)[11]	885
Nursing Schools (Diploma)[11]	78
Occupational Therapy Schools[4]	142
Optometry Schools[4]	17
Pharmacy Schools[4]	92
Podiatry Schools[4]	7
Public Health Schools[4]	37
Residency Programs (accredited)[9]	8,494
Health Insurance Carriers and 3rd-Party Administrators[10]	4,578
Grant awards[11]	76,088
Contractors[12]	4,245
State and territorial governments	57
Total	584,294

[1] Health, United States, 2007. U.S. Dept. of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. Nov. 2007.

[2] Nursing Home Data Compendium, 2007 edition. U.S. Dept. of Health and Human Services, Centers for Medicaid and Medicare Services.

[3] NPRM: Modification to Medical Data Code Set Standards to Adopt ICD–10–CM and ICD–10–PCS.

[4] From the NAICS Code 6213—Office of Other Health Care Practitioners (including Chiropractors, Optometrists, non-Physician Mental Health Practitioners, Physical Occupational and Speech Therapists, Podiatrists, and all other Miscellaneous Health Care Practitioners).

[5] From the NAICS Code 6214—Outpatient Care Centers (including Family Planning Centers, Outpatient Mental Health and Substance Abuse Centers, Other Outpatient Care Centers, HMO Medical Centers, Kidney Dialysis Centers, Freestanding Ambulatory Surgical and Emergency Centers, and all Other Outpatient Care Centers).

[3] The [* * *] suggestion that the requirement to provide options counseling [including abortion counseling] should not apply to employees of a grantee who object to providing such counseling on moral or religious grounds, is likewise rejected [* * *] [S]uch a requirement is not necessary: *under 42 U.S.C. 300a–7(d), grantees may not require individual employees who have such objections to provide such counseling* (emphasis added). 65 FR 41270 (July 3, 2000) [codified at 42 CFR 59 (2008)]; see also Letter from Secretary Tommy G. Thompson to Hon. W.F. Tauzin, September 24, 2002.

[6] 2005 NCPA-Pfizer Digest: Total, Prescription Sales Increase At Nation's Independent Pharmacies. National Community Pharmacies Association Press Release, May 12, 2005.
[7] Dental Education At-A-Glance, 2004. American Dental Education Association. Available at: *http://www.adea.org/CEPR/Documents/2004_Dental_Ed_At_A_Glance.pdf.*
[8] National Center for Health Workforce Analysis: U.S. Health Workforce Personnel Factbook. U.S. Dept. of Health and Human Services, Health Resources and Services Administration.
[9] Number of Accredited Programs by Academic Year (7/1/2007—6/30/2008). Accreditation Council for Graduate Medical Education. Available at: *http://www.acgme.org/adspublic/reports/accredited_programs.asp.*
[10] U.S. Department of Labor, Bureau of Labor Statistics, National Occupational Employment and Wage Estimates, May 2007.
[11] HHS Grants Statistics, 2007. Available at *http://www.hhs.gov/grantsnet.*
[12] General Services Administration (estimated).

The Department envisions three subcategories of potential costs for recipients and sub-recipients of Department funds: (1) Direct costs associated with the act of certification; (2) direct costs associated with collecting and maintaining certifications made by sub-recipients, and (3) indirect costs associated with certification.

The direct cost of certification is the cost of reviewing the certification language, reviewing relevant entity policies and procedures, and reviewing files before signing. We estimate that each of the 584,294 entities will spend an average of 30 minutes on these activities. Although some entities may need to sign a certification statement more than once, we assume that the entity will only carefully review the language, procedures and their files before signing the initial statement each year. We assume the cost of signing subsequent statements to be small. Some existing HHS certification forms specify the certification statement should be signed by the CEO, CFO, direct owner, or Chairman of the Board. According to Bureau of Labor Statistics wage data, the mean hourly wage for occupation code 11–1011, Chief Executives, is $72.77. We estimate the loaded rate to be $145.54. Thus, assuming that the recipient chooses to have a high-level employee such as a Chief Executive certify on its behalf, the cost associated with the act of certification is $42.5 million (584,294 × .5 × $145.54).

The direct cost of collecting and maintaining certifications made by sub-recipients is estimated as the labor cost. We assume that each of the 73,088 grant awards and 4,245 contractors doing business with HHS have at least one sub-recipient. We also assume that, on average, each grant awardee and contractor will spend one hour collecting and maintaining certifications made by sub-recipients. The mean hourly wage for office and administrative support occupations, occupation code 43–0000, is $15.00, or $30 loaded. Thus, the cost of collecting and maintaining records is estimated to be $2 million (77,333 entities × 1 hour × $30).

Indirect costs associated with the certification requirement might include costs for such actions as staffing/scheduling changes and internal reviews to assess compliance. There is insufficient data to estimate the number of funding recipients not currently compliant with the Church Amendments, PHS Act § 245, or the Weldon Amendment. However, because together these three federal statutes have been in existence for many years, we expect the incremental and indirect costs of certification to be minimal for Department funding recipients. We specifically request comment on this assumption.

The total quantifiable costs of the proposed regulation, if finalized, are estimated to be $44.5 million each year.

Regulatory Flexibility Act

HHS has examined the economic implications of this proposed rule as required by the Regulatory Flexibility Act (5 U.S.C. 601–612). If a rule has a significant economic impact on a substantial number of small entities, the Regulatory Flexibility Act (RFA) requires agencies to analyze regulatory options that would lessen the economic effect of the rule on small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, by virtue of either nonprofit status or having revenues of $6 million to $29 million in any 1 year. Individuals and States are not included in the definition of a small entity. While the proposed rule will affect a number of small entities, we preliminarily conclude that the costs of compliance are not economically significant (see discussion above). Moreover, in accordance with subsection 88.5(e) below, physicians, physician offices, and other health care practitioners participating in Medicare Part B or who are sub-recipients assisting in the implementation of a State Medicaid program are not subject to the written certification requirement. Thus, we conclude that this proposal, if finalized, will not impose significant costs on small entities. Therefore, the Secretary certifies that this rule will not result in a significant impact on a substantial number of small entities.

Executive Order 13132—Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has federalism implications.

All three acts enforced in this proposed regulation—the Church Amendments, PHS Act § 245, and the Weldon Amendment—impose restrictions on States, local governments, and public entities receiving funds from the Department, including under certain Department-implemented statutes. Insofar as these regulations impact State and local governments, they do so only to the extent that States and local governments would be required to submit certifications of compliance with the statutes and these regulations, as applicable. Since we expect the recipients of Department funds to comply with existing federal law, we anticipate the impact on States and local governments of the proposed certification requirement to be negligible.

The Department will consult with States and local governments to seek ways to minimize any burden imposed on the States and local governments by these proposed regulations, consistent with meeting the Department's objectives of ensuring: (1) Knowledge of the obligations imposed, and the rights and protections afforded, by these federal nondiscrimination provisions; and (2) compliance with the nondiscrimination provisions.

Unfunded Mandates Reform Act of 1995

Title II of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) requires cost-benefit and other analyses before any rulemaking if the rule would

include a "Federal mandate that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100,000,000 or more (adjusted annually for inflation) in any 1 year." The current inflation-adjusted statutory threshold is approximately $130 million. The Department has determined that this proposed rule would not constitute a significant rule under the Unfunded Mandates Reform Act.

Assessment of Federal Regulation and Policies on Families

Section 654 of the Treasury and General Government Appropriations Act of 1999 requires federal departments and agencies to determine whether a proposed policy or regulation could affect family well-being. If the determination is affirmative, then the Department or agency must prepare an impact assessment to address criteria specified in the law. These regulations will not have an impact on family well-being, as defined in the Act.

Paperwork Reduction Act of 1995

This proposed rule does not create any new requirements under the Paperwork Reduction Act of 1995.

List of Subjects in 45 CFR Part 88

Abortion, Civil rights, Colleges and universities, Employment, Government contracts, Government employees, Grant programs, Grants administration, Health care, Health insurance, Health professions, Hospitals, Insurance companies, Laboratories, Medicaid, Medical and dental schools, Medical research, Medicare, Mental health programs, Nursing homes, Public health, Religious discrimination, Religious liberties, Reporting and recordkeeping requirements, Rights of conscience, Scientists, State and local governments, Sterilization, Students.

Therefore, under the Church Amendments, 42 U.S.C. 300a–7, Public Health Service Act § 245, 42 U.S.C. 238n, and the Weldon Amendment, Consolidated Appropriations Act, 2008, Pub. L. No. 110–161, Div. G, § 508(d), 121 Stat. 1844, 2209, the Department of Health and Human Services proposes to add 45 CFR Part 88 to read as follows:

PART 88—ENSURING THAT DEPARTMENT OF HEALTH AND HUMAN SERVICES FUNDS DO NOT SUPPORT COERCIVE OR DISCRIMINATORY POLICIES OR PRACTICES

Sec.

88.1 Purpose.
88.2 Definitions.
88.3 Applicability.
88.4 Requirements and prohibitions.
88.5 Written certification of compliance.

Authority: 42 U.S.C. 300a–7, 42 U.S.C. 238n, Pub. L. 120–161, Div. G, section 508(d), 121 Stat. 1884, 2209, 31 U.S.C. 6306, 41 U.S.C. 253, 40 U.S.C. 471, 42 U.S.C. 1395w–22(j)(3)(B), and 42 U.S.C. 1396u–2(b)(3).

§ 88.1 Purpose.

The purpose of this part is to provide for the implementation and enforcement of the Church Amendments, 42 U.S.C. 300a–7, section 245 of the Public Health Service Act, 42 U.S.C. 238n, and the Weldon Amendment, Consolidated Appropriations Act, 2008, Public Law No. 110–161, Div. G, section 508(d), 121 Stat. 1844, 2209. These statutory provisions protect the rights of health care entities/entities, both individuals and institutions, to refuse to perform health care services to which they may object for religious, moral, ethical, or other reasons. Consistent with this objective to protect the conscience rights of health care entities/entities, the provisions in the Church Amendments, section 245 of the Public Health Service Act and the Weldon Amendment, and the implementing regulations contained in this Part are to be interpreted and implemented broadly to effectuate their protective purposes.

§ 88.2 Definitions

For the purposes of this part:

Assist in the Performance means to participate in any activity with a reasonable connection to a procedure, health service or health service program, or research activity, so long as the individual involved is a part of the workforce of a Department-funded entity. This includes counseling, referral, training, and other arrangements for the procedure, health service, or research activity.

Entity includes an individual physician or other health care professional, health care personnel, a participant in a program of training in the health professions, an applicant for training or study, a post graduate physician training program, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, laboratory or any other kind of health care organization or facility. It may also include components of State or local governments.

Health Care Entity includes an individual physician or other health care professional, health care personnel, a participant in a program of training in the health professions, an applicant for training or study in the health professions, a post graduate physician training program, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, laboratory or any other kind of health care organization or facility. It may also include components of State or local governments.

Health Service/Health Service Program includes any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded, in whole or in part, by the Department. It may also include components of State or local governments.

Individual means a member of the workforce of an entity/health care entity.

Instrument is the means by which federal funds are conveyed to a recipient, and includes grants, cooperative agreements, contracts, grants under a contract, memoranda of understanding, and any other funding or employment instrument or contract.

Recipient means an organization or individual receiving funds directly from the Department or component of the Department to carry out a project or program. The term includes State and local governments, public and private institutions of higher education, public and private hospitals, commercial organizations, and other quasi-public and private nonprofit organizations such as, but not limited to, community action agencies, research institutes, educational associations, and health centers. The term may include foreign or international organizations (such as agencies of the United Nations) which are recipients, sub-recipients, or contractors or subcontractors of recipients or sub-recipients at the discretion of the Department awarding agency.

Sub-recipient means an organization or individual receiving funds indirectly from the Department or component of the Department through a recipient or another sub-recipient to carry out a project or program. The term includes State and local governments, public and private institutions of higher education, public and private hospitals, commercial organizations, and other quasi-public and private nonprofit organizations such as, but not limited to, community action agencies, research institutes, educational associations, and health centers. The term may include foreign or international organizations (such as agencies of the United Nations) which are recipients, sub-recipients, or contractors or subcontractors of recipients or sub-recipients at the discretion of the Department awarding agency.

Workforce includes employees, volunteers, trainees, and other persons whose conduct, in the performance of

work for a Department-funded entity, is under the control or authority of such entity, whether or not they are paid by the Department-funded entity.

§ 88.3 Applicability.

(a) The Department of Health and Human Services is required to comply with §88.4(a), (b)(1), and (d)(1).

(b) Any State or local government that receives federal funds appropriated through the appropriations act for the Department of Health and Human Services is required to comply with *§§ 88.4(b)(1) and 88.5.*

(c) Any entity that receives federal funds appropriated through the appropriations act for the Department of Health and Human Services to implement any part of any federal program is required to comply with §§88.4(b)(2) and 88.5.

(d) Any State or local government that receives federal financial assistance is required to comply with §§88.4(a) and 88.5.

(e) Any State or local government, any part of any State or local government, or any other public entity must comply with §88.4(e).

(f)(1) Any entity, including a State or local government, that receives a grant, contract, loan, or loan guarantee under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Assistance and Bill of Rights Act of 2000, must comply with §§88.4(c)(1) and 88.5.

(2) In addition to complying with the provisions set forth in §88.4(c)(1), any such entity that is an educational institution, teaching hospital, or program for the training of health care professionals or health care workers shall also comply with §88.4(a)(2).

(g)(1) Any entity, including a State or local government, that carries out any part of any health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services must comply with §§88.4(d)(1) and 88.5.

(2) In addition to complying with the provisions set forth in paragraph (g)(1) of this section, any such entity that receives grants or contracts for biomedical or behavioral research under any program administered by the Secretary of Health and Human Services shall also comply with §88.4(d)(2).

§ 88.4 Requirements and prohibitions.

(a) Entities to whom this paragraph (a) applies shall not:

(1) Subject any institutional or individual health care entity to discrimination for refusing:

(i) To undergo training in the performance of abortions, or to require, provide, refer for, or make arrangements for training in the performance of abortions;

(ii) To perform, refer for, or make other arrangements for, abortions; or

(iii) To refer for abortions;

(2) Subject any institutional or individual health care entity to discrimination for attending or having attended a post-graduate physician training program, or any other program of training in the health professions, that does not or did not require attendees to perform induced abortions or require, provide, or refer for training in the performance of induced abortions, or make arrangements for the provision of such training;

(3) For the purposes of granting a legal status to a health care entity (including a license or certificate), or providing such entity with financial assistance, services or benefits, fail to deem accredited any postgraduate physician training program that would be accredited but for the accrediting agency's reliance upon an accreditation standard or standards that require an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether such standard provides exceptions or exemptions;

(b)(1) Any entity to whom this paragraph (b)(1) applies shall not subject any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for, abortion.

(2) Entities to whom this paragraph (b)(2) applies shall not subject any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortion as part of the federal program for which it receives funding.

(c) Entities to whom this paragraph (c) applies shall not:

(1) Discriminate against any physician or other health care professional in the employment, promotion, termination, or extension of staff or other privileges because he performed or assisted in the performance, or refused to perform or assist in the performance of a lawful sterilization procedure or abortion on the grounds that doing so would be contrary to his religious beliefs or moral convictions, or because of his religious beliefs or moral convictions concerning abortions or sterilization procedures themselves;

(2) Discriminate against or deny admission to any applicant for training or study because of reluctance or willingness to counsel, suggest, recommend, assist, or in any way participate in the performance of abortions or sterilizations contrary to or consistent with the applicant's religious beliefs or moral convictions.

(d) Entities to whom this paragraph (d) applies shall not:

(1) Require any individual to perform or assist in the performance of any part of a health service program or research activity funded by the Department if such service or activity would be contrary to his religious beliefs or moral convictions.

(2) Discriminate in the employment, promotion, termination, or the extension of staff or other privileges to any physician or other health care personnel because he performed, assisted in the performance, refused to perform, or refused to assist in the performance of any lawful health service or research activity on the grounds that his performance or assistance in performance of such service or activity would be contrary to his religious beliefs or moral convictions, or because of the religious beliefs or moral convictions concerning such activity themselves.

(e) Entities to whom this paragraph (e) applies shall not, on the basis that the individual or entity has received a grant, contract, loan, or loan guarantee under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Assistance and Bill of Rights Act of 2000, require:

(1) Such individual to perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions, or

(2) Such entity to:

(i) Make its facilities available for the performance of any sterilization procedure or abortion if the performance of such procedure or abortion in such facilities is prohibited by the entity on the basis of religious beliefs or moral convictions, or

(ii) Provide any personnel for the performance or assistance in the performance of any sterilization procedure or abortion if the performance or assistance in the performance of such procedure or abortion by such personnel would be contrary to the religious beliefs or moral convictions of such personnel.

§ 88.5 Written certification of compliance.

(a) *Certification requirement.* Except as provided in paragraph (e) of this

section, recipients shall include the written certifications as set forth in paragraph (c)(4) of this section in the application for the grant, cooperative agreement, contract, grant under a contract, memorandum of understanding or other funding or employment instrument or contract, as applicable. Except as provided in paragraph (e) of this section, sub-recipients must provide the Certification of Compliance as set out in paragraph (d)(3) of this section, submitted as part of its original agreement with the recipient in the execution of its grant, cooperative agreement, contract, grant under a contract, memorandum of understanding or other funding instrument, or in a separate writing, signed by the sub-recipients' officer or other person authorized to bind the sub-recipient. Certifications shall be made by an officer or other individual authorized to bind the recipient or sub-recipient. All certifications shall be addressed directly to the Department; recipients are required to submit their certifications directly to the Department. Recipients shall be in full compliance with all applicable certification requirements by no later than the beginning of the federal fiscal year following the effective date of this regulation.

(b) *Notification of certification requirement.* The Department shall notify recipients of funding of the certification requirement at the time of award through the Request for Proposal, Request for Agreement, Provider Agreement, contract, guidance, or other public announcement of the availability of funding. Recipients shall not construe anything in this paragraph to mean that an entity or organization is in any way exempt from providing the certification in the event the Department should fail to provide notification.

(c) *Certification by recipients.*

(1) Except as provided in paragraph (e) of this section, all recipients through any instrument must provide the Certification of Compliance as set out in paragraph (c)(4) of this section, submitted as part of the recipient's application for the grant, cooperative agreement, contract, grant under a contract, memorandum of understanding or other funding instrument or in a separate writing signed by the recipients' officer or other person authorized to bind the recipient.

(2) Recipients must file with the Department a renewed certification upon any renewal, extension, amendment, or modification of the grant, cooperative agreement, contract, grant under a contract, memorandum of understanding or other funding or employment instrument or contract that extends the term of such instrument or adds additional funds to it. Recipients that are already recipients as of the effective date of this regulation must file a certification upon any extension, amendment, or modification of the grant, cooperative agreement, contract, grant under a contract, memorandum of understanding or other funding instrument that extends the term of such instrument or adds additional funds to it.

(3) Recipients shall require certifications and re-certifications by all sub-recipients that receive funding through their association with the recipient. Recipients shall require these certifications and re-certifications as often as recipients are required to sign or amend the instrument, for as long as the relationship between the recipient and the sub-recipient lasts. Recipients shall collect and maintain sub-recipient certifications for as long as the relationship between the recipient and the sub-recipient lasts, and for a reasonable time after the relationship ends, for the purpose of investigations, litigation, or other purposes.

(4) *The certification.* Except as provided in paragraph (e) of this section, all recipients shall provide the following certification:

As the duly authorized representative of the recipient I certify that the recipient of funds made available through this [instrument] will not discriminate on the basis of an entity's past involvement in, or refusal to assist in the performance of, the practices of abortion or sterilization, and will not require involvement in procedures that violate an individual's conscience as part of any part of any health service program, in accord with all applicable sections of 45 CFR part 88.

I further certify that the recipient acknowledges that any violation of these certifications shall be grounds for termination by the Department of any grant, cooperative agreement, contract, grant under a contract, memorandum of understanding or other funding or employment instrument or contract prior to the end of its term and recovery of appropriated funds expended prior to termination. I further certify that, except as provided in 45 CFR 88.5(e), the recipient will include this certification requirement in any [instrument] to a sub-recipient of funds made available under this instrument, and will require, except as provided in 45 CFR 88.5(e), such sub-recipient to provide the same certification that the recipient organization or entity provided. I further certify the recipient organization will collect and maintain sub-recipient certifications for as long as the relationship between the recipient and the sub-recipient lasts, and for a reasonable time after the relationship ends, for the purpose of investigations, litigation, or other purposes.

(d) *Certification by sub-recipients.*

(1) Except as provided in paragraph (e) of this section, organizations or entities that are sub-recipients of the organization or entity providing the initial Certification of Compliance must submit to the recipient for maintenance by the recipient through which the sub-recipient receives Department funds Certification of Compliance as set out in paragraph (d)(3) of this section, as part of the grant, cooperative agreement, contract, grant under a contract, memorandum of understanding or other funding instrument between the recipient and the sub-recipient or in a separate writing signed by the sub-recipients' officer or other person authorized to bind the sub-recipient.

(2) Except as provided in paragraph (e) of this section, sub-recipients of funds shall renew certification to the recipient through which it receives Department funds upon any renewal, extension, amendment, or modification of the grant, cooperative agreement, contract, grant under a contract, memorandum of understanding or other funding or employment instrument or contract that extends the term of such instrument or adds additional funds to it. Sub-recipients shall submit such renewals to the recipient entities through which they receive Department funding. Entities that are already sub-recipients as of the effective date of this regulation must certify upon any extension, amendment, or modification of the grant, cooperative agreement, contract, grant under a contract, memorandum of understanding or other funding instrument that extends the term of such instrument or adds additional funds to it, and shall submit such certifications to the recipient entity through which they receive Department funding.

(3) *The certification.* Except as provided in paragraph (e) of this section, all sub-recipients of Department funds shall provide the following certification:

As the duly authorized representative of the sub-recipient I certify that the sub-recipient of funds made available through this [instrument] will not discriminate on the basis of an entity's past involvement in, or refusal to assist in the performance of, the practices of abortion or sterilization, and will not require involvement in procedures that violate an individual's conscience as part of any part of any health service program, in accord with all applicable sections of 45 CFR part 88.

I further certify that the sub-recipient acknowledges that these certifications by the sub-recipient of funds are certifications made directly to the Department and that any violation of these certifications shall be grounds for termination by the Department of the recipient's grant, cooperative agreement,

contract, grant under a contract, memorandum of understanding or other funding or employment instrument or contract prior to the end of its term and recovery of appropriated funds expended prior to termination. I further certify that the sub-recipient will submit all certifications to the recipient entity through which it received Department funds.

(e) *Exceptions.* Provided that such individuals or organizations are not recipients or sub-recipients of Department funds through another instrument, program, or mechanism, other than those set forth in paragraphs (e)(1) through (3) of this section, the following individuals or organizations shall not be required to comply with the written certification requirement set forth in this section:

(1) A physician, as defined in 42 U.S.C. 1395(r), physician office, or other health care practitioner participating in Part B of the Medicare program;

(2) A physician, as defined in 42 U.S.C. 1395(r), physician office, or other health care practitioner which participates in Part B of the Medicare program, when such individuals or organizations are sub-recipients of Department funds through a Medicare Advantage plan; or

(3) A sub-recipient of Department funds through a State Medicaid program.

Dated: August 20, 2008.

Michael O. Leavitt,

Secretary.

[FR Doc. E8–19744 Filed 8–21–08; 2:00 pm]

BILLING CODE 4150–28–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 1

[MD Docket No. 08–65; FCC 08–182]

Assessment and Collection of Regulatory Fees for Fiscal Year 2008

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: In this document, we seek comment on changes to the regulatory fee schedule and methodology.

DATES: Comments are due September 25, 2008, and reply comments are due October 27, 2008.

ADDRESSES: You may submit comments, identified by MD Docket No. 08–65, by any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Federal Communications Commission's Web Site: http://www.fcc.gov/cgb/ecfs.* Follow the instructions for submitting comments.
- *E-mail: ecfs@fcc.gov.* Include MD Docket No. 08–65 in the subject line of the message.
- Mail: Commercial overnight mail (other than U.S. Postal Service Express Mail, and Priority Mail, must be sent to 9300 East Hampton Drive, Capitol Heights, MD 20743. U.S. Postal Service first-class, Express, and Priority mail should be addressed to 445 12th Street, SW., Washington, DC 20554.
- *People with Disabilities:* Contact the FCC to request reasonable accommodations (accessible format documents, sign language interpreters, CART, etc.) by email: *FCC504@fcc.gov* or phone: (202) 418–0530 or TTY (202) 418–0432.

FOR FURTHER INFORMATION CONTACT: CORES Helpdesk at (877) 480–3201, option 4 or *ARINQUIRIES@fcc.gov.*

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Further Notice of Proposed Rulemaking, MD Docket No. 08–65, FCC 08–182 adopted on August 1, 2008 and released on August 6, 2008. The full text of this document is available is available for inspection and copying during normal business hours in the FCC Reference Center (Room CY–A257), 445 12th Street, SW., Washington, DC 20554. The complete text of this document also may be purchased from the Commission's copy contractor, Best Copy and Printing, Inc., 445 12th Street, SW., Room CY–B402, Washington, DC 20554. The full text may also be downloaded at *http://www.fcc.gov.*

Pursuant to sections 1.1206(b), 1.1202 and 1.1203 of the Commission's rules, CFR 1.1206(b), 1.1202, 1.1203, this is as a "permit-but-disclose" proceeding. *Ex parte* presentations are permissible if disclosed in accordance with Commission rules, except during the Sunshine Agenda period when presentations, *ex parte* or otherwise, are generally prohibited. Persons making oral *ex parte* presentations are reminded that a memorandum summarizing a presentation must contain a summary of the substance of the presentation and not merely a listing of the subjects discussed. More than a one- or two-sentence description of the views and arguments presented is generally required.[1] Additional rules pertaining to oral and written presentations are set forth in section 1.1206(b).

Pursuant to sections 1.415 and 1.419 of the Commission's rules, 47 CFR 1.415, 1.419, interested parties may file comments on or before the dates indicated on the first page of this document. Comments may be filed using: (1) The Commission's Electronic Comment Filing System ("ECFS"), (2) the Federal Government's eRulemaking Portal, or (3) procedures for filing paper copies. *See Electronic Filing of Documents in Rulemaking Proceedings,* 63 FR 24121 (1998), 13 FCC Rcd 11322 (1998).

- *Electronic Filers:* Comments may be filed electronically using the Internet by accessing the ECFS: *http://www.fcc.gov/cgb/ecfs* or the Federal eRulemaking Portal: *http://www.regulations.gov.* Filers should follow the instructions provided on the Web site for submitting comments. For ECFS filers, if multiple docket or rulemaking numbers appear in the caption of this proceeding, filers must transmit one electronic copy of the comments for each docket or rulemaking number referenced in the caption. In completing the transmittal screen, filers should include their full name, U.S. Postal Service mailing address, and the applicable docket or rulemaking number. Parties may also submit an electronic comment by Internet e-mail. To get filing instructions, filers should send an e-mail to *ecfs@fcc.gov,* and include the following words in the body of the message, "get form." A sample form and directions will be sent in response.
- *Paper Filers:* Parties who choose to file by paper must file an original and four copies of each filing. If more than one docket or rulemaking number appears in the caption of this proceeding, filers must submit two additional copies for each additional docket or rulemaking number. Filings can be sent by hand or messenger delivery, by commercial overnight courier, or by first-class or overnight U.S. Postal Service mail (although we continue to experience delays in receiving U.S. Postal Service mail). All filings must be addressed to the Commission's Secretary, Office of the Secretary, Federal Communications Commission.
- The Commission's contractor will receive hand-delivered or messenger-delivered paper filings for the Commission's Secretary at 236 Massachusetts Avenue, NE., Suite 110, Washington, DC 20002. The filing hours at this location are 8 a.m. to 7 p.m. All hand deliveries must be held together with rubber bands or fasteners. Any envelopes must be disposed of before entering the building.
- Commercial overnight mail (other than U.S. Postal Service Express Mail and Priority Mail) must be sent to 9300 East Hampton Drive, Capitol Heights, MD 20743.

[1] See 47 CFR 1.1206(b)(2).

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For Immediate Release
Office of the Press Secretary
October 31, 2008

National Adoption Month, 2008

A Proclamation by the President of the United States of America

During National Adoption Month, we recognize the compassion of adoptive and foster families as we seek to raise awareness of the need for every child in America to have a safe, loving, and permanent home.

Adopting a child is a great joy and also a great responsibility. Parents are a child's first teachers, and adoptive families can help children learn character and values, the importance of giving back to their community and country, and the courage to realize their potential. On November 15, caring parents across our Nation will celebrate National Adoption Day by finalizing their adoptions and bringing home children in need of a hopeful life.

My Administration is committed to helping young people find the love, stability, and support that a family can provide. We have joined with community and faith-based organizations to raise public awareness of foster children awaiting adoption. With the help of the Congress, we are assisting families in overcoming the financial barriers to adopting children through programs such as the Adoption Incentives Program. In addition, the Collaboration to AdoptUsKids project, which can be found at adoptuskids.org, provides guidance and resources for parents exploring adoption.

During National Adoption Month, we honor adoptive and foster parents who have shown America the depth and kindness of the human heart. Their love and dedication inspire the next generation of Americans to achieve their dreams and demonstrate the true spirit of our Nation.

NOW, THEREFORE, I, GEORGE W. BUSH, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim November 2008 as National Adoption Month. I call upon all Americans to observe this month with appropriate programs and activities to honor adoptive families and to participate in efforts to find permanent homes for waiting children.

IN WITNESS WHEREOF, I have hereunto set my hand this thirty-first day of October, in the year of our Lord two thousand eight, and of the Independence of the United States of America the two hundred and thirty-third.

GEORGE W. BUSH



Federal Register

Friday,
December 19, 2008

Part VI

Department of Health and Human Services

45 CFR Part 88
Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 88

RIN 0991–AB48

Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law

AGENCY: Office of the Secretary, HHS.
ACTION: Final rule.

SUMMARY: The Department of Health and Human Services (HHS) is issuing a final rule to ensure that Department funds do not support morally coercive or discriminatory practices or policies in violation of federal law, pursuant to the Church Amendments (42 U.S.C. 300a–7), Public Health Service (PHS) Act § 245 (42 U.S.C. 238n), and the Weldon Amendment (Consolidated Appropriations Act, 2008, Public Law 110–161, Div. G, § 508(d), 121 Stat. 1844, 2209). This final rule defines certain key terms. In order to ensure that recipients of Department funds know about their legal obligations under these federal health care conscience protection laws, the Department is requiring written certification by certain recipients that they will comply with all three statutes, as applicable. Finally, this final rule assigns responsibility for complaint handling and investigation among the Department's Office for Civil Rights and Department program offices.

DATES: This rule is effective January 20, 2009.

FOR FURTHER INFORMATION CONTACT: For further information regarding this rule, contact: Brenda Destro, (202) 401–2305, Office of Public Health and Science, Department of Health and Human Services, Room 728E, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201. For information regarding how to file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services, contact: Vermell Lancaster, (202) 260–7180, Office for Civil Rights, Department of Health and Human Services, Room 533F, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

SUPPLEMENTARY INFORMATION:

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I. Introduction

Statutory Background

Several provisions of federal law prohibit recipients of certain federal funds from coercing individuals in the health care field into participating in actions they find religiously or morally objectionable. These same provisions also prohibit discrimination on the basis of one's objection to, participation in, or refusal to participate in, specific medical procedures, including abortion or sterilization. In addition, there is a statutory provision that prohibits the federal government and State and local governments from discriminating against individual and institutional providers who refuse, among other things, to receive training in abortions, require or provide such training, perform abortions, or refer for or make arrangements for abortions or training in abortions. More recently, an appropriations provision has been enacted (and reenacted or incorporated into every appropriations act since the appropriations act for Fiscal Year 2005) that prohibits certain federal agencies and programs and State and local governments that receive certain federal funds from discriminating against individuals and institutions that refuse to, among other things, provide, refer for, pay for, or cover, abortion. These statutes are collectively referred to as the "federal health care conscience protection statutes." This rule is intended to ensure that, in the delivery of health care and other health services, recipients of Department funds do not support coercive or discriminatory practices in violation of these laws.

Conscience Clauses/Church Amendments (42 U.S.C. 300a–7)

The conscience provisions contained in 42 U.S.C. 300a–7 (collectively known as the "Church Amendments") were enacted at various times during the 1970s in response to debates over whether receipt of federal funds required the recipients of such funds to perform abortions or sterilizations. The first conscience provision in the Church Amendments, 42 U.S.C. 300a–7(b), provides that "[t]he receipt of any grant, contract, loan, or loan guarantee under [certain statutes implemented by the Department of Health and Human Services] * * * by any individual or entity does not authorize any court or any public official or other public authority to require": (1) The individual to perform or assist in a sterilization procedure or an abortion, if it would be contrary to his/her religious beliefs or moral convictions; (2) the entity to make its facilities available for sterilization procedures or abortions, if the performance of sterilization procedures or abortions in the facilities is prohibited by the entity on the basis of religious beliefs or moral convictions; or (3) the entity to provide personnel for the performance of sterilization procedures or abortions, if it would be contrary to the religious beliefs or moral convictions of such personnel.

The second conscience provision in the Church Amendments, 42 U.S.C. 300a–7(c)(1), prohibits any entity which receives a grant, contract, loan, or loan guarantee under certain Department-implemented statutes from discriminating against any physician or other health care personnel in employment, promotion, termination of employment, or the extension of staff or other privileges because the individual either "performed or assisted in the performance of a lawful sterilization procedure or abortion, or because he refused to perform or assist in the performance of such a procedure or abortion on the grounds that his performance or assistance in the performance of the procedure or abortion would be contrary to his religious beliefs or moral convictions, or because of his religious beliefs or moral convictions respecting sterilization procedures or abortions."

The third conscience provision, contained in 42 U.S.C. 300a–7(c)(2), prohibits any entity which receives a grant or contract for biomedical or behavioral research under any program administered by the Department from discriminating against any physician or other health care personnel in employment, promotion, termination of employment, or extension of staff or other privileges "because he performed or assisted in the performance of any lawful health service or research activity, or because he refused to perform or assist in the performance of any such service or activity on the grounds that his performance of such service or activity would be contrary to his religious beliefs or moral convictions, or because of his religious beliefs or moral convictions respecting any such service or activity."

The fourth conscience provision, 42 U.S.C. 300a–7(d), provides that "[n]o individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by [the Department] if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions."

The final conscience provision contained in the Church Amendments, 42 U.S.C. 300a–7(e), prohibits any entity that receives a grant, contract, loan, or loan guarantee under certain Departmentally implemented statutes from denying admission to, or otherwise discriminating against, "any applicant (including for internships and residencies) for training or study because of the applicant's reluctance, or willingness, to counsel, suggest, recommend, assist, or in any way participate in the performance of abortions or sterilizations contrary to or consistent with the applicant's religious beliefs or moral convictions."

Public Health Service Act § 245 [42 U.S.C. 238n]

Enacted in 1996, section 245 of the Public Health Service Act (PHS Act) prohibits the federal government and any State or local government receiving federal financial assistance from discriminating against any health care entity on the basis that the entity (1) refuses to receive training in the performance of abortions, to require or provide such training, to perform such abortions, or to provide referrals for such training or such abortions; (2) refuses to make arrangements for such activities; or (3) attends or attended a post-graduate physician training program or any other training program in the health professions that does not (or did not) perform abortions or require, provide, or refer for training in the performance of abortions or make arrangements for the provision of such training. For the purposes of this protection, the statute defines "financial assistance" as including, "with respect to a government program," "governmental payments provided as reimbursement for carrying out health-related activities." In addition, PHS Act § 245 requires that, in determining whether to grant legal status to a health care entity (including a State's determination of whether to issue a license or certificate (such as a medical license)), the federal government and any State or local government receiving federal financial assistance deem accredited any post-graduate physician training program that would be accredited, but for the reliance on an accrediting standard that, regardless of whether such standard provides exceptions or exemptions, requires an entity: (1) To perform induced abortions; or (2) to require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training.

Weldon Amendment [Consolidated Appropriations Act, 2008, Public Law 110–161, Div. G, § 508(d), 121 Stat. 1844, 2209 (Dec. 26, 2007)]

The Weldon Amendment, originally adopted as section 508(d) of the Labor-HHS Division (Division F) of the 2005 Consolidated Appropriations Act, Public Law 108–447 (Dec. 8, 2004), has been readopted (or incorporated by reference) in each subsequent HHS appropriations act. Title V of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2006, Public Law 109–149, § 508(d), 119 Stat. 2833, 2879–80; Revised Continuing Appropriations Resolution of 2007, Public Law 110–5, § 2, 121 Stat. 8, 9; Consolidated Appropriations Act, 2008, Public Law 110–161, Div. G, § 508(d), 121 Stat. 1844, 2209; Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009, Public Law 110–329, Div. A, § 101, 122 Stat. 3574, 3575. The Weldon Amendment provides that "[n]one of the funds made available under this Act [making appropriations for the Departments of Labor, Health and Human Services, and Education] may be made available to a federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions." It also defines "health care entity" to include "an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan."

The Proposed Rule

On August 26, 2008 (73 FR 50274), the Office of the Secretary, Department of Health and Human Services, published a Notice of Proposed Rulemaking (proposed rule) entitled, "Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law." The proposed rule set forth the purpose of the proposed rule, proposed definitions to clarify the meaning of statutory requirements, and proposed to require certain recipients and sub-recipients of Departmental funds to certify their compliance with the statutory requirements.

The Comment period closed on September 25, 2008.

The Final Rule

As noted in the preamble to the proposed rule, the Department is concerned about the development of an environment in sectors of the health care field that is intolerant of individual objections to abortion or other individual religious beliefs or moral convictions. Such developments may discourage individuals from entering health care professions. Such developments also promote the mistaken belief that rights of conscience and self-determination extend to all persons, except health care providers. Additionally, religious and faith-based organizations have a long tradition of providing medical care in the United States, and they continue to do so today—some of these are among the largest providers of health care in this nation. Such institutions may have traditions of issuing clear public guidance which informs the members of their workforces, including physicians having privileges at their institutions, of the parameters under which they should operate in accordance with the organization's overall mission and ethics. A trend that isolates and excludes some among various religious, cultural, and/or ethnic groups from participating in the delivery of health care is especially troublesome when considering current and anticipated shortages of health care professionals in many medical disciplines and regions of the country.

The Department is committed to its mission of expanding patient access to necessary health care services. Americans can enjoy healthier, happier, and more productive lives through access to, and appropriate utilization of, all of the life-saving and life-improving procedures and services produced by medical innovation. The Department has a long history of demonstrated success in facilitating the improvement of lives in this way.

A necessary element in ensuring the best possible care for patients is protecting the integrity of the doctor-patient relationship. Patients need full access to their health care provider's best judgment as informed by practice, knowledge, and experience. This

relationship requires open communication between both parties so patients can be confident that the care they seek and receive is endorsed by their health care provider. It is one of the reasons for the common practice of patients meeting with several health care providers in order to find the one in whom they are most confident about entrusting their care. This helps ensure patients receive the care they believe is appropriate, and that doctors provide care that they are comfortable providing.

The doctor-patient relationship requires a balancing of interests. The patient has an interest in obtaining legal health care services—and, in the context of federally funded health care programs, an eligible patient may have the right to obtain certain health care services from certain entities. This must be balanced against the statutory right of the provider in the context of a federally funded entity to not be discriminated against based on a refusal to participate in a service to which they have objections, such as abortion. As stated above, Congress recognized those provider rights in several statutes.

The Department seeks to ensure this balance through raising awareness of federal health care conscience protection laws by specifically including reference to the nondiscrimination provisions contained in the Church Amendments, PHS Act § 245, and the Weldon Amendment in certifications currently required of most existing and potential recipients of Department funds. It also seeks to provide for Departmental enforcement of these three statutes.

Toward these ends, the Department has concluded that regulations and related efforts are necessary, in order to (1) educate the public and health care providers on the obligations imposed, and protections afforded, by federal law; (2) work with State and local governments and other recipients of funds from the Department to ensure compliance with the nondiscrimination requirements embodied in the Church Amendments, PHS Act § 245, and the Weldon Amendment; (3) when such compliance efforts prove unsuccessful, enforce these health care conscience protection laws through the various Department mechanisms currently in existence, to ensure that Department funds do not support morally coercive or discriminatory practices or policies in violation of federal law; and (4) otherwise take an active role in promoting open communication within the health care field, and between providers and patients, fostering a more inclusive, tolerant environment in the health care industry than may currently exist.

The ability of patients to access health care services, including abortion and reproductive health services, is long-established and is not changed in this rule. Instead, this rule implements federal laws protecting health care workers and institutions from being compelled to participate in, or from being discriminated against for refusal to participate in, health services or research activities that may violate their consciences, including abortion and sterilization, by entities that receive certain funding from the Department. [It also implements the provisions of federal law which protect health care personnel from being discriminated against for their participation in any lawful health service or research activity, including abortion and sterilization, by entities that receive certain funding from the Department.] Delivery of health care services is significantly improved when patients and health care providers have full, open, and honest conversations about the services they request and provide. These conversations are particularly useful at the beginning of a patient-provider relationship. This rule should help generate greater transparency between patients and providers and foster open discussion, which should strengthen relationships between patients and providers, as well as those between entities and their employees.

This final rule sets out, and provides further definition of, the rights and responsibilities created by the federal health care provider conscience provisions. It clarifies the scope of protections to applicable members of the Department's workforce, as well as health care entities and members of the workforces of entities receiving Department funds. This final rule also requires certain recipients and sub-recipients of Department funds to certify compliance with these federal requirements. In order to ensure proper enforcement, this final rule defines certain terms for the purposes of this final rule.

As was stated in the preamble to the proposed rule, the Office for Civil Rights (OCR) of the Department of Health and Human Services has been designated to receive complaints of discrimination and coercion based on the healthcare conscience protection statutes and this regulation. OCR will coordinate handling of complaints with the staff of the Departmental programs from which the entity, with respect to whom a complaint has been filed, receives funding (f.e., Department funding component). Enforcement of the requirements set forth in this regulation will be conducted by staff of the Department funding component through the usual and ordinary program mechanisms. Compliance with the requirements promulgated herein will likely be examined as part of any broader compliance review conducted by Department staff. If the Department becomes aware that a State or local government or an entity may have undertaken activities that could lead to violation of, or may actually be in violation of, the requirements or prohibitions promulgated herein, the Department will work with such government or entity to assist such government or entity to comply or come into compliance with such requirements or prohibitions. If, despite the Department's assistance, compliance is not achieved, the Department will consider all legal options, including termination of funding, return of funds paid out in violation of health care conscience protection provisions under 45 CFR parts 74, 92, and 96, as applicable.

II. Comments on the Proposed Rule

On August 26, 2008 (73 FR 50274), Department of Health and Human Services published the proposed rule. The Department received a large volume of Comments on the proposed rule, both from Commenters supporting the proposed rule, as well as from those opposing the proposed rule. Comments came from a wide variety of individuals and organizations, including private citizens, individual and institutional health care providers, religious organizations, patient advocacy groups, professional organizations, universities and research institutions, consumer organizations, and State and federal agencies and representatives. Comments dealt with a range of issues surrounding the proposed rule, including the need for the rule; what kinds of workers would be protected by the proposed rule; what services are covered by the proposed rule; whether health care workers use the regulation to discriminate against patients; what significant implementation issues could be associated with the rule; legal arguments; and the cost impacts of the proposed rule. Many Comments from health care providers, members of the public, and others confirmed the need to promulgate this regulation to raise awareness of federal conscience protections and provide for their enforcement.

A summary of the substantive Comments, and the Department's Responses to those Comments, follows.

A. Comments on Proposed New § 88.1—Purpose

No Comments were received pertaining to this section.

B. Comments on Proposed New § 88.2—Definitions

Assist in the Performance

Comment: Many Comments suggested that the proposed definition of "assist in the performance" was too broad. These Comments focused primarily on the inclusion of referral, training, and other arrangements within the ambit of this statutory term, claiming that this would allow an individual or institution to refuse to provide information or counseling about an objectionable procedure to which he or it objected. Commenters also expressed concern that the definition was too broad because, they asserted, a health care provider has an obligation to provide or assist patients with a referral or other information that allows the patient to receive health care services, regardless of the health care provider's conscientious objection.

Response: Commenters raising these concerns may lack understanding of the context in which the term "assist in the performance" is used in the statutes and in this regulation. The term is only used in the Church Amendments and in the provisions of this regulation that implement those statutory provisions. As noted above (see section 1), all provisions of the Church Amendment use the term "assist in the performance" to ensure that individuals are protected from being required to assist in the performance of certain health care services or research activities, and from being discriminated against on the basis that the individual (1) assisted in the performance of a legal health service or research activity, or (2) refused to assist in the performance of such a health service or research activity because it would be contrary to his religious beliefs or moral conviction. Given that context, in interpreting the term "assist in the performance," the Department has sought to provide broad protection for individuals, consistent with the plain language of the statutes. As a policy matter, the Department believes that limiting the definition of the statutory term "assist in the performance" only to those activities that constitute direct involvement with a procedure, health service, or research activity, falls short of implementing the protections Congress intended under federal law. However, we recognized the potential for abuse if the term was unlimited. Accordingly, we proposed—and here finalize—a definition of "assist in the performance" that is limited to "any activity with a reasonable connection to a procedure, health service or health service program, or research activity." We also finalize the limitation in the definition that required the individual involved to be "a part of the workforce of a Department-funded entity."

We wish to clarify here the scope of federal law respecting the protections afforded with respect to "assist[ing] in the performance" of a procedure, health service, or research activity. Whether the relevant provision of the Church Amendments uses the term "individual" [42 U.S.C. 300a–7(b)(1), (d)], "personnel" [42 U.S.C. 300a–7(b)(2)(B)], "any physician or other health care personnel" [42 U.S.C. 300a–7(c)(1)–(2)], or applicant [ ] for training or study" [42 U.S.C. 300a–7(e)], the term "assist in the performance" of a procedure, health service, or research activity applies to people. Thus, the protections of the Church Amendments with respect to "assist[ing] in the performance" of a procedure, health service, or research activity are afforded only with respect to people. To the extent such entities' or institutions' refusal to assist in the performance of such an activity would not be protected by PHS Act § 245, the Weldon Amendment, or the Church Amendments at section 300a–7(b)(2), such entities or institutions would have to arrange to provide any information or service otherwise required by law.

Individual and Workforce

Comment: Some Comments questioned whether the proposed definitions of the terms "individual" and "workforce" are too broad. Comments suggested that the definitions of these two terms would require a health care facility to apply the protections to all of its employees and contractors, no matter how removed their involvement is from the delivery of abortion or sterilization services. Other Comments expressed concern that the proposed definition of "workforce" would extend the conscience protections to volunteers and trainees. Commenters were also concerned that physicians, hospitals, and other health care institutions may find the definition burdensome in various areas of their operation (*e.g.*, janitorial services, medical recordkeeping, security, reception services). Lastly, Comments asserted that the definition of "workforce" needs to be changed to provide a complete list of the types of individuals who fall within it.

Response: The Department believes that its proposed definition of "individual" is consistent with the statutory language and the intent of Congress as gleaned from an examination of the provisions in context. We had proposed to define "individual" as "a member of the workforce of an entity/health care entity."

As noted above, the term "individual" is used in two provisions of the Church Amendments: 42 U.S.C. 300a–7(b)(1)[1] and 42 U.S.C. 300a–7(d).[2] In other provisions of the Church Amendments, Congress chose to use more clearly limiting terms: "personnel" (42 U.S.C. 300a–7(b)(2)(B)], "any physician or other health care personnel" (42 U.S.C. 300a–7(c)(1)&(2)], or "applicant [] for training or study" [42 U.S.C. 300a–7(e)]. In addition, these other provisions are explicitly limited to discrimination in the employment/privileging or education/training contexts, while 42 U.S.C. 300a–7(d) is not so limited: it provides that "[n]o individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by [HHS]" if doing so "would be contrary to his religious beliefs or moral convictions." Given this context, we believe that Congress did not intend that the term "individual" be limited to employees or health care personnel with privileges at a Department-funded entity, and that it is reasonable to include volunteers and trainees in the definition of "workforce." These laws are intended to protect the conscience rights of all individuals participating in health care services, and research programs and activities receiving certain federal funds, or that are administered by the Department. The Department provides a definition of the term "workforce" to serve as a limiting criterion to ensure that individuals that are not under the control of an entity receiving Department funds do not claim the protection afforded by the statutes. We further note that, where the individual is assisting in the performance of a sterilization procedure or abortion (or

[1] 42 U.S.C. 300a–7(b)(1) provides that the "[t]he receipt of any grant, contract, loan, or loan guarantee under [certain statutes implemented by HHS] * * * by any individual * * * does not authorize any court or any public official or other public authority to require" the individual to perform or assist in a sterilization procedure or an abortion if it would be contrary to his/her religious beliefs or moral convictions.

[2] 42 U.S.C. 300a–7(d) provides that "[n]o individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by [HHS]" if doing so "would be contrary to his religious beliefs or moral convictions."

any other health service or research activity) in which the provisions of the Church Amendments are relevant, the definition of "assist in the performance" further limits the protection to "any activity with a reasonable connection to a procedure, health service or health program, or research activity * * *." Thus, we disagree with the Comment that the definitions would require a health care facility to apply protections to all of its employees and contractors no matter how far removed from the performance of sterilization procedures or abortion. The Department acknowledges that these definitions would include volunteers and trainees. It is clear that the statutes specifically envision that these protections apply to training programs, students, and applicants for training or study in the health professions. Regarding the Comment that physicians, hospitals or other providers may find it difficult or burdensome to comply with this requirement, the Department points to the fact that these requirements are not new, but are rather existing conditions on certain federal funds that recipients should be following already.

The Department agrees with the Comment that the term "workforce" should provide a complete identification of covered individuals, and will therefore replace the word "includes" with the word "means", to provide a clearer and more definitive definition.

As indicated in the proposed rule—and consistent with the scope of the Church Amendments, which include physicians and other health care providers that have privileges with an entity receiving funding from the Department—we intended the concept of "workforce" to include physicians and other health care providers who have privileges at the entity funded by the Department. After publication of the proposed rule, it came to the Department's attention that the language of the "workforce" definition may not be clear on this issue. Accordingly, to ensure clarity on this point, we are revising the definition of "workforce" by adding at the end "or health care providers holding privileges with the entity." The definition now reads: "'workforce' means employees, volunteers, trainees, contractors, and other persons whose conduct, in the performance of work for a Department-funded entity, is under the control or authority of such entity, whether or not they are paid by the Department-funded entity, or health care providers holding privileges with the entity."

Health Care Entity/Entity

Comment: A number of Comments suggested that the definitions of "health care entity" and "entity" are too broad and go beyond those in the Public Health Service Act and the Weldon Amendment. They assert that the Department exceeded its rule-making authority when it applied the legal standard enunciated in the Weldon Amendment and Public Health Service Act to "health care entities" that are not encompassed by the definitions set forth in those statutes. Comments also requested that the Department clarify whether a health care entity includes pharmacists, nurses, occupational therapists, public-health workers, janitors working for health care entities, and technicians, as well as psychiatrists, psychologists, counselors, and other mental health workers, while others suggested that pharmacists should not be included. Lastly, one Commenter expressed concern that the proposed rule did not specify what amount of Departmental funding would place an entity under the purview of these regulations.

Response: The Department believes the definitions proposed in the proposed rule and adopted herein are appropriate and within its authority. In providing definitions of the term "health care entity" in their statutes, the Weldon Amendment and Public Health Services Act use the word "include." As a matter of statutory drafting and construction, the use of that word indicates that the list following it is not exhaustive. In seeking to issue this regulation, the Department thought it would be beneficial to provide a clear and consistent definition that it would apply when implementing any of the three statutes. In proposing the definition, the Department intended it to be appropriately broad, but did not attempt to specifically list every possible entity or health profession classification, to avoid the situation that new health care professional classifications—or current health care professions inadvertently not listed—were not protected. As such, the Department used the terms "health care professional" and "health care personnel" to cover other professions such as pharmacists, nurses, occupational therapists, public-health workers, and technicians, as well as psychiatrists, psychologists, counselors, and other mental health workers. The Department rejects the suggestion that pharmacists or pharmacies be specifically excluded from the definition because that would seem inconsistent with both the text and the purpose of the statutes. Lastly, the Department is concerned that some Commenters may incorrectly believe that there is a minimum financial threshold below which entities may receive a certain amount of Departmental funds without being subject to the statutory provisions and these implementing regulations. As in other cases, such as Title VI of the Civil Rights Act of 1964, when an entity elects to receive any amount of federal funds, that entity agrees to follow all conditions and rules that apply to the use of those funds or upon which receipt of the funds is conditioned.

Health Service/Health Service Program

Comment: Several Comments declared that the definitions of "health service" and "health service program" inappropriately expand the scope of the conscience provisions to all medical treatments or services, biomedical and behavioral research, activities related to providing medicine, health care, or other services related to health or wellness [including programs such as Medicare and Medicaid]. Some observed that the definitions include certain public health programs, such as vaccinations and family planning. Lastly, other Comments on these proposed definitions suggested that the definition of "health service program" be expanded to specifically include assisted suicide, transgender-related surgery and assisted reproductive technologies.

Response: Commenters' objections to this definition are fundamentally an objection to the Department's interpretation of the scope of the statutory protections themselves. We proposed to define "health service program" as including any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded, in whole or in part, by the Department, which may include components of programs operated by State or local governments. There is nothing in the statute to suggest that the term "health service program" in 42 U.S.C. 300a–7(d) is to be read narrowly. Moreover, given the context of the provision in which it appears, while individuals and health care personnel are protected with respect to their participation in research activities, it would not be the result of a broad understanding of "health service," but because such individuals and healthcare personnel are engaged in performing or assisting in the performance of research activities funded under programs administered by the Department, which are subject to statutory protection. See 42 U.S.C. 300a–7(d). The definition and

the statutory protections apply to health services and research activities that are funded in whole or in part by the Department. For the Department to adopt a definition that removes protection from entire programs that are appropriately included in the definition, given the statutory context, would be inconsistent with our understanding of the purpose of the statutory provisions. The observation that some of these programs may involve important public health issues that may be controversial or objectionable to some is not a justification to eliminate the statutory protections. The Comment that seeks the inclusion of "assisted suicide" and other procedures in the definition of "health service program" is misinformed. This definition does not set out a list or description of the types of procedures to which a protected individual may or may not object, but the types of programs under which such protection exists.

While the Department had proposed to define the term "health service," the Department has determined that the term is self-explanatory, and that a definition is not necessary, or may potentially confuse recipients. Accordingly, we do not finalize a definition of the term.

Recipient/Sub-Recipient

Comment: Several Comments expressed concern over extending the applicability of the proposed definitions of "recipient" and "sub-recipient" to foreign non-governmental organizations or international organizations (such as agencies of the United Nations) without reference to existing federal law governing U.S. foreign policy. These Comments claimed that it could create confusion among federal agencies about which laws to follow and could lead to unforeseen foreign policy complications. They added that it may also create confusion for entities that receive United States funding, but are located outside of the United States.

Response: The Department does not believe a conflict exists between these statutory requirements and U.S. foreign policy related to the use of federal funds abroad. To reduce any potential confusion among federal agencies, we proposed and here finalize a definitions of recipient and sub-recipient which permit the Department awarding agency to exercise discretion as to whether the terms include foreign or international organizations (such as agencies of the United Nations).

Other Definitions

Comment: Many Commenters asserted the term "abortion" should be defined in the regulation, some believing that, without such definition, the proposed rule does not provide sufficient information to direct health care providers to meet the obligations of the requirements. The main division among Commenters regarding the definition of abortion was whether certain contraceptive methods or services that have the potential to terminate a fertilized egg after conception but before implantation are considered abortion under the proposed rule. Several Commenters claimed that the proposed rule would seriously jeopardize Title X programs and Medicaid services if "abortion" is not clearly defined to exclude contraceptive services.

Response: After the full consideration of Comments on this issue, the Department declines to add a definition of abortion to the rule. As indicated by the Comments, such questions over the nature of abortion and the ending of a life are highly controversial and strongly debated. The Department believes it can enforce the federal health care conscience protection laws without an abortion definition just as the Department has enforced Hyde Amendment, Consolidated Appropriations Act, 2008, Public Law 110–161, Div. G, §§ 507, 508(a)–(c), 121 Stat. 1844, 2208 (Dec. 26, 2007), abortion funding restrictions without a formal definition. Additionally, nothing in this rule alters the obligation of federal Title X programs to deliver contraceptive services to clients in need as authorized by law and regulation.

Comment: Comments requested that the Department define many other terms or phrases that are used in the regulation. Some Comments suggested that the Department adopt a narrow definition of the term "discrimination" and make clear that the reassignment of an employee who states a religious or moral objection to a certain activity (such as abortion) does not constitute discrimination.

Response: The Department believes that these terms are sufficiently clear, and do not need further definition. The Department does not believe that a definition of the statutory term "discrimination" is necessary. The term "discrimination" is widely understood, and significant federal case law exists to aid entities in knowing what types of actions do or do not constitute unlawful discrimination. The Department expressly rejects the suggestion that the reassignment of an employee who states a religious or moral objection to a certain activity (such as abortion) may not constitute discrimination in all cases. Like most discrimination cases, the outcomes are dependent on the facts. It seems likely that there are situations where the reassignment of an employee for the refusal to perform a specific procedure could constitute unlawful discrimination. Likewise, the Department recognizes that circumstances exist where the reassignment of such an employee would not constitute unlawful discrimination. We encourage employers subject to the rule to have discussions with their employees that lead to mutually agreeable resolutions.

Comment: Some Comments asked that the Department define the terms "religious belief" and "moral conviction" to ensure that they would not be interpreted broadly.

Response: The Department declines to adopt particular definitions of these terms because the common definitions are plainly understood, and the Department intends that common sense interpretations apply. A well-defined body of federal law exists in this general topic, and the U.S. Supreme Court has repeatedly clarified that these terms are to be read broadly.

C. Comments on Proposed New § 88.3—Applicability

No Comments were received specifically pertaining to this section.

D. Comments on Proposed New § 88.4—Requirements and Prohibitions

No Comments were received specifically pertaining to this section.

E. Comments on Proposed New § 88.5—Written Certification of Compliance

Comment: Several Comments stated that the requirement for written certification in proposed section 88.5 would be duplicative or unnecessary because current regulations already require written certification of compliance with federal nondiscrimination and civil rights laws. Other Comments suggested that the certifications be modified in order to avoid confusion on the part of recipients and sub-recipients.

Response: We find that a specific written certification is necessary to protect institutions under those laws. Many recipients (and sub-recipients) of Department funds currently must certify compliance with certain listed federal nondiscrimination laws, yet federal health care conscience protection laws are separate laws not specifically mentioned in existing forms. As part of a broad effort to raise awareness in the public, in the health care community, among recipients of Department funds, and among protected individuals and institutions, of their rights and responsibilities under existing federal

health care conscience protection laws, as well as to facilitate enforcement of these laws, the regulation requires certain recipients and sub-recipients of Department funds to certify their compliance in writing. Wherever possible, Department programs will attempt to integrate certifications required under this regulation into existing forms.

The Department has modified the certifications in section 88.5. They have been made clear so that recipients and sub-recipients know, by means of the certifications themselves, with which provisions they must comply based on the type of entity the recipient is or the type of funding mechanism through which they receive funds.

Comment: Comments asserted that the Department is overstepping its authority by making compliance with the federal health care conscience protection statutes a condition of payment, stating Congress has not made compliance a condition of payment and would have said so if that were its intent.

Response: The Department disagrees that the proposed rule exceeds its authority. It is important to emphasize that the Department and recipients of Department funds, including State and local governments, are obligated to comply with the health care protection conscience laws that have been in effect for many years, which prohibit federal funds from being used in a discriminatory or coercive manner against institutional and individual health care entities and workers for their participation or refusal to participate in abortions; other certain medical procedures, health services, or research activities that they find objectionable on religious or moral grounds. By employing existing regulatory enforcement measures to ensure compliance with such statutory requirements under 45 CFR parts 74, 92, and 96, as well as other measures, the Department does not exceed its authority, but rather is carrying out its obligation to enforce existing laws.

F. Comments Received in Response: Specific Requests for Comments in the Proposed Rule

Current Awareness of and Compliance With Provider Conscience Protections

Comment: This regulation implements existing federal health care conscience protection laws contained in the Church Amendments, the Public Health Service Act § 245 and the Weldon Amendment. Several Comments objected to the regulation on the grounds that these laws were sufficient in themselves and that their implementation by regulation was unnecessary or redundant. Generally, these Comments suggested that the health care field is sufficiently aware of the statutory protections available for provider conscience, and that no further regulatory effort was required in order to provide awareness of these laws or to assure compliance with them. Several other Comments, however, reported widespread lack of knowledge regarding these laws and inconsistent application of them. These Comments generally supported the regulation as a necessary and useful mechanism to support statutory protection. In addition, numerous Comments reported what they believed to be individual instances of violation of conscience, including health care providers suffering loss of employment, adverse actions during medical training, and discrimination in residency placement, among other consequences, due to their assertion of their conscience rights. Some Commenters also reported pressure to perform certain procedures from State authorities, professional organizations, or employers that appeared to the Commenters to be inconsistent with federal conscience protections.

Response: The Comments received in Response to the proposed rule support the Department position that the regulation is necessary to implement the statutes. While many people in the health care field may have general knowledge that conscience protections exist for providers, the scope of these protections is not always widely understood. Because Congress has enacted several different protections, an individual or organization may be aware that, for instance, a physician may not be compelled to perform abortions, but may not be aware of other aspects of the statutes providing conscience protection. Others may become aware of these laws, at least in detail, only when a dispute arises and a provider or entity attempts to assert their conscience rights; there may be subsequent disagreement over the nature of the rights asserted. The Department believes that coordinating the several related statutory protections, by incorporating their various requirements into this regulation, will allow for greater clarity and awareness of these protections within the health care field, in conjunction with other public education efforts connected with this regulation. In addition, the issuance of a regulation will allow for greater ease of administration, provide a Departmental point of contact for complaints regarding violations of the statutes and this regulation, and provide a uniform mechanism for investigating complaints of noncompliance. The types of noncompliance reported by Commenters are expected to be reduced as a result of this regulation.

Methods To Address Compliance Problems and Increase Awareness

Comment: Commenters who supported and opposed the rule both noted that the Department must increase awareness of health care provider conscientious objection rights, and the obligations this rule may pose for employers, entities, and States. Some Commenters also responded to the Department's request for Comments on methods which may be used by the Department and others to increase awareness among health care providers of their rights under laws protecting providers from discrimination for exercising their conscience rights.

Commenters who opposed the rule suggested that, as an alternative to further federal regulation, the Department should prepare and distribute informational materials to individual and institutional health care providers and State and local governments, and make these materials available on the HHS Web site. A Commenter also proposed that the Department develop continuing education courses for health care practitioners and attorneys, and that existing certifications that recipients of Departmental funds must currently sign could be modified to achieve the objectives of the rule.

Response: The Department agrees that the suggestions offered by Commenters of mechanisms for improving awareness of conscience rights among health care providers would increase the effectiveness of the rule. However, the rule seeks to achieve not only greater awareness of provider conscience rights, but also a more consistent understanding of the scope of these rights (and the corresponding obligations), greater ease of administration, provision of a Departmental point of contact for complaints regarding violations of the statutes and this regulation, a uniform mechanism for investigating complaints of noncompliance, and, as a result, greater compliance with the laws protecting these rights.

Comment: Commenters who supported the rule also offered suggestions on how both the Department and covered entities could increase awareness of the legal protections for health care provider conscience. Among the suggested activities were posting notices in high-traffic areas of buildings receiving

Department funds, providing information within educational programs that receive Department funds, including information in applications for training, applications for residency programs, and private insurance plans benefit descriptions, posting information on the Department or provider Web sites, including of information in employee handbooks, and sending e-mail or postal communications directly to providers. Comments were made on how to best attract attention to such postings by making them distinct from other materials in which they might be included.

Response: The Department agrees that these suggestions would contribute to significantly greater public awareness of health care provider conscience protections. The Department encourages covered entities to undertake such public awareness activities. The Department also recognizes that it must undertake reasonable outreach efforts in order for the rule to be effective at increasing awareness of, and compliance with, provider conscience protections in the statutes and this implementing regulation. Thus, the Department will consider all avenues available for increasing public awareness of health care conscience protection laws. Requiring certification of compliance by entities receiving Department funds provides an important vehicle for increasing awareness of health care conscience protection laws and ensuring compliance with them.

Comment: Some Comments declared that the description of notice/posting of health care provider conscience protections in the proposed rule should be enhanced. One argued that posting of notices on bulletin boards, where they appear among multiple notices, is not a very effective way of communicating the protections afforded under the regulation and statutes. Other Comments requested that notices of federal health care conscience protection statutes should be conspicuous and posted in such locations as provider offices and pharmacies and in such public communications as advertising, health plan promotion materials, Medicaid literature, Web sites, as well as applications for training, residency, and educational programs, and in employee/volunteer handbooks.

Response: The Department agrees that informing health care entities of their rights and responsibilities under federal health care provider conscience provisions is important to ensuring institutional and individual conscience rights are protected. Consequently, the Department encourages covered entities to undertake such educational/public awareness activities. Within its statutory authorities, the Department is exploring a number of options, including many of those suggested by Comments as well as others, to provide further public education and notice of federal health care conscience protection laws and this regulation.

Exceptions to the Written Certification Requirement in Proposed New § 88.5

Comment: Several Comments expressed concern that the certification requirement would create an administrative burden, and one Commenter suggested that the Department should not impose the certification requirements of the regulation on every Department grantee regardless of the grant's purpose.

Response: In its Notice of Proposed Rule Making, the Department solicited Comments on whether further exceptions should be made from certification requirements for recipients or sub-recipients of federal funds, where such recipients or sub-recipients receive Department funds for purposes unrelated to the provision of health care or medical research. Because there is concern among Commenters over any burden of a certification, including that stemming from certifications required without regard to a grant's purpose, and because there appears to be little objection to limiting the certification requirement in the way put forth for Comments in the proposed rule, the Department has determined to make further exceptions to the certification requirement for Departmental programs whose purpose is unrelated to health care provision, including certain programs currently administered by the Administration for Children and Families and the Administration on Aging. These programs often involve the provision of grants to States and other governments, or cash assistance or vouchers rather than direct services, and they are not likely to involve medical research, the participation of health care providers, or referral to health care providers. These programs are unlikely to encounter the circumstances contemplated by this regulation, and therefore the assurance of compliance represented by a certification is not considered necessary by the Department for such programs. The regulatory text has been changed by addition of sections 88.5(e)(4) and (e)(5), together with associated language and example programs in the preamble. Finally, in section 88.5(e)(6), we provide an exception from the written certification requirement for Indian tribes and tribal Organizations when contracting with the Indian Health Service under the Indian Self-Determination and Education Assistance Act. Of course, these entities must still comply with the relevant statutes, even if they are not under an obligation to make a certification.

Should Language Specify Written Certification Is a Material Prerequisite to Payment of Department Funds

Comment: The Department requested Comments on whether written certification of compliance with nondiscrimination provisions should contain language specifying that the certification is a material prerequisite to the payment of Department funds. The Department received a number of Comments in Response to this request, both in favor of and against including such language in the written certification of compliance. Those in favor of including material prerequisite language felt that such language was important as part of the written certification process to protect individuals and institutions from discriminatory treatment. Others stated that certification should not be a prerequisite for Department funding, noting that explicitly tying payment to compliance with the certification requirement would subject the certification process to the federal False Claims Act. One Commenter stated that, absent more explicit guidance on the policies and practices that will satisfy compliance, written certification should not be a material prerequisite to payment of Department funds.

Response: The Department does not consider the written certification of compliance to be a material prerequisite to the payment of Department funds any more than in any other similarly worded statute or regulation. As stated above, the Department intends to work with recipients and sub-recipients of Department funds to ensure compliance with the requirements or prohibitions promulgated in this regulation, and, if such assistance fails to achieve compliance, the Department will consider all legal options, including termination of funding and return of funds paid out in violation of health care conscience protection provisions under 45 CFR parts 74, 92, and 96, as applicable.

G. General Comments

Comment: Many Comments stated concern that the proposed regulation could serve as a pretext for health care workers to claim religious beliefs or moral objections under the protections

the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, Monday through Friday of each week from 8:30 a.m. to 4 p.m.

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FOR FURTHER INFORMATION CONTACT: Brenda Destro, (202) 401–2305, Office of Public Health and Science, Department of Health and Human Services, Room 726E, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

SUPPLEMENTARY INFORMATION:

I. Background

Religious liberty and freedom of conscience have long been protected in the Constitution and laws of the United States. Workers in all sectors of the economy enjoy legal protection of their consciences and religious liberties. In federal law, there are several provisions that prohibit recipients of certain federal funds from coercing individuals in the health care field into participating in actions they find religiously or morally objectionable. These same provisions also prohibit discrimination on the basis of one's objection to, participation in, or refusal to participate in, specific medical procedures, including abortion or sterilization. In addition, there is a provision that prohibits the federal governments and state and local governments from discriminating against individual and institutional providers who refuse, among other things, to receive training in abortions, require or provide such training, perform abortions, or refer for or make arrangements for abortions or training in abortions. More recently, an appropriations provision has been enacted that prohibits certain federal agencies and programs and State and local governments that receive certain federal funds from discriminating against individuals and institutions that refuse to, among other things, provide, refer for, pay for, or cover, abortion.

Conscience Clauses/Church Amendments [42 U.S.C. 300a–7]

The conscience provisions contained in 42 U.S.C. 300a–7 (collectively known as the "Church Amendments") were enacted at various times during the 1970s in response to debates over whether receipt of federal funds required the recipients of such funds to provide abortions or sterilizations. The first conscience provision in the Church Amendments, 42 U.S.C. 300a–7(b), provides that "[t]he receipt of any grant, contract, loan, or loan guarantee under [certain statutes implemented by the Department of Health and Human Services] * * * by any individual or entity does not authorize any court or any public official or other public authority to require": (1) The individual to perform or assist in a sterilization procedure or an abortion, if it would be contrary to his/her religious beliefs or moral convictions; (2) the entity to make its facilities available for sterilization procedures or abortions, if the performance of sterilization procedures or abortions in the facilities is prohibited by the entity on the basis of religious beliefs or moral convictions; or (3) the entity to provide personnel for the performance of sterilization procedures or abortions, if it would be contrary to the religious beliefs or moral convictions of such personnel.

The second conscience provision in the Church Amendments, 42 U.S.C. 300a–7(c)(1), prohibits any entity which receives a grant, contract, loan, or loan guarantee under certain Department-implemented statutes from discriminating against any physician or other health care personnel in employment, promotion, termination of employment, or the extension of staff or other privileges because the individual either "performed or assisted in the performance of a lawful sterilization procedure or abortion," or "because he refused to perform or assist in the performance of such a procedure or abortion on the grounds that his performance or assistance in the performance of the procedure or abortion would be contrary to his religious beliefs or moral convictions, or because of his religious beliefs or moral convictions respecting sterilization procedures or abortions."

The third conscience provision, contained in 42 U.S.C. 300a–7(c)(2), prohibits any entity which receives a grant or contract for biomedical or behavioral research under any program administered by the Department from discriminating against any physician or other health care personnel in employment, promotion, termination of employment, or extension of staff or other privileges "because he performed or assisted in the performance of any lawful health service or research activity," or "because he refused to perform or assist in the performance of any such service or activity on the grounds that his performance of such service or activity would be contrary to his religious beliefs or moral convictions, or because of his religious beliefs or moral convictions respecting any such service or activity."

The fourth conscience provision, 42 U.S.C. 300a–7(d), provides that "[n]o individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by [the Department] if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions."

The final conscience provision contained in the Church Amendments, 42 U.S.C. 300a–7(e), prohibits any entity that receives a grant, contract, loan, or loan guarantee under certain Departmentally implemented statutes from denying admission to, or otherwise discriminating against, "any applicant (including for internships and residencies) for training or study because of the applicant's reluctance, or willingness, to counsel, suggest, recommend, assist, or in any way participate in the performance of abortions or sterilizations contrary to or consistent with the applicant's religious beliefs or moral convictions."

Public Health Service Act § 245 [42 U.S.C. 238n]

Enacted in 1996, section 245 of the Public Health Service Act (PHS Act) prohibits the federal government and any State or local government receiving federal financial assistance from discriminating against any health care entity on the basis that the entity: (1) Refuses to receive training in the performance of abortions, to require or provide such training, to perform such abortions, or to provide referrals for such training or such abortions; (2) refuses to make arrangements for such activities; or (3) attends or attended a post-graduate physician training program or any other training program in the health professions that does not (or did not) perform abortions or require, provide, or refer for training in the performance of abortions or make

recipients of Department funds are still required to comply with these laws; this regulation is intended to raise awareness of the laws among the public, protected health care entities, and recipients of Department funds, as well as to provide for enforcement of federal conscience protections.

Second, the current shortage of health care providers in certain areas of the country provides additional justification for protecting conscience rights. Many Comments we received, including those of many health care providers, stated that forcing providers to perform or participate in procedures that violate their consciences discourages individuals from entering or remaining in careers in the health professions. One Commenter wrote, "by insisting that those who are willing to violate their consciences in the delivery of health care are the only persons who should enter the health care field, one contributes to the creation of a health care delivery system of professionals who blindly follow directives rather than conscience, putting society at risk." Unlike some Commenters, we believe that problems of access to health care can be resolved without requiring health care providers to violate their consciences. By protecting conscience rights in accord with federal law, we wish to encourage more individuals and institutions to participate in Department-funded health service programs in accord with their consciences and, thereby, increase access to quality health care services.

Third, with regard to contraceptive services, the Department continues to support efforts to make safe and effective contraceptives and family planning services available to women—and men—who cannot otherwise afford them. This regulation will ensure that such programs are carried out in a way that is consistent with existing federal health care conscience protection laws. While Comments posed many hypothetical situations in which they claimed access to contraceptive services would be limited, we have found no evidence that issuing these regulations to better ensure compliance with existing federal health care conscience protection laws will create additional barriers to accessing contraceptive services.

Fourth, we note that many Commenters who believed that this rule will significantly restrict access to contraceptives or increase teen pregnancies also submitted Comments stating that the rule was unnecessary because health care provider conscience protection laws are being followed and no provider rights are currently being violated. These two statements are contradictory. If access to any service significantly declined with the implementation of this rule and all other factors remained unchanged, that fact could be evidence that health care providers in question had previously been compelled to deliver the service over their conscience objections.

Comment: Comments argued that any revised rule should include guidance discussing ways to balance the rights of providers and patients, and one Commenter stated that any final rule should contain "a forceful statement of patients' rights to receive health care services in accordance with their religious beliefs or conscience." The Commenter also argued that any certification should require health care entities to certify that the rights of patients are respected to the extent required by law.

Response: Patients' ability to access health care services, including abortion and reproductive health services, is long-established and is not changed in this rule. In issuing regulations implementing federal laws protecting health care entities' conscience rights, we recognize that many current or prospective recipients of Department funds must already certify or assure their compliance with certain federal nondiscrimination laws as a part of existing funding applications. We also encourage all participants in the health care system, including patients, health care providers, and those entities receiving Department funds, to review existing laws, regulations, and guidance, including the U.S. Constitution and federal laws enacted by Congress prohibiting discrimination by health care entities receiving certain federal funds. (For more information on these issues, visit the Web site of the Office for Civil Rights of the Department of Health and Human Services at *http://www.hhs.gov/ocr.*) We also encourage full and open communication between patients and providers on sensitive issues surrounding the provision of health care services, including issues of morality and conscience. Patients are best served when their providers communicate clearly and early about any services they decline to provide or participate in. We similarly encourage full and open communication between providers and their employers or the entities with which they have privileges on issues concerning the services the provider may be unwilling to perform. This would facilitate the appropriate accommodation of a provider's religious or moral objections to particular services, while at the same time enabling the employer/institution to meet the needs of its patients.

The Department seeks to strike a careful balance between the health care provider conscience protections provided in federal law, on the one hand, and patients' needs and the needs of the health care system on the other hand. A health care system that is intolerant of individual conscience, certain religious beliefs, ethnic and cultural traditions, or moral convictions serves to discourage individuals with diverse backgrounds and perspectives from entering the health care professions, further exacerbating health care access shortages and reducing quality of care. It is more likely to lead to situations in which a patient is receiving services or procedures from a provider who is not fully committed to the choice of care. We seek a health care field in which patients can be more confident that their provider shares their views and concerns as identified through mutually open communication. The final regulation takes a cautioned and balanced approach to ensure compliance with federal health care conscience protection laws by defining key terms, stating requirements and prohibitions, and requiring certain recipients and sub-recipients of Department funds to provide written certification of compliance. In so doing, we wish to promote diversity in the health professions, increasing access to health care services.

Comment: Some Comments expressed concern that the proposed rule could restrict access to contraceptives which are being used for purposes other than preventing pregnancy or are being used in conjunction with other medical treatments.

Response: According to 42 U.S.C. 300a–7(d), which applies to any program funded in whole or in part under a program administered by the Department, no protected individual may be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or part under a program implemented by HHS contrary to that individual's religious beliefs or moral convictions; the motivation of the patient or intended use of the service is irrelevant under the statute. We note that nothing in this rule changes the obligations of the federal Title X program or Medicaid to deliver contraceptives to eligible patients in need. However, we reiterate that we have found no evidence that these regulations will create new barriers in accessing contraception unless those contraceptives are currently delivered over the religious or moral objections of

the provider in such programs or research activities.

Comment: Some Comments requested the creation of a hotline to report patient access to care problems.

Response: Again, we do not anticipate a reduction in access to legal health services as a result of this regulation, much less a significant enough change to warrant the creation of a hotline. As a result, we decline to create a specific hotline solely to report patient access to care problems as part of this regulation. However, we encourage members of the public to visit *http://www.hhs.gov/about/ref.html* for a list of available hotlines and information resources regarding Department programs and activities.

Comment: Comments asserted that the proposed rule, if finalized, would disrupt the ethical and legal requirements of providers to obtain informed consent from their patients. Commenters argued that principles of informed consent require health care providers to inform patients about all treatment options or reasonable alternatives, including those to which they object or refuse to perform because it would violate their consciences.

Response: We recognize that informed consent is crucial to the provision of quality health care services. This final rule raises awareness and provides for the enforcement of federal laws, some of which have been in effect for many years, protecting the conscience rights of health care entities. We are aware that nearly all States have laws protecting health care practitioners' rights of conscience to some degree or another, many providing full exemptions to any health care practitioner who conscientiously refuses to participate in an abortion. Over the last four decades, medical professional associations, such as the American Medical Association (AMA), have reaffirmed the rights of physicians and other health care personnel to practice medicine without violating their moral principles.[3] Despite the widespread and sustained existence of federal and State laws protecting the consciences of health care providers, we have found no evidence that protecting conscience rights disrupts the informed consent process between providers and patients. Rather, we believe the provider-patient relationship is best served by open communication of conscience issues surrounding the provision of health care services, including any conscientious objections providers or patients may have to providing, assisting, participating in, or receiving certain services or procedures.

To avoid potential conflicts from occurring, we emphasize the importance of and strongly encourage early, open, and respectful communication between providers and patients surrounding sensitive issues of health care, including issues of conscience, so that both parties' consciences are respected as patients are provided with necessary information to make informed decisions about their health care and choice of provider. We disagree that health care providers' consciences must be violated in order to meet requirements of informed consent in the provision of medical services.

Comment: Several Comments asserted that the proposed regulation could negatively impact and potentially hinder scientific research, arguing that hospital, academic, nonprofit, and corporate research activities that receive Department funds could have difficulty fulfilling their research contracts if workers were allowed to refuse participation. Offering several research activities as examples, Comments argued that Department-funded research institutions could be compromised because of personnel objections to conducting or supporting the research conducted there. Other Comments argued that health care quality and safety will be compromised by the proposed regulation because of the refusal of staff to do their jobs. Similarly, some Comments expressed concern that the regulation will adversely impact the academic rigor of medical education. They argued that professors at publicly funded medical schools could refuse to teach medical procedures or information they find morally objectionable, which would reduce the quality and breadth of medical education.

Response: The Department does not find evidence supporting the Comments' assertions. In enacting federal health care conscience protection laws, including the Church Amendments, PHS Act § 245, and the Weldon Amendment, Congress has clearly stated a policy that Department funding should not support coercive or discriminatory practices that violate individual conscience. The Church Amendments contain specific provisions relating to scientific research, while both the Church Amendments and PHS Act § 245 contain provisions applying to physician training and other training programs in the health professions regarding abortion and sterilization. Some provisions of the Church Amendments, for instance, which specifically mention scientific research [42 U.S.C. 300a–7(c)(2), "biomedical or behavioral research," "research activity"; 42 U.S.C. 300a–7(d), "research activity"] and discrimination against applicants for training or study (42 U.S.C. 300a–1(a)), have been in effect for over three decades. PHS Act § 245 has been in effect since the mid-1990s. The Department is unaware of evidence showing a negative impact of federal conscience provisions on Department-funded scientific research, health services programs, training, or instruction in the health professions; nor have Comments provided evidence supporting the claim that regulations implementing existing federal conscience protections and requirements would hinder such activities. We also disagree with the Commenters' assertions to the extent that Commenters suggest that institutions must require health care providers to violate their consciences in order to conduct health services, training, or research activities.

Comment: Comments expressed concern that the proposed regulation will expand the ability of insurers to refuse to provide health care services, information, and referrals to patients. Other Comments expressed concern that the regulation could impact funding for programs that benefit immigrants or victims of domestic violence.

Response: As previously stated, this regulation does not expand the scope of existing federal conscience protections for health care entities, including health insurance plans. Rather, it provides for Departmental implementation and enforcement of existing federal health care conscience protection laws and educates the public and the health care community about laws protecting the consciences of health care entities that refuse to participate in abortions or other services in the case of Departmental grantees. We are unaware of any way in which the regulation could impact funding for programs that benefit immigrants or victims of domestic violence.

Comment: One Commenter thought the rule would increase spending and add a significant strain on Medicaid.

Response: We have not found evidence supporting the Commenter's assertion that the final rule would increase spending in Medicaid, in part because this final rule does not expand the scope of existing federal health care conscience protection laws, some of which have been in place for over thirty years.

Comment: Several Comments disagreed with the Department's assertion in the proposed rule that the

[3] See, e.g., AMA House of Delegates Policy H–5.995 (Issued 1973; reaffirmed 1992, 1996, 1997, and 2000).

regulation will not have an impact on family well being. Another Commenter stated that the Treasury and General Government Appropriations Act of 1999 requires the Department to determine if the proposed rule would affect family well-being. The Commenter stated that, if family well-being is affected, the Department must provide an impact assessment of these effects. The Commenter also stated that the proposed rule does not adequately address the impact on family well-being.

Response: As stated in the proposed rule, the Department has determined that the final rule will not affect family well-being within the meaning of section 654 of the Treasury and General Government Appropriations Act, 1999, enacted as part of the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (Pub. L. 105–277, 112 Stat. 2681). This final rule defines certain key terms, ensures that recipients of Department funds know about their legal obligations under existing federal health care provider conscience protection provisions, and requires written certification by certain recipients that they will comply with such provisions, as applicable.

Comment: Some Comments asserted that the proposed regulation follows from general laws restricting religious discrimination, such as Title VII of the Civil Rights Act of 1964, or the religious exercise clause of the First Amendment to the United States Constitution. Commenters on this topic disagreed over whether this suggested connection made the regulation necessary to implement core constitutional principles, or unnecessary because these rights are protected in other ways. Commenters pointed out current grantees, for instance, already certify to obey all nondiscrimination laws, and that a specific certification on conscience protection, as contemplated in the proposed regulation, would not be necessary.

Response: The Department agrees with Comments noting that federal health care conscience protections are consistent with constitutional and other statutory protections of religious belief and moral conviction. However, Congress has enacted specific and detailed legislation in the area of health care provider conscience applicable to recipients of certain federal funds which is broader in scope than protections afforded under Title VII and the other examples cited by some Commenters. Because they implement health care-specific statutory provisions applicable to recipients of certain federal funds, these regulations offer more administrable and directive guidance than do other existing laws prohibiting religious discrimination. Many organizations and individuals may not be aware of the scope of the conscience protections or their relationship to other federal nondiscrimination laws when certifying compliance with the latter. The Department believes that the responsibilities of certifying entities will be made clearer by a certification that explains federal health care conscience protection laws explicitly.

Comment: A few Comments suggested that the Department should gather more evidence of noncompliance before regulating in this area, for example, by commissioning a national survey to determine the prevalence of civil rights violations of provider conscience, and that, in the absence of statistical evidence that a significant number of violations are occurring, refrain from issuing implementing regulations.

Response: The Department disagrees that such a survey is a necessary precondition to issuing this regulation. The basis for the regulation is the existence of the several federal health care conscience protection laws. There are a number of purposes served by regulating in this area, including, but not limited to, making the health care community more aware of these rights and clarifying their scope through the exercise of agency expertise, as well as assuring compliance. The Department has good reason to believe that there are risks of non-compliance. By their nature, civil rights protections create responsibilities for entities such as recipients of federal funds or employers to do things they otherwise may not do. It has been the Department's experience that, in the absence of a clear statement of responsibilities, civil rights are less effectively exercised. Commenters did not indicate what they believed would be an "acceptable" level of civil rights violations preventable by this regulation. The Department's goal is compliance with federal law. In Response to the proposed rule, numerous Comments were received, including from those in the health care community, that indicated serious misunderstandings regarding statutory health care provider conscience protections, or which expressed a narrower view of the scope of these protections than is consistent with the Department's interpretation. Especially in light of the additional Comments alleging violations of conscience protection, this Commentary reinforces the Department's view that, in the absence of a clear statement of responsibilities, there is a serious risk that, either from misunderstanding or from a groundless and overly narrow view of health care provider conscience rights, these conscience rights will not be fully protected. How often these violations occur is not known, and it is unclear whether a valid survey could be conducted to determine this figure. Some health care providers may not at this time be aware their rights are being violated when they are compelled to act against their conscience, or they may not attempt to report such violations. As a result of this regulation, a procedure will be put in place to receive and compile complaints, extend protection to those who make them, and the complaints will be reviewed for validity. Consequently, a more reliable estimate of the prevalence of actual violations is likely to be obtained, which will enable the Department to track the extent of noncompliance over time.

Comment: Several Comments were concerned about the absence of implementation guidance in the proposed rule for communication of a provider's individual conscience objections to entities and to patients. Commenters presented a variety of suggestions for additional guidance in the rule concerning communication of a health care provider with his or her employer and patients. Several Comments recommended a requirement that employees submit a written statement of their conscience objection or objections. Some Comments suggested a requirement for posting or providing notice of limitations to health care services provided at a facility or office. One Commenter pointed out that the State of Illinois requires pharmacies that do not carry emergency contraception to post a sign directing patients to other pharmacies that do.

Response: We strongly encourage early, open, and mutually respectful communication of conscience concerns that may arise in the provision of medical services, including between employees and employers as well as between providers and patients. However, we concluded that it was neither feasible nor prudent in this final rule to provide specific guidance on methods and means for such communication given the vast array of circumstances and settings in which communications regarding conscience are likely to take place.

Comment: Comments stated that the proposed rule did not clarify what safeguards health care facilities were required to have in place when a medical professional refused to provide a particular service.

Response: In general, the Department acknowledges that not every institutional or individual health care provider offers every legal health service, and requiring them to do so would be neither appropriate nor prudent. At the same time, we encourage and expect health care facilities to take measures to protect conscience rights while ensuring access to health care services. The myriad number of circumstances occurring across different health care settings where the need to protect conscience rights may arise leads us to decline to prescribe particular measures in this final rule. Because federal health care conscience protection laws have been in place for many years, we fully expect health care entities to take the necessary steps to protect conscience rights while meeting the needs of their patients.

Comment: Another Commentor stated that the proposed rule does not address whether refusal to perform a service must be a consistent, across-the-board refusal, or whether it can be a "graded refusal." For example, the proposed rule does not clarify if an employee can refuse to schedule sterilizations for young or single women but not for married women.

Response: We reiterate here that, for abortion-related activities as covered by the Weldon Amendment and Public Health Service Act § 245, a health care entity's refusal can be on any ground. (42 U.S.C. 300a–7(d), which applies to any program funded in whole or in part under a program administered by the Department, requires that no individual may be required to perform or assist in the performance of any part of a health service program or research activity contrary to that individual's religious beliefs or moral convictions. For involvement in abortion and sterilization as covered by the rest of 42 U.S.C. 300a–7, again, provisions require that no health care personnel be discriminated against for, among other reasons, his/her refusal to perform or assist in the performance of a sterilization procedure (or abortion) contrary to that professional's religious beliefs or moral convictions. Thus, in the case of these statutes, it is the individual's religious beliefs or moral convictions that will control in a particular case, rather than the frequency of the objection.

In addition, as we have previously noted, if the decision is being made based on an individual's characteristics that are federally protected, that is impermissible.

Comment: Comments argued that if a provider is unwilling to provide a certain service, it should give the patient a referral for that service. One Commentor asserted that providers should give patients a "meaningful referral that will ensure that the patients receive continuity of care without facing an undue burden, such as traveling long distances or encountering additional barriers to obtaining the desired services."

Response: Providers who object to participation in abortion or a particular health service may provide information on other options, if asked, but are under no obligation to do so. First, with respect to abortion, both PHS Act § 245 and the Weldon Amendment (among other things) specifically prohibit discrimination by the federal government and State and local governments, and federal agencies and programs, and State and local governments, respectively, against health care entities who refuse to refer for abortion. The Department could not enforce such a referral requirement without violating these provisions. With respect to entities imposing requirements on their employees or members of their workforces, the Church Amendments, while not identifying specific medical practices or services, uses very broad language to characterize the wide array of practices and services to be protected. For example, 42 U.S.C. 300a–7(d) states that individuals may not be required to perform or assist in the performance of "any part of" an objectionable health service program or research activity. For many health care providers, including many who Commented on the proposed rule, referral means assisting in the performance of objectionable procedures or services such as abortion and would violate their consciences. One health care practitioner Commenting on the proposed rule stated that referrals are a form of participation in objectionable acts, and forcing providers to provide referrals would effectively circumvent their moral objection. Federal law recognizes and protects the conscience rights of individuals and entities when it comes to referral for certain objectionable services. Taking the Church Amendments, the Weldon Amendment, and Public Health Service Act § 245 together, the regulation interprets these three federal laws in a way that is consistent with both the letter and the spirit of the law.

Comment: Some Comments argued that the proposed regulation seems to run counter to the Hippocratic Oath's admonition to "do no harm" to patients. Comments pointed out that health care providers must take this oath and agree to treat patients without judgment and provide patients with the care they need.

Response: According to the National Institutes of Health's National Library of Medicine (NLM), the Hippocratic Oath is an ancient medical text requiring new physicians to swear oaths by a number of deities to uphold several professional ethical imperatives, the most widely known of which is "to do no harm." Notably, the NLM translation of the Hippocratic Oath also includes the prohibitions, "I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan, and similarly I will not give a woman a pessary to cause an abortion." The NLM further states that most medical schools do not require graduates to take the Hippocratic Oath. For those physicians who take the Hippocratic Oath or other similar oaths, federal law protects health care providers whose consciences lead them to recognize that participation in certain activities, such as abortion, harms others. Conscience is consistent with and is a necessary part of quality care.

Comment: Commenters expressed concern about impacts on health care delivery, burdens and costs (particularly on small employers), and overlap with existing protections afforded to protect religious conscience of healthcare workers under Title VII of the Civil Rights Act of 1964, and suggested that the Department adopt elements of Title VII jurisprudence in enforcing these laws. Commenters also stated that health care providers must be able to address staffing issues and otherwise appropriately screen job applicants to determine if they are capable and willing to perform the core services required of the job.

Response: We do not believe that it is necessary or appropriate to incorporate elements of Title VII jurisprudence into this provider conscience regulation. Title VII was enacted nine years before the first of the health care conscience protection laws was passed; it includes specific language with respect to reasonable accommodation and undue hardship with respect to religion. In contrast, the Church Amendment, the first of the health care conscience protection laws, is specific as to its prohibitions, and contains none of the reasonable accommodation or undue hardship language Congress elected to include in Title VII. This is also true of the additional health care conscience protection laws that Congress subsequently enacted. Notwithstanding the existence of Title VII, Congress passed a series of laws to explicitly protect provider conscience without using Title VII's formulation. Moreover, where Title VII is restricted to the

employment context, the provider conscience provisions are not so limited. As a result, we believe it is a reasonable interpretation of the statutes that Congress sought to ensure provider conscience protections that are distinct from, and extend beyond, those under Title VII. The Department's enforcement of the provider conscience laws will be informed, for example, by comparison to Title VII religious discrimination jurisprudence.

Congress enacted Title VII of the Civil Rights Act of 1964 to protect employees from discrimination by their employers with respect to certain individual characteristics, including religion. It applies to all employers of a certain size, regardless of whether the employer receives federal funding. In the context of the Title VII prohibition on employment discrimination on the basis of religion, Congress in 1972 limited the protection afforded to employees by defining "religion" as "all aspects of religious observance and practice, as well as belief, unless an employer demonstrates that he is unable to reasonably accommodate an employee's or prospective employee's religious observance or practice without undue hardship on the conduct of the employer's business." Under the Title VII standard, an employer is, thus, only required to attempt to reasonably accommodate its current or prospective employee's religious objections if it would not place an undue burden on the employer. In contrast, the health care conscience protection provisions apply only to recipients of federal funding, and primarily to recipients of funding from the Department, regardless of size. Congress was capable of incorporating an express balancing of interests in health care conscience protection provisions, but it chose not to, in spite of its general familiarity with the balancing test in the Civil Rights Act religious nondiscrimination provision. We believe that it is reasonable to interpret this action by Congress to impose higher standards for provider conscience on employers in the health care and medical research that receives Departmental funding than is imposed on employers in general. Thus, we believe it is a reasonable interpretation that Congress in this context imposed a choice not between reasonable accommodations and undue burden, but between accommodation of religious belief or moral convictions and federal funding. Where an employer will not accommodate an employee's sincere religious belief or moral conviction, it may cease being eligible for federal funds and lose certain federal funding.

While it is a reasonable interpretation of the statutes that Congress did not intended to limit provider conscience protections to those provided to employees under the Title VII legal framework for religious accommodation requests, we also interpret nothing in the provider conscience statutes as preventing employers from accommodating employees' sincerely held religious beliefs, observances, and practices when requested as a means of accomplishing the same protections for provider conscience. As long as employees in the health care field are free from being discriminated against or required to participate in abortions or services they find religiously or morally objectionable, employers are free to balance employee rights with other interests in conducting their business operations. We envision that, through open communication between employees and employers about each other's respective needs and requirements, and by employers providing accommodations of employees' religious beliefs and moral convictions, full compliance with the health care conscience protection laws and organizational objectives can best be achieved.

Similarly, we do not foresee that the health care conscience protection laws and this regulation would necessarily constrain employers in the health care field to hire individuals or accept volunteers who, due to their religious beliefs or moral convictions, refuse to perform job duties that comprise the significant majority or the entirety of duties required by the position.

There are a number of reasons why these and other staffing concerns might not be constrained by protections afforded to health care workers on the basis of conscience. First, employers have no obligation under the health care conscience protection laws to employ persons who are unqualified to perform the functions required of the jobs that they seek to fill. A job applicant must be qualified or, typically among a pool of qualified applicants, the best qualified, to perform the core services of a job for which he/she is applying. It is difficult to conceive of a circumstance in which an applicant who is fundamentally opposed on religious or moral grounds to a particular medical procedure, health service program, or research activity, would be among the best qualified to perform that procedure, service, or activity. Additionally, a job applicant with a sincerely held religious belief or moral conviction against a lawful health service or activity would be unlikely to apply for a job in which that precise health service or activity constitutes a significant majority or the entirety of the job. That said, employers are to be expected to make rational hiring decisions based on due consideration of an applicant's knowledge, skills, ability, and desire to perform the essential functions of a job. To the extent a health care employer's adverse decision is based on an applicant's inability to perform the essential functions of a job, the decision would not typically constitute discrimination under the regulation even if the applicant had expressed an unwillingness to perform those functions on conscience grounds. However, an adverse decision predicated on an applicant's alleged "inability" could constitute unlawful discrimination if the employer's stated reasons are pretextual; for example, if the employer is using the definition of essential functions as a pretext for excluding applicants with certain religious beliefs or moral convictions. In applying this standard, the Department will remain vigilant against discrimination and the potential for employers to use an applicant's qualifications as a pretext for unlawful discrimination.

Comment: Comments requested clarification regarding the application of the written certification requirement in the proposed rule to programs receiving federal funding under the President's Emergency Plan for AIDS Relief (PEPFAR).

Response: PEPFAR funding is distributed to several federal agencies, including the federal Centers for Disease Control and Prevention (CDC) within the Department. If the activities of CDC under PEPFAR are funded from the annual Labor, Health and Human Services appropriations act, the Weldon Amendment would apply, as would certain provisions of the Church Amendments.

To the extent that CDC's PEPFAR programs are funded solely from the Department of State appropriations, the Weldon Amendment would not apply because the funds for PEPFAR would come from the Department of State's appropriations act. The Weldon Amendment applies to funds appropriated under the Labor/HHS appropriations act to which the Weldon Amendment is a rider. PHS Act § 245, 42 U.S.C. 238n, would not apply because section 245 applies to the federal government and to State and local governments receiving federal financial assistance. The Church Amendments at 42 U.S.C. 300a–7(b), (c)(1) and (e) apply to activities funded and carried out under the PHS Act, the Community Mental Health Centers Act,

and/or the Developmental Disabilities Assistance and Bill of Rights Act of 2000, and, thus, would not be applicable.

There are two provisions of the Church Amendments that apply more broadly. The Church Amendments at 42 U.S.C. 300a–7(c)(2) applies to grants or contracts for biomedical or behavioral research under any program administered by the Secretary of Health and Human Services. CDC's PEPFAR programs do not customarily involve such research.

The Church Amendments at 42 U.S.C. 300a–7(d) provides that "[n]o individual shall be required to perform or assist in the performance of any part of a *health service program* or research activity *funded in whole or part under a program administered by the Secretary of Health and Human Services* if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions." 42 U.S.C. 300a–7(d) (emphasis added). PEPFAR is a program administered, in part, by HHS. PEPFAR funds are appropriated under the State Department's authorities and then transferred to HHS and fund grant programs that are developed, administered and implemented by HHS/CDC which provide health services, including HIV prevention, treatment, and care. Accordingly, CDC's PEPFAR programs would be subject to the requirements/prohibitions in 42 U.S.C. 300a–7(d), and foreign or international organizations (such as agencies of the United Nations) which are recipients or sub-recipients under CDC's PEPFAR programs may be recipients or sub-recipients for the purposes of this rule at CDC's discretion. We note that these requirements are consistent with a conscience protection clause already existing in the PEPFAR authorizing statute.

Comment: One Commentor requested clarification on the Office for Civil Rights' (OCR) experience and knowledge of employment discrimination and how OCR would handle a potential increase in workload associated with its role in the proposed rule as the office designated to receive complaints of discrimination.

Response: With a Headquarters office in Washington, DC, ten regional and two field offices located throughout the United States, OCR promotes and ensures that individuals have equal access to, and opportunity to participate in, and receive services from, all relevant Department-funded programs without facing unlawful discrimination, and that the privacy of their health information is protected. OCR is the sole agency within the Department charged with responsibility for enforcing these important federal protections. Through the enforcement work of its Headquarters policy staff and regional investigators, OCR annually resolves more than 12,000 citizen complaints alleging discrimination or a violation of the Privacy Rule under the Health Insurance Portability and Accountability Act (HIPAA). OCR provides training and technical assistance annually to individuals and health care entities nationwide that receive certain funds from the Department through its public education and compliance activities to promote and ensure compliance with applicable federal laws requiring nondiscriminatory access to Department programs and services and protection of the privacy of individually identifiable health information under the HIPAA Privacy Rule. OCR is therefore well-positioned within the Department to fulfill its designated role as the point of contact to receive, and coordinate with the Department-funding components the handling of, complaints from individual and institutional health care providers and entities seeking protection from discrimination in connection with particular practices, or from compulsion to perform health care activities, that they find religiously or morally objectionable. The Department-funding components will bear the actual responsibility for enforcement of the health care conscience protection laws through their usual and ordinary program mechanisms, which include termination of funding and return of funds paid out in violation of the health care provider conscience protection provisions under 45 CFR parts 74, 92, and 96.

OCR also has considerable experience working collaboratively with the Department-funding components to identify barriers and implement practices that can avoid potential discrimination in services, and also in supporting funding components' enforcement responsibilities. For example, OCR conducts fully coordinated investigations with the Administration for Children and Families (ACF) in its enforcement of the Multiethnic Placement Act (MEPA) of 1994, as amended by section 1808 of the Small Business Job Protection Act of 1996, which provides that state agencies may not delay or deny the placement of a child for adoption or into foster care on the basis of the race, color, or national origin of the adoptive or foster parent, or the child involved. OCR and ACF act collaboratively concerning the conduct of MEPA investigations and in resolution of MEPA complaints. Pursuant to a memorandum of understanding between OCR and ACF, OCR takes the lead in investigating violations; when OCR finds a violation of MEPA, ACF determines whether to require a monetary payment by the state as part of the resolution agreement and whether to require that the payment be an integral part of the resolution. In these ways, OCR routinely works with the staff of Departmental programs and brings its expertise to bear to ensure compliance with federal nondiscrimination requirements.

With respect to OCR's experience and knowledge in the area of employment discrimination complaints, OCR has served as the designated entity within the Department to receive a variety of discrimination complaints for over 40 years, including employment discrimination complaints. OCR's authority covers discrimination based on race, color, national origin, age, disability, sex, and religion. OCR's designated responsibilities under the provider conscience regulation to receive and coordinate the handling of discrimination complaints under the statutes and this implementing regulation, with the Departmental programs funding the entities at issue in any complaint, therefore, fall clearly within OCR's area of expertise and responsibility within the Department.

Comment: One Commentor noted that designating OCR as the office to receive complaints appears to overlap with EEOC jurisdiction, and could confuse employees as to when and where to file complaints.

Response: OCR, EEOC, and other federal agencies have developed procedures over the years to ensure appropriate handling of federal nondiscrimination complaints where there is overlapping jurisdiction.

The agencies responsible for federal nondiscrimination laws, including OCR and EEOC, coordinate to ensure these procedures are working and also confer on a case-by-case basis when needed to work out instances where there may be shared jurisdiction. As part of this coordination, federal agencies, including OCR, use a variety of methods, including consumer brochures, fact sheets, grassroots meetings, and the Internet, to get information to the public about their federal civil rights and when, where, and how to file discrimination complaints depending upon the facts of the complaint. The Department will continue to use appropriate means to educate the public about their rights and

how to file a complaint under the provider conscience regulation.

The Department agrees that it will be important to ensure that the regulated entities and their employees are aware that the EEOC retains its primary jurisdiction in the area of enforcing protections under Title VII prohibiting employment discrimination based on religion. The Department will explore all avenues available, in coordination with the EEOC, for increasing public awareness of both health care conscience protection laws and Title VII's protections against employment discrimination based on religion. Where there are overlapping interests between the EEOC and the Department with respect to enforcement of protections against religious discrimination in employment, the EEOC and OCR roles and responsibilities are set forth in a federal regulation which has been in effect for 25 years, 29 CFR part 1601, 48 FR 3574 (January 25, 1983) (as amended) (*Procedures for Complaints of Employment Discrimination Filed against Recipients of Federal Financial Assistance*). This regulation provides for coordination between EEOC and OCR for review, investigation, and resolution of certain overlapping employment discrimination complaints, including those based on religion.

Comment: Several Comments questioned the authority of the Secretary to issue this regulation. They pointed out that several of the statutory provisions such as the Church amendments lacked an explicit delegation of rulemaking authority to the Department. Several of these Commentators also stated the "housekeeping statute," 5 U.S.C. 301, does not authorize the Department to promulgate standards for entities outside the agency, and that this rule is, therefore, *ultra vires*.

Response: The Supreme Court has recognized the best, but not only, means by which an agency may promulgate binding legislative rules is through the issuance of regulations through notice and Comment rulemaking pursuant to delegated rulemaking authority. *United States* v. *Mead*, 533 U.S. 218 (2000). The Court has also found Chevron deference applicable where an agency has considerable expertise over a complex area and has given the issue careful consideration. *Barnhart* v. *Walton*, 535 U.S. 212 (2002); *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). Lower courts have also recognized binding deference to the Department in determining whether recipients of federal funds are complying with myriad federal requirements. *Pharmaceutical Manfs.* v. *Thompson*, 362 F.3d 817 (DC Cir. 2004). All these deference factors are applicable here, and in addition to the notice and Comment the Secretary has conducted here.

Regardless of the Department's authority to promulgate legislative rules in this instance, it is well settled in case law that every agency has the inherent authority to issue interpretive rules and rules of agency practice and procedure. Pierce, *Administrative Law* at 306 (4th ed. 2002). The compliance requirements set forth in this rule do not substantively alter or amend the obligations of the respective statutes. *IBM Broadcasting* v. *FCC*, 22 F3d 320 (DC Cir. 1994). While specific certification of compliance for the health care conscience protection laws is new, recipients of federal funding have long certified compliance with other applicable federal laws, including civil rights laws. While this needed change in procedure may prompt a minor increase in the costs of compliance for some entities, that does not alter the procedural nature of the rule. *Hurson* v. *Glickman*, 229 F3d 277 (DC Cir. 2000).

Furthermore, provisions of the rule which do no more than define terms are reasonably drawn from the existing statutes. *Hector* v. *Dept. of Agriculture*, 82 F3d 165 (7th Cir. 1996). Particularly as Congress intended the conscience protections to apply broadly across institutions and individuals, the Department has ample authority to issue these interpretive provisions.

Comment: Several Comments raised the question of how this regulation may conflict with rules governing other Department programs. Some expressed concerns that the rule was inconsistent with program requirements of the Medicaid, Community Health Center, and Title X Family Planning programs, as well as the treatment requirements under the Emergency Medical Training and Active Labor Act (EMTALA). Specifically, Comments assert that this regulation is inconsistent with the requirement that institutions provide care in an emergency, a requirement that includes no exception for religious or moral objections to the needed service, and that the regulatory requirements for family planning clinics under Title X of the Public Health Service Act require Title X projects to offer pregnant women non-directive counseling, and referrals upon request for prenatal care and delivery, infant care, foster care or adoption, and abortion.

Response: The Department does not operate its programs in conflict with the existing federal protections being further implemented by this rule. The Department believes that many Commenters are confused as to the programmatic requirements of various Departmental programs, and suggests that concerned parties seek clarification from individual program offices as appropriate. Similarly, the Department believes that Commenters mistakenly confuse certain legal requirements on institutions or health care entities as requirements on individual providers. With respect to emergency treatment, the obligations of EMTALA are imposed on hospital under 1867 of the Social Security Act only if they elect to operate an emergency room and are also limited to the capabilities of the particular hospital. The requirement under EMTALA that such hospitals treat and stabilize patients who present in an emergency is not in conflict with the Church Amendments' requirement that certain recipients of Department funds not force any individual to participate in a health service program that they object to based on a religious belief or moral conviction. While this and other hypothetical situations were raised in the Comments, the Department is not aware of any instance where a facility required to provide emergency care under EMTALA was unable to do so because its entire staff objected to the service on religious or moral grounds. With regards to the Title X program, Commenters are correct that the current regulatory requirement that grantees must provide counseling and referrals for abortion upon request (42 CFR 59.5(a)(5)) is inconsistent with the health care provider conscience protection statutory provisions and this regulation. The Office of Population Affairs, which administers the Title X program, is aware of this conflict with the statutory requirements and, as such, would not enforce this Title X regulatory requirement on objecting grantees or applicants.

Comment: Multiple Comments questioned the balance between provisions in the Department's proposed rule and requested clarification on EMTALA requirements and how they will be upheld if the Department's proposed rule is promulgated.

Response: The Department notes that this Comment would only be relevant where a hospital, as opposed to an individual, has an objection to performing abortions that are necessary to stabilize the mother, as that term has been interpreted in the context of EMTALA. The Department is unaware of any hospital that has such a policy. Furthermore, the laws this regulation supports have existed alongside