Office of the General Counsel

3211 FOURTH STREET NE • WASHINGTON DC 20017-1194 • 202-541-3300 • FAX 202-541-3337

March 20, 2013

Submitted Electronically

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Notice of Proposed Rulemaking on Preventive Services
File Code No. CMS-9968-P

Dear Sir or Madam:

On behalf of the United States Conference of Catholic Bishops, we respectfully submit the following comments on the Notice of Proposed Rulemaking ("NPRM") on preventive services. 78 Fed. Reg. 8456 (Feb. 6, 2013).

The current proposal, like previous ones, would mandate coverage of abortifacient drugs, contraceptives, sterilization procedures for women, and related education and counseling in health plans.[1] The comments we file today reflect the same basic themes as the comments we filed on earlier Administration proposals on this topic:[2]

---

[1] We use the term "mandate" or "contraceptive mandate" as shorthand for the requirement that plans cover the aforementioned items. We use the term "contraceptive coverage," as the NPRM does, to mean coverage of all these items.

[2] Our previous comments, filed in August 2011 and May 2012, are available at http://www.usccb.org/about/general-counsel/rulemaking. Also available at the same link are our September 2010 comments, which predate the mandate but explain why contraceptives and sterilization procedures are not appropriately viewed as "preventive services" and should not be mandated.

• Like earlier iterations, the latest proposed regulation requires coverage of sterilization, contraception, and drugs and devices that can cause abortions. These are items and procedures that, unlike other mandated "preventive services," do not prevent disease. Instead, they are associated with an increased risk of adverse health outcomes, including conditions that other "preventive services" are designed to prevent. The proposed regulation is therefore at odds with the purpose of the preventive services provision of the Affordable Care Act ("ACA" or "the Act") upon which that regulation purports to be based. In addition, insofar as the regulation requires coverage of drugs that can operate to cause an abortion, the mandate violates the following: (a) provisions of ACA on abortion and non-preemption, (b) a distinct federal law forbidding government discrimination against health plans that do not cover abortion, and (c) the Administration's own public assurances, both before and after enactment of ACA, that the Act does not require, and would not be construed to require, coverage of abortion. We have raised all these issues previously.

• Under the current proposal, no exemption or accommodation is available at all for the vast majority of individual or institutional stakeholders with religious or moral objections to contraceptive coverage. Virtually all Americans who enroll in a health plan will ultimately be required to have contraceptive coverage for themselves and their dependents, whether they want it or not. Likewise, unless it qualifies as a "religious employer," every organization that offers a health plan to its employees (including many religious organizations) will be required to fund or facilitate contraceptive coverage, whether or not the employer or its employees object to such coverage. This requirement to fund or facilitate produces a serious moral problem for these stakeholders. We have raised all these issues previously.

• Although the definition of an exempt "religious employer" has been revised to eliminate some of the intrusive and constitutionally improper government inquiries into religious teaching and beliefs that were inherent in an earlier definition, the current proposal continues to define "religious employer" in a way that—by the government's own admission—excludes a wide array of employers that are undeniably religious. Those employers therefore remain subject to the mandate. Generally the nonprofit religious organizations that fall on the "non-

exempt" side of this religious gerrymander include those organizations that contribute most visibly to the common good through the provision of health, educational, and social services. We have previously raised problems associated with dividing the religious community into those "religious enough" to qualify for the exemption from the mandate, and those not—especially when that division falsely assumes that preaching one's faith is "religious," while living it out is not. We have likewise previously raised objections to linking the exemption to provisions of the tax code that have nothing to do with health care or conscience.

- The Administration has offered what it calls an "accommodation" for nonprofit religious organizations that fall outside its narrow definition of "religious employer." The "accommodation" is based on a number of questionable factual assumptions. Even if all of those assumptions were sound, the "accommodation" still requires the objecting religious organization to fund or otherwise facilitate the morally objectionable coverage. Such organizations and their employees remain deprived of their right to live and work under a health plan consonant with their explicit religious beliefs and commitments. We have raised these problems previously, and we raise them again here.

- The mandate continues to represent an unprecedented (and now sustained) violation of religious liberty by the federal government. As applied to individuals and organizations with a religious objection to contraceptive coverage, the mandate violates the First Amendment, the Religious Freedom Restoration Act, and the Administrative Procedure Act. We are willing, now as always, to work with the Administration to reach a just and lawful resolution of these issues. In the meantime, along with others, we will continue to look for resolution of these issues in Congress[3] and in the courts.[4]

Our more detailed comments follow.

---

[3] *See* H.R. 940, Health Care Conscience Rights Act of 2013, introduced March 4, 2013 by Rep. Diane Black. Currently the bill has over a hundred co-sponsors.

[4] At least 50 lawsuits, with over 150 plaintiffs, have been filed to date challenging the mandate. *See* http://www.becketfund.org/hhsinformationcentral/.

I. The Mandate is Unchanged.

The NPRM makes no change in the underlying mandate. For reasons discussed more fully in our earlier comments, we believe the mandate should be rescinded. Contraceptives and sterilization procedures, unlike other mandated "preventive services," do not "prevent" disease. Instead, they disrupt the healthy functioning of the human reproductive system. Furthermore, various contraceptives are associated with adverse health outcomes, including an increased risk of such serious conditions as breast cancer, cardiac failure, and stroke. *See* our comments of August 31, 2011, at 3-4; *see also* our comments of September 17, 2010, at 4. The contraceptive mandate is therefore at war with the statutory provision on which it claims to be based, a provision that seeks to ensure coverage of services that prevent disease, rather than increase the risk of it.

Insofar as it requires coverage of *abortifacient* drugs and devices in particular, the mandate also violates: (a) a provision of ACA dealing with abortion coverage; (b) a provision of ACA dealing with non-preemption of state law; (c) a federal law (the Weldon Amendment) that forbids government discrimination against health plans that do not cover abortion; and (d) the Administration's own public assurances that ACA does not require abortion coverage. The mandate runs afoul of these laws *wholly apart from* the various religious freedom issues that the mandate also creates. We have raised these issues previously, and we raise them again here.

A. Violation of ACA's Abortion Provision.

Section 1303(b)(1)(A) of ACA states that "nothing in this title"—*i.e.*, title I of the Act, which includes the provision dealing with "preventive services"—"shall be construed to require a qualified health plan to provide coverage of [abortion] services … as part of its essential health benefits for any plan year." As Section 1303 goes on to state, it is "the issuer" of a plan that "shall determine whether or not the plan provides coverage of [abortion] services…." Thus, under ACA, it is not the government, but plan issuers, that have the authority to decide whether a plan covers abortion.

There is no indication in the text or legislative history of ACA that Congress intended on the one hand to bar coverage of surgical abortion, but on the other hand to permit—indeed, mandate—coverage of so-called medical (*i.e.*, drug-induced) abortion. Indeed, Congress itself drew no distinction between surgical

and medical abortion when, in ACA, it decided to give plans the discretion whether or not to cover abortion. To impute this senseless distinction to Congress would be an unreasonable construction of the Act.

In particular, one drug approved by the FDA for "emergency contraception" and therefore covered by the mandate, Ella or ulipristal, is said to be just as effective in avoiding a sustained pregnancy even if taken almost a week after sexual activity. Ella is a close analogue to the abortion drug RU-486, described by many medical authorities as having the same ability to induce an abortion even after implantation. In fact, if the FDA in the future were to approve RU-486 for "emergency contraception," a step recommended by officials of the World Health Organization ("WHO"), the Administration's proposed regulation would automatically mandate coverage of RU-486 as well.[5]

B. Violation of ACA's Non-Preemption Provision.

Insofar as it requires coverage of any abortifacient drug, the mandate also conflicts with State laws in at least 21 states that restrict abortion coverage in all plans or in all exchange-participating plans.[6] Section 1303(c)(1) of ACA states

[5] On Ella's close similarity in formula and mode of action to the abortion drug RU-486, see the sources cited in our August 2011 comment letter (p. 5 n.10), and European Medicines Agency, *Evaluation of Medicines for Human Use: CHMP Assessment for Ellaone* (2009), at 8 ("Ulipristal acetate prevents progesterone from occupying its receptor, thus the gene transcription normally turned on by progesterone is blocked, and the proteins necessary to begin and maintain pregnancy are not synthesized") and 16 (in animal tests "ulipristal acetate is embryotoxic at low doses"). WHO experts now call RU-486 itself the "method of choice" for "emergency contraception." S. Mittal and P. Aggarwal, *Interventions for emergency contraception: RHL commentary* (last revised: 1 November 2012), the WHO Reproductive Health Library (Geneva: World Health Organization), available at http://apps.who.int/rhl/fertility/contraception/cd001324_mittals_com/en/index.html. If the FDA follows suit, the drug universally known as "the abortion pill" will automatically be included in the "contraceptive" mandate.

[6] Those states are Alabama, Arizona, Florida, Idaho, Indiana, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Virginia, and Wisconsin. *See* Ala. Code §§ 26-23C-1 to 26-23C-4; Ariz. Rev. Stat. Ann. § 20-121; Fla. Stat. Ann. §§ 627.64995, 627.66996, 641.31099; Idaho Code Ann. §§ 41-1848, 41-2142, 41-2210A, 41-3439; Ind. Code Ann. §§ 27-8-33-1, 27-8-33-4; Kan. Stat. Ann. § 40-2,190; Ky. Rev. Stat. Ann. § 304.5-160; La. Rev. Stat. Ann. § 22:1014; Miss. Code Ann. §§ 41-41-95 to 41-41-99; Mo. Ann. Stat. § 376.805; Neb. Rev. Stat. §§ 44-8401 to 44-8404; N.D. Cent. Code § 14-02.3-03; Ohio Rev. Code Ann. § 3901.87; Okla.

that nothing in the Act preempts, or has any effect on, any State law regarding abortion coverage. It follows that any construction of the Act that would preempt State law precluding abortion coverage would violate Section 1303(c)(1). Yet this is precisely what the Administration has done by mandating coverage of abortifacient drugs under the preventive services provision of ACA. As to such drugs, therefore, the mandate is invalid where it conflicts with any state law restricting abortion coverage.

C. Violation of the Weldon Amendment.

Under the Weldon Amendment, which has been included in every Labor/HHS appropriations law since 2004, no Labor/HHS funds may be made available to any government agency (including HHS) that discriminates against any health plan on the basis that the plan does not provide abortion coverage.[7] Obviously, to require that plans cover any form of abortion, as a condition for being offered at all, is the most direct form of abortion-based discrimination against plans that seek to exclude such coverage. Insofar as the mandate requires such coverage, it violates the Weldon Amendment.

D. Violation of Administration Assurances Against Mandatory Coverage of Abortion.

The mandate violates the Administration's public assurances, both before and after enactment of ACA, that the Act would not be construed to require coverage of abortion. Such assurances played a major role in securing final passage of the bill, and were formalized in an Executive Order issued by the President. *See* Executive Order 13535, "Ensuring Enforcement and Implementation of Abortion Restrictions in the Patient Protection and Affordable Care Act," 75 Fed. Reg. 15599 (Mar. 24, 2010).

Stat. Ann. tit. 63, § 1-741.3; R.I. Gen. Laws Ann. § 27-18-28; S.C. Code Ann. § 38-71-238; S.D. Codified Laws § 58-17-147; Tenn. Code Ann. § 56-26-134; Utah Code Ann. § 31A-22-726; Va. Acts 2011, c. 823; Wis. Stat. Ann. § 632.8985.

[7] For the text of the Weldon Amendment, *see* Consolidated Appropriations Act, 2012, Pub. L. No. 112-74, Div. F, § 507(d) (2012).

II. The NPRM Offers No Exemption or Accommodation of Any Kind for Most Stakeholders.

Well-deserved attention has been paid to the mandate's impact on religious organizations, and the scope of any related exemption or accommodation. This, however, should not obscure the fact that, for the overwhelming majority of stakeholders, the proposed regulation offers *no exemption or accommodation of any kind whatsoever*. Those without an exemption or accommodation include conscientiously-opposed individuals, for-profit employers (whether secular or religious), nonprofit employers that are not explicitly religious organizations (even in cases where their objection is religious in nature), insurers, and third-party administrators. Respect for their consciences demands some adequate legal protection, but under the current proposed regulation they have none.

A. Institutions.

For-profit organizations (whether religiously-affiliated or not) and nonprofit organizations having no explicit religious affiliation receive no exemption or accommodation under the proposed regulation. To take one example, even a publisher of Bibles is forbidden to offer its employees a health plan that complies with the publisher's espoused Biblical values. The contraceptive mandate has been preliminarily enjoined in just such a case. *Tyndale Home Publishers v. Sebelius*, No. 12-1635 (RBW), 2012 WL 5817323 (D.D.C. Nov. 16, 2012) (granting preliminary injunction).

Courts have recognized that the mandate violates religious freedom in other cases as well. So far, at least eleven other *for-profit* plaintiffs with religious objections to covering sterilization, contraceptives, or abortifacient drugs have obtained either preliminary or temporary injunctive relief against the mandate. *Annex Medical v. Sebelius*, No. 13-1118 (8th Cir. Feb. 1, 2013) (granting motion for preliminary injunction pending appeal); *Grote v. Sebelius*, No. 13-1077, 2013 WL 362725 (7th Cir. Jan. 30, 2013) (same); *Korte v. Sebelius*, No. 12-3841, 2012 WL 6757353 (7th Cir. Dec. 28, 2012) (same); *O'Brien v. U.S. Dep't of Health & Human Servs.*, No. 12-3357 (8th Cir. Nov. 28, 2012) (granting stay pending appeal); *Monaghan v. Sebelius*, No. 12-15488 (E.D. Mich. Mar. 14, 2013) (granting preliminary injunction); *Sioux Chief Mfg. Co. v. Sebelius*, No. 13-0036-CV-W-ODS (W.D. Mo. Feb. 28, 2013) (same); *Triune Health Group v. U.S. Dep't of Health & Human Servs.*, No. 12 C 6756 (N.D. Ill. Jan. 3, 2013) (same); *Sharpe Holdings v. U.S. Dep't of Health & Human Servs.*, No. 2:12-CV-92-DDN, 2012

WL 6738489 (E.D. Mo. Dec. 31, 2012) (granting temporary restraining order); *Am. Pulverizer Co. v. U.S. Dep't of Health & Human Servs.*, No. 12-3459-CV-S-RED, 2012 WL 6951316 (W.D. Mo. Dec. 20, 2012) (granting preliminary injunction); *Legatus v. Sebelius*, No. 12-12061, 2012 WL 5359630 (E.D. Mich. Oct. 31, 2012) (same); *Newland v. Sebelius*, No. 1:12-cv-1123-JLK, 2012 WL 3069154 (D. Colo. July 27, 2012) (same). The cited cases, though not yet finally dispositive on the merits, only tend to confirm the existence and gravity of the religious freedom problems we have repeatedly highlighted. And because courts have been willing to recognize the problem so clearly in the for-profit context, we would expect recognition at least as widespread and strong in cases brought by nonprofit and religious organizations, which generally have yet to reach the merits.

In addition, the proposed regulation fails to recognize the religious and moral objections of insurers and third-party administrators ("TPAs"). All insurers and third-party administrators will be required to provide, or administer and arrange for, respectively, a plan with contraceptive coverage, with the narrow exception of insurers and TPAs that serve only exempt "religious employers."

B. Individuals.

Under the Administration's proposal, virtually all Americans who purchase a health plan will ultimately be required to have coverage for contraceptives and sterilization procedures for themselves and their dependents, whether they want such coverage or not. Even the employees of religious organizations that do not qualify as exempt "religious employers" will have no choice in the matter, for the NPRM indicates they are to be "automatically" enrolled in a plan that covers the mandated items. 78 Fed. Reg. at 8463.[8] This appears to be a change from the

[8] Language indicating that the separate coverage will be mandatory rather than voluntary appears throughout the preamble of the NPRM and in the text of the proposed regulation. *See, e.g.*, 78 Fed. Reg. at 8473 (stating in the proposed regulation that for insured plans, the issuer "must automatically provide health insurance coverage for … contraceptive services … through a separate health insurance policy … for each plan participant and beneficiary"); *id*. at 8474 (same); *id*. at 8475 (same); ; *id*. at 8473 (stating in the proposed regulation that insurers must inform group plan participants and beneficiaries that "[y]ou and any covered dependents will be enrolled" in the contraceptive-only policy); *id*. at 8474 (same); *id*. at 8475 (same); *id*. at 8463 (stating in the preamble that for insured plans the "issuer would automatically enroll plan participants and beneficiaries" in an individual contraceptive-only policy); *id*. (stating in the preamble that for self-insured plans "a third party administrator … would automatically arrange" such policies). On the other hand, the language of "offer" does appear once in the preamble of the NPRM in reference to this coverage. *See id.* (stating that for insured plans, contraceptive-

Administration's earlier proposal to have insurers "*offer* contraceptive coverage directly to the employer's plan participants (and their beneficiaries) *who desire it*." 77 Fed. Reg. 8725, 8728 (Feb. 15, 2012) (emphasis added).[9] While some argue that the mandate vindicates the value of individual women's choice over the religious values of their employers, in fact women will have no freedom of choice either – not the freedom to decline such coverage, nor even the freedom to keep their own minor children from being offered "free" and "private" contraceptive services and related "education and counseling" without their consent.[10] The mandate therefore poses a threat not only to the rights of employers, religious and secular, but to the religious freedom and parental rights of individuals as well.

---

only coverage "would be offered … to plan participants and beneficiaries"). The heavy preponderance of language in both the ANPRM and NPRM, and in the actual text of the proposed regulation, seem to indicate a shift away from voluntary and toward mandatory coverage of contraception for employees of "accommodated" employers. In any event, a clarification is necessary, and we urge the Administration to resolve any ambiguity in favor of giving women the choice to opt out of this coverage.

[9] President Obama reinforced this message the same day, stating: "Every woman should be in control of the decisions that affect her own health. Period. … [I]f a woman's employer is a charity or a hospital that has a religious objection to providing contraceptive services as part of their [sic] health plan, the insurance company – not the hospital, not the charity – will be required to *reach out and offer* the woman contraceptive care free of charge, without co-pays and without hassles." Remarks of the President on Preventive Care, February 10, 2012, at www.whitehouse.gov/the-press-office/2012/02/10/remarks-president-preventive-care (emphasis added).

[10] In addition, in the case of an insured plan, employees of "eligible organizations" who themselves have a religious objection to contraceptive coverage will be contributing to a pool of funds from which the insurer will draw to pay claims for contraceptives and sterilization procedures (as no other pool of funds is available from which to pay such claims). Thus, those employees of "eligible organizations" who share their employer's religious objection to such coverage, like the employer itself, will ultimately be paying for *other people's* contraceptives and sterilization procedures, even if they themselves and their dependents do not use such items or undergo such procedures. We describe the funding problem in greater detail below in Part IV.A. of our comments.

III. Though Improved Slightly in One Respect, the "Religious Employer" Exemption Is Worsened in Another Respect and Remains Problematic in Several Others.

A. The Government's Proposed Definition of "Religious Employer" Eliminates Some Problematic Language.

Under the exemption finalized in February 2012, an exempt "religious employer" was one that met each of four criteria: (1) its purpose is the inculcation of religious values, (2) it primarily hires persons who share the organization's religious tenets, (3) it primarily serves persons who share those tenets, and (4) it is a nonprofit organization of a type described in section 6033(a)(1) and 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code.[11] The proposed regulation would eliminate prongs (1) through (3) of this four-pronged test. As a result, some of the intrusive and constitutionally improper government inquiries that were inherent in the earlier definition have been eliminated. Although this represents a small improvement in the definition, it continues to be highly objectionable, as discussed further below.

B. The Government's Proposed Definition of "Religious Employer" Still Excludes Most *Bona Fide* Religious Employers and Therefore Is Still Too Narrow.

The Administration continues to exclude from the definition of "religious employer" a wide array of organizations that undeniably are "religious" and undeniably "employ" people. Just as before the NPRM, most Catholic ministries of service—such as Catholic hospitals, charities, and schools—are deemed not to be "religious employers" and therefore remain subject to the mandate. By its own admission, the NPRM's change to the definition of "religious employer" will "not expand the universe of employer plans that would qualify for the exemption beyond that which was intended in the 2012 final rules." 78 Fed. Reg. at 8461. The exemption was too narrow before the NPRM, and having changed only slightly in scope, it remains too narrow. Instead, the definition of "religious employer" should include all *bona fide* religious employers.

[11] Section 6033(a)(3)(A)(i) and (iii) refer to churches, their integrated auxiliaries, conventions or associations of churches, and the exclusively religious activities of a religious order.

C. The Government's Proposed Definition of "Religious Employer" Still Reduces Religious Freedom to Freedom of Worship by Limiting the Exemption Almost Exclusively to Houses of Worship.

As the NPRM itself explains, "the primary goal" of the original definition of "religious employer" was "to exempt the group health plans of houses of worship," and the proposed change to that original definition is designed to achieve that same goal more effectively. *See* 78 Fed. Reg. at 8461. That goal continues to pose a great religious freedom problem, for it continues to create a division—alien to our tradition—between our houses of worship and our ministries of service, and continues to treat the latter as if they had secondary religious importance.[12] Moreover, providing full protection only to houses of worship implies that only the activities of houses of worship are entitled to such protection. But just as religion is not limited to worship, the freedom of religion is not limited to the freedom of worship. Religious freedom must also include the freedom to abide by Church teachings, even outside the four walls of the sanctuary.[13]

As explained further below, the operative language of the Church Amendment of 1973 is the only complete solution to the problem of improperly defining our religious community, for that language avoids entirely the question of which people or groups are deserving of religious freedom protection.[14] The identity of the person or group having the religious freedom objection should not matter; what should matter instead is whether the person or group faces

[12] *See* USCCB Administrative Committee, "United for Religious Freedom" (Mar. 14, 2012) (reaffirmed by acclamation of full body of U.S. Catholic Bishops on June 13, 2012).

[13] From the earliest centuries of the Christian church, "the exercise of charity became established as one of her essential activities, along with the administration of the sacraments and the proclamation of the word: love for widows and orphans, prisoners, and the sick and needy of every kind, is as essential to her as the ministry of the sacraments and preaching of the Gospel." Pope Benedict XVI, Encyclical Letter *Deus caritas est* (2005), no. 22.

[14] Obviously, we are not urging the government simply to "cut and paste" the Church Amendment into the regulations, but instead to apply its core principle in this context. The key point is that conscience protection, as reflected in the Church Amendment and countless other federal laws affording protection to those with religious or moral objections, should continue to be available to *all* individuals and entities with such objections, as they have been over the last several decades, and not simply to some subset of the political community (let alone to some subset of the religious community).

government coercion to violate conscience. Religious freedom is for *all* who face this threat, not just some.

D. The Government's Proposed Definition of "Religious Employer" Still Cannot Be Reconciled with the Longstanding Precedent of Generous Federal Government Conscience Protection in the Health Care Context.

Although the new proposed definition of "religious employer"—the fourth part of the original four-part test—does derive from existing federal law, it is wholly unprecedented in its use as a conscience protection at the federal level. The fourth prong describes some (but not all) of the religious institutions that are exempt from the general requirement that nonprofit organizations file the IRS Form 990. In that context, that definition served to reduce the church-state entanglement issues inherent in mandating financial reporting and accountability on the part of churches and religious organizations. However, it does not, and was never intended to, protect against a government requirement that may violate conscience. The Form 990 filing exemptions therefore have no relevance whatsoever to church welfare or benefit plans.

Indeed, if ultimately implemented, the new proposed definition would represent the narrowest protection of conscience in health care anywhere in federal law. As we have noted repeatedly in prior comments, federal conscience protections in the health care context are typically robust. Foremost among these is the Church Amendment of 1973, 42 U.S.C. §300a-7. Its operative language—which protects against government coercion of conduct that "would be contrary to [the] religious beliefs or moral convictions" of individuals or entities—has enjoyed broad bipartisan support, and has been repeated in numerous federal conscience laws over the forty years since its original passage.[15] As we have urged repeatedly before, language like this represents the only complete solution to the religious freedom problems caused by the mandate.

The NPRM's proposed definition not only disregards this leading option in continuity with the strong, bipartisan tradition of generous federal conscience protection, it disregards an alternative exemption that, while still substantially

[15] *See* USCCB Secretariat of Pro-Life Activities, "Current Federal Laws Protecting Conscience Rights" (2012) (available at http://www.usccb.org/issues-and-action/religious-liberty/conscience-protection/upload/Federal-Conscience-Laws.pdf).

flawed, would represent a far less radical break from the past. Other prominent commenters have proposed a definition of "religious employer" based on the category of employers whose benefit plans may qualify as "Church Plans" under the Employee Retirement Income Security Act (ERISA). *See* I.R.C. § 414(e). USCCB has declined to endorse this proposal, because it would not extend protection to all nonprofit religious employers,[16] or to any for-profit employers with a religious objection. On the other hand, it is at least based on a law that has some—rather than absolutely no—bearing on health insurance plans, and it would cover substantially more employers than the currently proposed exemption.

In sum, the revised exemption proposed in the NPRM continues the persistent refusal to follow in the mainstream of federal conscience protection language, or even to opt for a relatively modest departure from that mainstream. If the "houses of worship"-focused approach to conscience protection survives in this context, it will soon spread to others. Regulatory assurances to the contrary are ineffectual, as they cannot and do not control what may happen beyond the present rulemaking process. Once again, we urge the Administration in the strongest possible terms to reject this radical departure, and to return instead to the bipartisan consensus of the last forty years, which is embodied in the core language of the Church Amendment and the numerous federal conscience protection laws that have followed it.

E. The Government's Proposed Definition of "Religious Employer" Would Narrow the Exemption Further by Excluding Otherwise Exempt Employers That Extend Their Coverage to the Employees of Other Employers.

In at least one significant respect the modified definition may make the universe of eligible plans *smaller*. Previously, the Administration suggested that the employees of a non-exempt religious organization might be enrolled in the health plan of an affiliated, exempt religious employer; such a plan would not be required to include contraceptive coverage. 77 Fed. Reg. 16501, 16502 (March 21,

[16] We note that the NPRM's proposed definition of "eligible organization"—if it described the scope of an exemption from the mandate, rather than an "accommodation"—would also represent a substantial improvement in relation to the current proposed definition of "religious employer," since it would encompass all self-identified, nonprofit, religious employers with a religious objection. Unfortunately, this definition instead represents still another less constrictive understanding of "religious employer" that has been needlessly bypassed.

2012) (advance notice of proposed rulemaking); *see* our comments of May 15, 2012, p. 18 (requesting clarification on this issue). In its latest proposed regulation, however, the Administration states that such opportunities will not be available. 78 Fed. Reg. at 8467 (stating that any exemption or accommodation will be available only on an "employer-by-employer basis"). Thus, under this latest proposed regulation, the range of organizations exempt from the mandate would actually shrink.

F. The Government's Proposed Definition of "Religious Employer" Is Not Reasonably Related to a Legitimate Government Objective.

As explained above, the proposed test for deciding whether an organization is a "religious employer" is lifted from an entirely different statutory context, one having no bearing whatsoever on health plans or conscience protection. Congress's concern in enacting the Form 990 filing exemptions was financial accountability and tax administration—not health insurance or conscience. As the proposed test for deciding whether an organization is a "religious employer" bears no rational relationship to any legitimate governmental interest that the mandate or the exemption purports to advance, it does not withstand constitutional scrutiny.

As it happens, religious employers that do not fit the regulation's definition of "religious employer" include those organizations that contribute most visibly to the common good through the provision of health, educational, and social services, including Catholic hospitals, colleges, universities, and charities. The Administration claims that employees of such organizations are less likely than the employees of churches, conventions and associations of churches, integrated auxiliaries and religious orders to share their employer's views about contraceptives and sterilization. 78 Fed. Reg. at 8461-62. What knowledge the government could have about employees' individual religious beliefs seems entirely speculative, as well as irrelevant to the question whether the mandate infringes on the employer's own religious convictions and those of at least some of its employees.

In any event, the Administration's claim of a disparity in religious belief between employee and employer ignores four facts: (1) employees of religiously-affiliated hospitals, colleges, universities, and charities have *chosen* to be employed by such organizations and therefore, as to any employee benefits that those employers provide, have implicitly agreed to the employer's terms of employment, including compensation and benefits; (2) with the rare exception of

employee-pay-all coverage, the employees' health coverage is offered, sponsored and paid for in part *by the employer*; (3) employees who disagree with their employer's objection to contraceptive and sterilization coverage are not foreclosed from obtaining such coverage *on their own and from another source* (including through a group or individual plan that they can purchase on the Exchange); and (4) the workplaces of exempt and nonexempt religious organizations in many instances are comparable in terms of the services they provide, and the religious reasons why they provide them.

The last point requires elaboration. The Administration concedes that "if a church maintains a soup kitchen that provides free meals to low-income individuals," that should have no effect on its exempt status. 78 Fed. Reg. at 8461. However, if the very same church forms an unaffiliated separate corporation through which devout believers can provide free meals to low-income individuals in compliance with Jesus' call to feed the hungry, then that organization is *not* exempt even though it does precisely what the church would do directly had it not housed the services under a separate organization. Thus, the availability of an exemption from the contraceptive mandate will often depend upon, as it were, the accident of corporate form rather than what the church believes and does. In our example, the church and separately-incorporated organization provide the same services. Each is motivated by the same religious belief. Given those similarities, we fail to see how the government's interest in ensuring access to health coverage while accommodating conscience is furthered by denying an exemption, based solely on how the organization providing soup kitchen services is structured.

As another example of the lack of reasonable relation between the Form 990 filing requirement and the exemption, consider the activities of a religious order. If the order engages in "exclusively religious" activities, its health plan is exempt from the mandate. But if the very same religious order runs a religious bookstore, sells fruit preserves, or performs some other work as a means of supporting itself, any health coverage offered in connection with the latter is not exempt from the contraceptive mandate even if the only employees are the devout members of the order or lay people who share its beliefs.

Even if an exemption from the Form 990 filing requirement bore a reasonable relation to the exemption from the mandate (which, we explain above, is not the case), the latter is under-inclusive. Many organizations, including "educational organizations" below the college level that are affiliated with a church or operated by a religious organization, are exempt from the requirement to file an

annual return. *See* 26 C.F.R. § 1.6033-2(g). But these organizations, exempt as they are from the filing requirement, are not exempt from the mandate because they are not churches, conventions or associations of churches, integrated auxiliaries, or the exclusively religious activities of religious orders. If exemption from the Form 990 filing requirement is a reasonable proxy for exemption from the mandate, then why are churches, conventions and associations of churches, integrated auxiliaries, and the exclusively religious activities of religious orders the *only* non-filers exempt from the mandate?

IV. The Accommodation Described in the NPRM Does Not Appear to Meaningfully Accommodate Even Those Stakeholders That Qualify for It.

Now as before, it does not appear that what the Administration describes as an "accommodation" for "eligible organizations" (those religious employers that do not qualify for an exemption) will actually relieve them of the burden on religious liberty that the mandate creates.

A. Insured plans.

Under the proposed regulation, the plan sponsor (the employer) and enrollees (employees and their dependents) would pay for a group plan that excludes contraceptive coverage. The issuer of the group plan would then "automatically" issue a "separate" individual policy to each enrollee for contraceptive coverage. 78 Fed. Reg. at 8462-63. The NPRM recites that the issuer would assume "sole responsibility, independent of the eligible organization and its plan," for providing such an individual policy, and would do so "without cost sharing, premium, fee, or other charge to plan participants and beneficiaries." *Id*. at 8462. In addition, the NPRM states that "no fee or other charge in connection with [the contraceptive] coverage is imposed on the eligible organization or its [group] plan." *Id*.

If there is no charge to the plan sponsor or enrollees, the question arises: what funds will the insurer use to pay for contraceptives, sterilization procedures, and related education and counseling? The NPRM does not say, but says only that "such … coverage is *cost neutral* because [the insurer] would be insuring the *same set of individuals* under both policies and would experience lower costs from

improvements in women's health and fewer childbirths." *Id*. at 8463 (emphasis added).

This cost-neutral assumption ignores the insurer's additional administrative costs in administering the companion contraceptive coverage program. In any event, even if this assumption were valid, there is only one funding stream from which contraceptives, sterilization procedures, and related education and counseling for these enrollees can be paid: contributions made by the sponsor of the group plan and its enrollees. It necessarily follows that, even though contraceptive coverage is housed under "separate" individual plans, it is not truly separate, and the objecting employer and enrollees are ultimately paying for the objectionable services through their contributions. As there is no statutory authority, and there would appear to be legal constraints, for requiring an insurer to pay for contraceptives and sterilization procedures out of *other* clients' resources, employer and employee contributions to the group plan provide the only pool of funds from which payments for contraceptives and sterilization under the individual contraceptive-only policies can be made.

This seems especially obvious when, as here, the cost savings of reduced childbirths are cited by the Administration as paying for contraceptives and sterilization. As the NPRM itself points out, this only makes sense if the reimbursements come from funds paid *for those same individuals* for childbirth coverage. And those premiums for coverage of childbirth came from the employee and employer. In other words, some of the funds the employer and employee paid for childbirth coverage will, arguably, not be needed for childbirths, and so will be available to reimburse for contraceptives and sterilization instead.[17]

[17] In pointing out this implication of the Administration's statements, of course, we are not endorsing the apparent assumption that contraceptive coverage necessarily "saves" the "costs" of childbirth, that children are ultimately a burden on rather than a contribution to the economic and other aspects of American well-being, or that, in a society where overall fertility rates are already below replacement levels, there is a compelling or even legitimate government interest in persuading religious Americans or their employees to have fewer children. On the implications of the plunging U.S. birthrate, *see* T. Bahrampour, "U.S. birthrate plummets to its lowest level since 1920," *The Washington Post*, November 29, 2012, at http://articles.washingtonpost.com/2012-11-29/local/35585758_1_birthrate-immigrant-women-population-growth ("The decline could have far-reaching implications for U.S. economic and social policy. A continuing decrease could challenge long-held assumptions that births to immigrants will help maintain the U.S. population and create the taxpaying workforce needed to support the aging baby-boom generation.").

Thus, notwithstanding the Administration's claim that the issuer cannot, "directly or indirectly" (78 Fed. Reg. at 8473), charge the employer or employee for contraceptive coverage, there still seems to be a funding tie between the employer and the objectionable coverage. In addition, the attempted segregation of contraceptive and sterilization procedures is ineffective because plan premiums (and adjustments to premiums) are ultimately based on total claims history, which will now include claims for contraceptives and sterilization procedures—regardless of whether the organization objects to the coverage of those items, and regardless of whether those services are listed in the plan summary or other plan documents.

Put in other terms, if there are actually reduced claims against the employer's main plan as a result of its employees having separate contraceptive-only plans, then in the ordinary course, those cost savings would result in the accommodated employer's paying reduced premiums in subsequent years. But under the proposed accommodation for insured plans, if claims against the main plan actually are reduced, the employer would *not* pay a reduced premium for that plan. Instead, the employer's premium would remain as high as previously, even though its claims experience should result in a lower premium. And it is precisely that increment of premium over the actual experience-based cost that would pay for the separate contraceptive-only policy. In this way, the accommodated employer's (and employees') premiums for the main health plan are paying for the contraceptive-only policy.

Even apart from the proposed rule's flawed accounting mechanisms, the claimed "accommodation" still requires religious organizations to facilitate access to objectionable services in direct contravention of their sincerely-held religious beliefs. Insofar as the insurer is providing *individual* policies for contraceptive coverage by virtue of the participants' enrollment in the *group* plan, the purchase of contraceptives and sterilization procedures is ultimately facilitated by the group plan which the religious objector has offered to, and purchased for, its employees. So even if the purchaser's premiums were somehow segregated to eliminate the funding tie, it is not evident that it would resolve the moral problem. In effect, offering a group health plan would operate automatically as a "ticket" or "trigger" for contraceptive coverage. The employee (and her dependents such as female minor children) will receive this "entitlement" whether she wants it or not, triggered by her enrollment in a health plan from her religious employer (albeit not a "religious employer" as the Administration defines it).

As we have pointed out before, this is different from a situation in which an employee uses his or her salary for purposes the employer believes to be intrinsically evil. The difference is that the employee's salary is not earmarked for the purchase of anything – once paid, those funds simply belong to the employee. Health care premiums, by contrast, are paid specifically for the purchase of a health plan. And the fact that the insurer provides contraceptives for "free" under policies that are provided automatically because of enrollment in the employer-sponsored group plan would likewise seem sufficient to establish a burden on the employer's religious freedom.[18]

Our comments on this proposal are not new. We pointed to the problems of both funding *and* facilitating contraceptive coverage when the idea of having insurers provide contraceptive coverage was first aired. *See* our comments of May 15, 2012, pp. 10-18. As we pointed out then (pp. 12-13), suppression of religious freedom can take at least two forms. It can take the form of making conscientious objectors actively *cooperate with what they see as morally forbidden*. But it can also take the form of depriving those objectors of the right (a right that others continue to exercise) *to do what they see as morally required*. Under the proposed regulation, those who favor contraceptive coverage will retain the right they have always had as employers to provide a health plan consistent with their values. Objecting employers, including many religious organizations, will lose that right, because any plan they offer will be turned into a conduit for the objectionable coverage. The practical outcome for employees and their children is exactly the same as if the organization had no objection. Employees who share the objecting organization's religious tenets are similarly deprived of the freedom to choose a workplace organized according to their own values, and are forced to accept coverage for their families to which they have their own religious or moral objection.[19]

---

[18] It is also morally problematic that the group plan is serving as a gateway for speech ("related education and counseling"), including persuasive speech to minor children, that squarely contradicts the plan sponsor's religious or moral beliefs and possibly those of the adult employee as well. *See, e.g., Keller v. State Bar of California*, 496 U.S. 1 (1990) (holding that state bar members could not be compelled to finance political and ideological activities with which they disagree); *Abood v. Detroit Board of Education*, 431 U.S. 209 (1977) (holding that state employees could not be required, consistent with the First Amendment, to provide financial support for ideological union activities unrelated to collective bargaining).

[19] We should also point out that because all enrollees in the contraceptive-free group plan are provided with individual contraceptive-only policies, *both* the plan sponsor *and* all contributing employees in the group plan are, ultimately, paying for and facilitating access to contraceptives

B. Self-insured plans.

As described in the NPRM,[20] the Administration proposes that the plan sponsor and employees may pay for a self-insured group plan that excludes contraceptive coverage. However, the third-party administrator ("TPA") is then to find an insurer that will automatically issue individual contraceptive-only plans to all persons enrolled in the group plan (that is, all employees and their dependents). 78 Fed. Reg. at 8463.[21] Since the insurer is not providing these individually-insured persons with group coverage of other (non-contraceptive) items and services, the Administration cannot (and does not) make any claim of cost savings as a result of enrollment in the self-insured group plan. As described in the NPRM, however, issuers of contraceptive-only plans will be given an adjustment in the Federally-facilitated Exchange ("FFE") user fee they would otherwise be required to pay to participate in that Exchange.[22] The insurer, in turn, is required to

---

and sterilization procedures *even if* many of the enrolled employees and their dependents do not personally make use of the contraceptive-only policy by obtaining contraceptives. In other words, the individual contraceptive-only policies function like one large contraceptive-only group plan, for the persons enrolled in the non-contraceptive group plan are *identical* in all respects to the persons enrolled in the contraceptive-only policies (whether characterized as individual policies or as one large group policy). As a result, conscientiously-opposed employers and employees are, in the aggregate, paying for and facilitating *other* employees' contraceptives and sterilization procedures.

[20] The NPRM does not include the text of a proposed regulation with respect to self-insured plans, but the preamble includes a description of how enrollees in such plans would obtain contraceptive coverage. Our analysis is based on that description. Further comment must await publication of a proposed regulation on self-insured plans.

[21] The first of the three options described for self-insured plans states only that TPAs will have an "economic incentive" to arrange for contraceptive coverage (which could be read to mean something less than a "requirement" to make such arrangements); elsewhere, the NPRM states that under *all three* options, contraceptive coverage will be provided "automatically." 78 Fed. Reg. at 8463. Obviously we believe contraceptive coverage should not be required, and we ask for clarification on this point.

[22] A recently published regulation defines an FFE as "an Exchange established and operated within a State by the Secretary [of HHS] under section 1321(c)(1) of the Affordable Care Act." 78 Fed. Reg. 15410, 15532 (March 11, 2013). Section 1321(c)(1) authorizes the Secretary to establish an FFE if a state fails to do so. In support of such FFEs, the Administration has proposed that participating issuers pay a monthly user fee. *Id.* at 73213. It is this fee that the Administration now proposes to adjust, as a mechanism for encouraging insurers to offer

share a portion of that adjustment with the TPA to offset the latter's administrative cost in arranging individual contraceptive-only coverage.

A number of assumptions are built into this proposal. For example, the proposal assumes that (a) the plan sponsor with a religious or moral objection to contraceptive coverage does not self-administer the plan, (b) the sponsor will be both willing and able to find a TPA that does not share its objection and is willing to arrange such coverage, and (c) TPAs in turn will be willing and able to find an insurer to provide such coverage, and only as consideration for an adjustment in the insurer's FFE user fee. This, in turn, assumes that (d) there is a market of willing insurers that participate, or have an affiliate that participates, in the FFE for which (e) the costs of contraceptives and sterilization procedure will not outpace the adjustment in the insurer's (or its affiliate's) FFE user fee.[23] There may be other assumptions built into the Administration's proposal that would be familiar to those who sell or administer plans and on which they can comment further.[24]

Even if all these assumptions were sound, which we question, the underlying approach would still pose a moral problem because *the group plan itself* continues to facilitate access to items and procedures to which the employer has a religious or moral objection. In other words, even if the objecting employer's monetary contributions did not directly pay for contraceptives and sterilization procedures, the plan itself would continue to function as a morally objectionable gateway or "ticket" to such coverage.[25] Thus, as described earlier in the context of insured

---

individual contraceptive-only policies and as a means of paying for such policies and the items they cover.

[23] The Administration's promise to "assist in identifying issuers" of contraceptive-only policies (78 Fed. Reg. at 8463) does not, of course, ensure that there will be an economically viable market for such issuers.

[24] *See*, *e.g.*, NPRM Comments from the Self-Insurance Institute of America, Inc. (Feb. 25, 2013).

[25] This is especially explicit in some of the proposed ways for making this intricate proposal function. For example, one scenario envisions that the employer's simple act of self-certifying that it objects to contraceptive coverage "would have the effect of designating the third party administrator as the plan administrator under section 3(16) of ERISA solely for the purpose of fulfilling the requirement that the plan provide contraceptive coverage without cost sharing." 78 Fed. Reg. at 8464. In other words, the plan sponsor's very act of stating its religious objection to this coverage is what gives the TPA the legal authority under ERISA to impose such coverage on all of the sponsor's employees and their dependents.

plans, the self-insured plan (and the self-certification of non-coverage that the sponsor provides to the TPA) would automatically trigger contraceptive coverage. The moral dilemma for the plan sponsor with a religious or moral objection to such coverage lies in being forced to trigger the objectionable coverage *even if* the funds paying for the group plan are not also used to pay for the contraceptive coverage.

The particular ways in which the proposed regulation calls on various parties to facilitate coverage to which they may have a religious or moral objection only deepens the dilemma. The sponsor must (1) identify a TPA able and willing to arrange the objectionable coverage; (2) provide the TPA with a certification that the group plan does not include the objectionable coverage; and (3) provide the TPA, as it usually does, with the names and identifying information of enrollees so the TPA can administer the plan, which in this case will include arranging for an individual contraceptive-only plan for those enrollees, the very thing that the sponsor objects to.[26]

Again, our views on this are not new. We pointed out the problem of improperly facilitating contraceptive coverage when the idea of having TPAs arrange such coverage was first aired. *See* our comments of May 15, 2012, pp. 13-18. As we observed then, the problem relates not only to cooperation with what the plan sponsor views as immoral. Here, as in the case of insured plans, it is also an infringement of religious freedom for government to deprive stakeholders of the opportunity (which others continue to enjoy) to do what they regard as a necessary good—namely, to offer, buy, or enroll in a health plan that conforms to their most basic religious or moral convictions.[27] As we said in previous comments,

---

[26] The NPRM notes that, under one of three alternative proposals for self-insured plans, "there would be no obligation on a third party administrator to enter into or continue a third party administration contract with an eligible organization if the third party administrator were to object" to arranging for contraceptive-only coverage. 78 Fed. Reg. at 8464. Though not explicitly stated, this also appears to be equally true of the two other alternative proposals for self-insured plans. Obviously, if a TPA refuses for conscientious reasons to enter into or to continue a TPA contract with an eligible organization, that organization must find another TPA, specifically one that does not share its (or its previous TPA's) objection to contraceptive coverage. And the TPA that shares the employer's religious beliefs, in turn, is being told that it must either violate those beliefs or exit the marketplace. Indeed, some TPAs may themselves be religious organizations, but they receive no exemption under the proposed regulation.

[27] It is especially difficult to understand why the Administration would present many employers with the Hobson's choice of abandoning its conscientious beliefs or ceasing to offer a health plan at all, when one of ACA's central goals is to *improve* access to health plans.

protecting a religious organization from being forced to act immorally, by depriving it of the ability to act at all, is no way to serve religious freedom.

V. Conclusion.

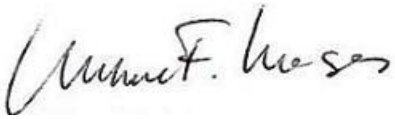
The proposed regulation keeps in place a regulatory definition of "preventive" health care which includes items that do not prevent disease, but rather are intended to render a woman temporarily or permanently infertile, and may be associated with adverse health outcomes. Under the proposed regulation, most stakeholders are offered no exemption or accommodation. The proposed regulation creates an exemption that artificially and arbitrarily carves up the religious community into those deemed "religious enough" for the exemption and those that are not, generally excluding those who practice their faith by most visibly serving the common good. Finally, under the proposed "accommodation" for non-exempt religious organizations, plan premiums or the plan, or both, would continue to serve as the source or conduit for the objectionable "services."

In short, the Administration continues to propose: (a) an unjust and unlawful mandate; (b) no exemption or "accommodation" at all for most stakeholders in the health insurance process, such as individual employees and for-profit employers; (c) an unreasonably and unlawfully narrow exemption for some nonprofit religious organizations, mostly houses of worship; and (d) an "accommodation" that still requires *bona fide* religious employers that fall outside the narrow government definition of "religious employer" to fund or facilitate the objectionable coverage.

Once again, we urge the Administration to reconsider this proposed course.

Respectfully submitted,

Anthony R. Picarello, Jr.
Associate General Secretary &
General Counsel



Michael F. Moses
Associate General Counsel
UNITED STATES CONFERENCE OF
CATHOLIC BISHOPS
3211 Fourth Street, NE
Washington, DC 20017
(202) 541-3300