



## Office of the General Counsel

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May 15, 2012

### **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: Advance Notice of Proposed Rulemaking on Preventive Services  
File Code No. CMS-9968-ANPRM**

Dear Sir or Madam:

On behalf of the United States Conference of Catholic Bishops, we respectfully submit the following comments on the Advance Notice of Proposed Rulemaking (“ANPRM”) on preventive services. 77 Fed. Reg. 16501 (March 21, 2012). The ANPRM expresses the Administration’s intention to propose additional regulations, in order to establish “alternative ways” of “ensuring contraceptive coverage for plan participants and beneficiaries” enrolled in plans offered by non-exempt “religious organizations” that object to such coverage while, at the same time, “accommodating such organizations.” *Id.* at 16501.

Our comments make essentially six points.

*First*, the ANPRM does not change the inclusion of “contraceptive services” in the list of mandated preventive services.<sup>1</sup> This aspect of the mandate is now a

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<sup>1</sup> We use the term “contraceptive services” as shorthand for all FDA-approved contraceptives (including drugs that can cause an abortion), sterilization procedures, and related education and counseling for women with reproductive capacity. We use the term “contraceptive mandate” or “mandate” to refer to the regulatory requirement that plans or policies cover contraceptive services. It is unclear whether the Administration is using these terms in the same way. As we have suggested in the past, and as we discuss below, the Administration should clarify what it means by these terms, particularly as it bears upon the scope of the exemption or any future “accommodation.”

final rule, entirely unchanged from August 2011. As we explained in our prior comments, the mandate is not only poor public policy, but unlawful.<sup>2</sup>

*Second*, the ANPRM does not change the Administration's four-pronged exemption for "religious employers." The exemption is now a final rule, entirely unchanged from August 2011. As we explained in our prior comments, the exemption is unprecedented in federal law, improperly narrow, and unlawful.

*Third*, many religious and other stakeholders with a conscientious objection to some or all of the mandated coverage are ineligible for either the exemption or the temporary enforcement safe harbor. These stakeholders will be subject to the mandate for plan or policy years beginning on or after August 1, 2012. The ANPRM does not even acknowledge this problem, least of all propose or allow for possible solutions to it. As a result, absent a change of course by the Administration or a court order granting relief,<sup>3</sup> individuals, insurers, for-profit employers, and many other stakeholders with a moral or religious objection to contraceptive coverage will be required in the next few months either to drop out of the health insurance marketplace, potentially triggering crippling penalties, or to provide coverage that violates their deeply-held convictions. As discussed in our previous comments, we believe that the contraceptive mandate violates the religious and conscience rights of these stakeholders and is unlawful.

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<sup>2</sup> Our August 2011 and September 2010 comments, both of which address the issue of contraceptives and conscience, are available at <http://www.usccb.org/about/general-counsel/rulemaking/upload/comments-to-hhs-on-preventive-services-2011-08.pdf>. We incorporate them herein by reference.

<sup>3</sup> At least eleven lawsuits have been filed to date challenging the contraceptive mandate and the unduly narrow religious exemption. *See, e.g., Belmont Abbey College v. Sebelius*, No. 1:11-cv-01989 (D.D.C.) (filed Nov. 10, 2011); *Colorado Christian University v. Sebelius*, No. 11-cv-03350-CMA-BNB (D. Colo.) (filed Dec. 21, 2011); *Eternal Word Television Network v. Sebelius*, No. 2:12-cv-00501-SLB (N.D. Ala.) (filed Feb. 9, 2012); *Priests for Life v. Sebelius*, No. 12-cv-753 (E.D.N.Y.) (filed Feb. 15, 2012); *Louisiana College v. Sebelius*, No. 1:12-cv-00463 (W.D. La.) (filed Feb. 18, 2012); *Ave Maria University v. Sebelius*, No. 2:12-cv-88-FRM-29SPC (M.D. Fla.) (filed Feb. 21, 2012); *Geneva College v. Sebelius*, No. 2:2012-cv-00207 (W.D. Pa.) (filed Feb. 21, 2012); *State of Nebraska v. United States Department of Health and Human Services*, No. 4:12-cv-03035 (D. Neb.) (filed Feb. 23, 2012); *O'Brien v. United States Department of Health and Human Services*, No. 4:2012-cv-00476 (E.D. Mo.) (filed Mar. 15, 2012); *Newland v. Sebelius*, No. 1:12-cv-1123 (D. Colo.) (filed Apr. 30, 2012); *Legatus v. Sebelius*, No. 2:12-cv-12061-RHC-MJH (E.D. Mich.) (filed May 7, 2012).

*Fourth*, the Administration has invited public comment on (but has not yet formally proposed) what it describes as a further “accommodation” for non-exempt “religious organizations.” Given the stated intent to accommodate only “religious” organizations, it is evident that whatever this further “accommodation” will or will not accomplish, secular stakeholders will be excluded from it. Even a nonprofit organization that is eligible for a one-year delay in enforcement under the temporary enforcement safe harbor will receive no “accommodation” if it is not also a “religious organization.” We believe that the contraceptive mandate violates the religious and conscience rights of these stakeholders as well and is unlawful.

*Fifth*, however the term “religious organization” is ultimately defined, the Administration’s suggested “accommodation” for such organizations, as described in the ANPRM, will not relieve them from the burden on religious liberty that the mandate creates. Under the ANPRM, the central problem for insured plans remains: conscientiously-objecting non-exempt religious organizations will still be required to provide plans that serve as a conduit for contraceptives and sterilization procedures to their own employees, and their premiums will help pay for those items. For self-insured plans, the Administration has invited comment on a number of different approaches. As a practical or moral matter, none of them will solve the problem that the mandate creates for non-exempt religious organizations with a conscientious objection to contraceptive coverage.

*Sixth*, the ANPRM raises a variety of new questions regarding the exemption and “accommodation,” such as whether an employer must be independently exempt for its employees to participate in an exempt plan; whether religious objections to some (but not all) contraceptives should be accommodated; and whether the past practice of offering contraceptive coverage should preclude accommodation. In each case, we urge resolution of these questions in favor of more, not less, religious freedom.

On balance, while the ANPRM may create an appearance of moderation and compromise, it does not actually offer any change in the Administration’s earlier stated positions on mandated contraceptive coverage, which are now enshrined in a final rule. The simplest and best solution to the various problems described above is the one the Administration so far has declined to adopt: to rescind the mandate. Failing this, the Administration should provide an exemption that protects all stakeholders with a religious or moral objection, in keeping with the consistent language and longstanding tradition of federal conscience protection law. Either

rescission or exemption would allow stakeholders that object to offering or purchasing contraceptive coverage to decline to do so, while allowing those who do not object to offering or purchasing such coverage to do so.

We are convinced that no public good is served by this unprecedented nationwide mandate, and that forcing individual and institutional stakeholders to sponsor and subsidize an otherwise widely available product over their religious and moral objections serves no legitimate, let alone compelling, government interest. Indeed, as stated in our August 2011 comments, such coercion is a serious violation of federal statutory and constitutional guarantees of religious liberty and rights of conscience. Absent prompt congressional attention to this infringement on fundamental civil liberties, we believe the only remaining recourse, in light of the approaching regulatory deadlines, is in the courts.

**1. The Mandate Is Finalized and Remains Unchanged.**

The ANPRM makes no change in the underlying contraceptive mandate. For reasons set forth more fully in our August 2011 comments, we continue to believe that the mandate should be rescinded.

First, contraceptives and sterilization procedures are not “health” services, and they 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. The contraceptive mandate is therefore at war with the statutory provision on which it purports to be based, a provision that seeks to ensure coverage of health services that prevent disease. Indeed, insofar as contraceptives are linked to an increased risk of the very diseases whose prevention is sought in the regulation, the regulation is at war with itself. *See* our August 2011 comments at 3-13; *see also* our comments of September 2010, for a further discussion of these issues.

Second, the mandate represents an unprecedented violation of religious liberty by the federal government. Specifically, as applied to individuals and organizations with a religious objection to some or all contraceptive coverage, we continue to believe that the mandate violates the First Amendment, the Religious Freedom Restoration Act (“RFRA”), and the Administrative Procedure Act (“APA”). In addition, insofar as it requires coverage of drugs that can operate to

cause an abortion, the mandate violates the Weldon amendment, certain provisions of the Patient Protection and Affordable Care Act (“PPACA” or “the Act”) dealing with abortion and non-preemption, and the Administration’s own public assurances, both before and after enactment of PPACA, that the Act does not require coverage of abortion. These points are discussed at length in our August 2011 comments.

The ANPRM makes no change in the mandate, and hence does not address or resolve any of these problems.

## **2. The Four-Part Exemption Is Finalized and Remains Unchanged.**

The ANPRM does not change the Administration’s extremely narrow four-part test for deciding which organizations are “religious enough” to warrant an exemption from the mandate.<sup>4</sup> Hence, the problems that we have described at length with respect to the exemption remain. See our August 2011 comments at 13-22.

The following points should be underscored.

First, despite requests for clarification, the Administration has failed publicly to clarify whether the four-pronged exemption for religious employers is intended to apply only to contraceptives, or also to sterilization and to education and counseling regarding contraceptives and sterilization. The ANPRM states that the exemption “is intended solely for purposes of the contraceptive coverage requirement . . .” 77 Fed. Reg. at 16502 (original emphasis). It remains unclear, however, whether the Administration is using the term “contraceptive coverage” here as shorthand for contraceptives, sterilization, and related education and

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<sup>4</sup> Under the exemption, a “religious employer” is one that meets all four of the following criteria: (a) its purpose is the inculcation of religious values, (b) it primarily hires persons who share the organization’s religious tenets, (c) it primarily serves persons who share those tenets, and (d) it is a nonprofit organization of a type described in sections 6033(a)(1) and 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code. 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. In our earlier comments, we asked the Administration why the exemption included a reference to section 6033(a)(1), but no clarification has been forthcoming.

counseling, as the HRSA chart of preventive services for women would seem to suggest; or instead to emphasize that the exemption applies only to contraceptives, and not to sterilization, or education and counseling regarding contraceptives or sterilization. The ANPRM fails to resolve this ambiguity. *See id.* at 16504 (stating in circular fashion that “contraceptive coverage” means “contraceptive coverage required under the HRSA guidelines”). If the exemption and any future “accommodation” only apply to contraceptives, then the mandate is all the more objectionable, because it would require even “exempt” religious employers to cover these other items. In our August 2011 comments, we urged the Administration to clarify its intent on this point. We continue to urge clarification.

Second, the exemption provides no protection for any individual, insurer, or secular organization with a moral or religious objection to contraceptive coverage, and it protects only some religious organizations while leaving a large number of conscientiously opposed religious organizations subject to the mandate.<sup>5</sup>

Indeed, for individuals with a conscientious objection to contraceptive coverage, the ANPRM actually exacerbates the problem. In its February 10 rule, the Administration proposed 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).<sup>6</sup> The ANPRM, however, no longer uses the language of “offer,” which allows for the possibility of

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<sup>5</sup> The ANPRM does not propose an exemption or accommodation for issuers or third-party administrators, but asks “whether an exemption or accommodation should be made” for “certain religious health insurance issuers or third-party administrators,” and seeks information “about the number and location of such issuers and administrators....” 77 Fed. Reg. at 16507. The “number and location” of religiously-affiliated issuers and third-party administrators, whatever that turns out to be, is not an argument against providing those issuers and administrators with an exemption. The protection of conscience is all the more important for those in the minority. No one (religiously-affiliated or not) with a moral or religious objection to contraceptive coverage should be required to offer or provide it.

<sup>6</sup> President Obama reinforced this message on February 10, 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 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 (Feb. 10, 2012) (available at [www.whitehouse.gov/the-press-office/2012/02/10/remarks-president-preventive-care](http://www.whitehouse.gov/the-press-office/2012/02/10/remarks-president-preventive-care)) (emphasis added).

acceptance or rejection. Instead, HHS would now require insurers or third-party administrators simply to “provide this coverage automatically to participants and beneficiaries covered under the organization’s plan (for example, without an application or enrollment process), and protect the privacy of participants and beneficiaries covered under the plan who use contraceptive services.” 77 Fed. Reg. at 16505 (emphases added).<sup>7</sup>

As a result, women will have less freedom, not more. They will not have the freedom to decline such coverage. They will not have the freedom to keep their own minor children from being offered “free” and “private” contraceptive services and related “education and counseling” without their consent. Thus, the mandate now poses a threat to the rights not only of employers, religious and secular, but of parents as well. It is even proposed that this intervention into the family may be delegated to “private, non-profit organization[s]” (77 Fed. Reg. at 16507), potentially including groups such as Planned Parenthood, which may volunteer for the task.<sup>8</sup>

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<sup>7</sup> This shift from optional to automatic coverage also contradicts the Secretary’s own public comments regarding the proposed “accommodation.” See, e.g., “Sebelius Explains White House’s Contraception Compromise,” *PBS News Hour* (Feb. 10, 2012) (describing purpose of mandate as “mak[ing] sure that millions of women, regardless of who their employer is, can make their own health decisions. . . . So, in this case, again, the insurance company would be reaching out to employees, making it clear that it is their choice whether to access contraceptive benefits.”) (emphasis added) (available at [www.pbs.org/newshour/bb/politics/jan-june12/contraception\\_02-10.html](http://www.pbs.org/newshour/bb/politics/jan-june12/contraception_02-10.html)).

<sup>8</sup> This circumvention of parental authority is no mere oversight. The Guttmacher Institute, Planned Parenthood’s former research affiliate, has long proposed that any health care reform legislation should ensure that “the full range of reproductive health services,” including all contraceptive methods, be provided “confidentially to all individuals covered,” including dependents. Guttmacher’s position paper emphasized that such coverage should be provided without “copayments and deductibles” not only to remove a cost barrier, but also “to facilitate the receipt of confidential care” (that is, minors can more easily access the services without parents’ knowledge or consent if they do not even need to have cash for the copayment). See Guttmacher Institute, “Implications for Health Care Reform,” in *Uneven & Unequal: Insurance Coverage and Reproductive Health Services* (Jan. 1995) (available at [http://findarticles.com/p/articles/mi\\_7355/is\\_1995\\_Jan/ai\\_n32003787/](http://findarticles.com/p/articles/mi_7355/is_1995_Jan/ai_n32003787/)). In these respects, the Administration seems to be following a script written long ago by groups strongly opposed both to our religious teaching and to parents’ right to guide their children on sensitive issues of sexuality and reproduction.

Third, while the Administration’s claims (77 Fed. Reg. at 16502) that the 4-part definition of “religious employer” is not “intended to set a precedent for any other purpose,”<sup>9</sup> the government has no power to prevent the definition from being used again in future regulations or legislation. In any event, the disclaimer raises a question: If the Administration does not consider the definition suitable as a model for future regulation or legislation, then one wonders why it considers the definition suitable for a nationwide contraceptive mandate.

A fourth and related point is this: Even if the definition of “religious employer” were never used elsewhere, it remains illegitimate and unconstitutional now. As we discussed at length in our August 2011 comments, the definition creates an impermissible gerrymander in which some religious organizations are deemed “religious enough” for the exemption, while others are not. It is patently wrong and unlawful, in our view, to claim that an organization is not “religious” if its purpose extends beyond inculcation of religious values, or if it substantially hires or serves persons other than its co-religionists, or if it fails to fit within Internal Revenue Code provisions having an entirely different purpose. Reduced to its simplest terms, an organization is “religious,” in the Administration’s view, only if it is insular, while organizations with a missionary or public outreach are deemed insufficiently “religious” to qualify for the exemption. We are free to worship our God, but not to serve our neighbor. As we noted previously, under this criterion, even Jesus would be deemed insufficiently “religious” to qualify for the exemption because he fed and healed people of many different beliefs. As discussed more fully in our August 2011 comments, neither this nor any other part of the exemption bears a reasonable relationship to any legitimate government objective.

The ANPRM does not address or resolve any of these problems.

**3. The Safe Harbor Remains Unchanged and Provides No Relief to Several Categories of Objecting Stakeholders.**

The Administration is offering what it characterizes as a “temporary enforcement safe harbor” to delay enforcement of the contraceptive mandate—but

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<sup>9</sup> See also 77 Fed. Reg. at 16504 (making a similar claim with respect to any definition of non-exempt “religious organizations” adopted in the future for such organizations).



only temporarily, and only for non-exempt nonprofit organizations that meet specified criteria.

The ANPRM does not expand or change in any way the safe harbor or the criteria of eligibility established by the February 10 final rule. As a result, non-grandfathered, non-exempt stakeholders that do not qualify for the safe harbor will be subject to the mandate for plan or policy years beginning on or after August 1, 2012. In short, the ANPRM does nothing at all to change the imminent impact that the mandate will have on the religious liberty and conscience rights of these stakeholders. More specifically, individuals, insurers, for-profit employers, nondenominational nonprofit employers with a pro-life stance that have a moral objection to abortion, and many others with a moral or religious objection to some or all of the mandated items, will face a choice: They can drop out of the health insurance marketplace altogether, or offer or provide the objectionable coverage.

For those who do not qualify, the safe harbor provides no relief. And for those who do qualify, the safe harbor provides only a temporary reprieve. We continue to believe, as explained in our August 2011 comments, that the contraceptive mandate violates the religious and conscience rights of these stakeholders and is unlawful.

**4. The “Accommodation” Described in the ANPRM Provides No Relief to Stakeholders That Fail to Qualify as “Religious Organizations.”**

The ANPRM states the Administration intends, at some point in the future, to propose and finalize an additional “accommodation” for non-exempt “religious organizations.” It is evident that whatever this further “accommodation” will or will not accomplish, and however the term “religious organizations” is defined for this purpose, the Administration’s stated intent is to exclude secular stakeholders with a religious or moral objection to contraceptive coverage. A fraternal organization, for example, devoted to the teachings of a particular religion, even though not formally associated with a church, would be ineligible for the “accommodation.” Thus, a nonprofit organization that happens to be eligible for

the one-year delay in enforcement under the safe harbor will receive no “accommodation” if it is not also a “religious organization.”<sup>10</sup>

For reasons set forth more fully in our August 2011 comments, we continue to believe that the contraceptive mandate violates the religious and conscience rights of these stakeholders and is unlawful.

**5. The “Accommodation” Described in the ANPRM Does Not Meaningfully Accommodate Even Those Stakeholders That Qualify for It.**

However the term “religious organization” is ultimately defined, the Administration’s proposed “accommodation” as defined in the ANPRM will not actually relieve those “religious organizations” of the burden on religious liberty that the mandate creates.

Under the ANPRM, the central problem for insured plans remains: Conscientiously-objecting non-exempt “religious organizations” will still be required to provide plans that channel contraceptives and sterilization procedures to their employees; and those organizations (and their employees) will still be required to pay premiums that help pay for those items. The use of premiums as the source of funding is evident in the ANPRM, which states as follows:

Issuers would pay for contraceptive coverage from the estimated savings from the elimination of the need to pay for services that would otherwise be used if contraceptives were not covered. Typically,

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<sup>10</sup> The ANPRM says that the future accommodation for “religious organizations” will apply to “some *or all* organizations that qualify for the temporary enforcement safe harbor, and possibly to additional organizations.” 77 Fed. Reg. at 16504 (emphasis added). Unless all “nonprofit organizations” are “religious organizations,” which is plainly not the case, then a future accommodation for religious organizations will not protect all nonprofit organizations, or even the entire subset of nonprofit organizations that satisfy the specified conditions for the safe harbor. Those conditions include having a religious objection. There is no requirement that the entity seeking safe harbor protection be a religious organization, but that is stated as a requirement for any entity seeking the future accommodation. *See, e.g.*, 77 Fed. Reg. at 16504 (inviting comment on which “religious organizations” should be eligible for the future “accommodation”); *id.* at 16505 (stating that the future accommodation is intended to ensure contraceptive coverage while protecting a nonprofit “religious organization” that objects to such coverage on religious grounds).

issuers build into their premiums projected costs and savings from a set of services. Premiums from multiple organizations are pooled in a “book of business” from which the issuer pays for services. To the extent that contraceptive coverage lowers the draw-down for other health care services from the pool, funds would be available to pay for contraceptive services without an additional premium charged to the religious organization or plan participants or beneficiaries.

77 Fed. Reg. at 16506 (emphasis added).<sup>11</sup>

This passage makes plain that there is only one funding stream from which contraceptive services can be paid: premiums. It necessarily follows that the objecting employer is ultimately paying for the objectionable services. The creation of a single account into which premiums from multiple organizations are paid does not solve the problem if objecting employers and employees are still paying into that account.

The question arises, in the case of insured plans, whether the insurer could be required by the government to create two accounts – one into which it places the premiums of non-objecting organizations, and the other into which it places the premiums of conscientiously-objecting organizations. Then the former, but not the latter, would be used to pay for contraceptive services. There are at least three problems with such a proposal.

First, there is no statutory authority for the federal government to require an insurer to use premium dollars paid into a health plan to subsidize services for persons who are not enrolled in that plan.

Second, the segregation of funds would be ineffective, because claims for contraceptives and sterilization procedures must still be paid—and paid by an employer that cannot achieve any alleged cost savings from reductions in births

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<sup>11</sup> The ANPRM states that “contraceptive coverage would not be included in the plan document, contract, or premium charged to the religious organization,” (77 Fed. Reg. at 16505) (emphasis added), but when it comes to explaining what funds will be used to pay for contraceptives and sterilization, the ANPRM can say only that it will come from premiums (*id.* at 16506). And the alleged cost savings from reduced use of “other health care services” are of course from averted live births, which are entirely paid for by the employer’s and employee’s premium dollars. It is these premium dollars that will become “available” to pay for contraceptive services instead.

among its own enrollees, because these payments are for contraceptive and sterilization services for non-enrollees. Unless the non-objecting employer is to be forced to raise its own premiums, those expenditures must be made up from premium dollars paid by the objecting employer—regardless of whether contraception and sterilization are listed in its plan summary or other plan documents. In short, having an insurer pay for contraceptives does not resolve the problem for plan sponsors who object to contraceptive coverage, because the plan premiums end up, over the sponsor’s objection, paying for contraceptives and sterilizations anyway.

Third, because the insurer is enabled to pay for contraceptives only because the objecting employer has purchased a plan from the insurer, that enabling decision of the employer still facilitates the purchase of contraceptives. So even if the purchaser’s premiums were somehow segregated, it would not resolve the moral problem. In effect, an employer’s offering any health plan will operate as a “ticket,” so to speak, entitling the bearer to reimbursement for the purchase of contraceptives to which she would not otherwise be entitled.

One might ask how this is any different from paying salary to an employee who then uses that salary toward 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 earmarked specifically for the purchase of health care. So if contraceptives and sterilization procedures are made available by virtue of the plan (even if not expressly listed in the plan summary), then the premiums have gone toward a plan that facilitated their purchase, even if those exact premium dollars were not used to purchase contraceptives.

Finally, the various intricate proposals to insulate religious organizations from any involvement in a major aspect of their own health plans miss an important point. One can suppress religion not only by making conscientious objectors actively cooperate with what they see as evil, but also by depriving them of the right (a right that others continue to exercise) to support what they see as good. 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 religious organizations will lose that right, because any plan they offer will be amended by others so that the practical outcome for employees is exactly the same as if the organization had no such objection. Those employees who share

the objecting organization's religious tenets are similarly deprived of the freedom to choose a work-place organized according to their own values, and are forced to accept coverage to which they have their own moral and religious objection. In general, 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.

For self-insured plans, the ANPRM invites comment on several different approaches involving third-party administrators ("TPAs") or other third parties, including whether:

- a TPA could pay for contraceptives from "drug rebates, service fees, disease management program fees, or other sources" (77 Fed. Reg. at 16507);
- a TPA might receive funds "from a private, non-profit organization to pay for contraceptives for the participants and beneficiaries covered under the plan of a religious organization" (*id.*);
- a TPA could "receive a credit or rebate on the amount that it pays under the reinsurance program under section 1341 [of PPACA] in order to fund contraceptive coverage for participants and beneficiaries covered under the plan of a religious organization that sponsors a self-insured plan" (*id.*);
- the federal government could "incentivize or require one or more of the insurers offering a multi-State plan also to provide, at no additional charge, contraceptive coverage to participants and beneficiaries covered under religious organizations' self-insured plans" (*id.*);
- a tax-deferred account could be used for payment of contraceptives (*id.*).

In general, these approaches continue to pose a moral problem because, in each case, the plan itself continues to function as either a source of funding for, or a conduit facilitating access to, items and procedures to which the employer has a moral and religious objection.

To take one example, a drug rebate is called a “rebate” because the drug manufacturer returns to the TPA (or perhaps, more accurately, credits to the TPA) some portion of the funds which the TPA itself has paid for drugs offered under the plan. But the TPA obtained those funds from the objecting employer’s premiums. In any event, even if premium dollars of an objecting employer did not actually pay for contraceptives, the plan itself would be functioning as a gateway to such payments. Thus, as described earlier in the context of insured plans,<sup>12</sup> the self-insured plan would serve as a kind of “ticket” for “free” contraceptives. It would be morally objectionable for an employer to provide anyone such a “ticket,” even if the ticket costs the employer nothing to provide. Simply put, a stakeholder cannot avoid moral responsibility for an act by shifting the responsibility to another. If it is immoral to do a particular act, then it is immoral to arrange for another to do the same act.

At bottom, the Administration’s proposal for a future “accommodation” through rulemaking cannot succeed under the terms that the Administration has set for itself, because it is trying to serve three goals that are inconsistent with each other:

1. To ensure that contraceptive coverage is provided to every woman, “no matter where she works,” to use the President’s words.
2. To make that coverage “free” in the sense that it is supported only by “the estimated savings from the elimination of the need to pay for services that would otherwise be used if contraceptives were not covered” (77 Fed. Reg. at 16506)—that is, by the premium dollars that otherwise would have had to pay for services such as childbirth and well-baby care.<sup>13</sup>

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<sup>12</sup> Because the approach the ANPRM has spelled out for insured plans also does not solve the moral problem, it is no consolation to be told that “nothing precludes a religious organization from switching from a self-insured plan to an insured plan such that a health insurance issuer rather than a [TPA] is responsible for providing the contraceptive coverage.” 77 Fed. Reg. at 16507.

<sup>13</sup> We cite this as a stated goal of the Administration, not as a likely practical reality, as many studies have detected little or no reduction in unintended pregnancies from programs to increase access to contraceptives. See page 3 of our September 2010 comment letter, cited in note 2 *supra*.

3. To make the coverage “separate” in the sense that it does not involve the employer with a religious objection, or that employer’s financial resources, so as to respect religious liberty.

In practice these goals cannot be reconciled.<sup>14</sup> For example, if, to serve Goal 1, contraceptive coverage is to be provided by others “automatically” to every employee of an employer with a religious objection, then Goal 3 is necessarily undermined: The employer will know that offering any health coverage to employees at all will be a necessary and sufficient cause for each employee to receive the objectionable coverage. That coverage will be added “automatically” as soon as the decision is made to provide overall coverage.

Likewise, Goals 2 and 3 cannot be served together. To serve Goal 2, the costs of contraceptives and sterilization must be paid by the premium dollars that otherwise would have supported childbirth. But those are the premium dollars of the objecting employer and its employees, so their financial resources will be directly involved. It is meaningless in this context to point out that insurers essentially “pool” risks among their clients. Other stakeholders without a religious objection already cover contraception and sterilization. If the intent is to make those other stakeholders pay the total cost of the coverage to which the religious employer objects, those others will have to increase their premium payments, because they cannot recoup that expenditure through any reduction of births among their own enrollees. But if that is not the intent, then the religious employer’s premium payments must still be used to cover part or all of the cost.<sup>15</sup>

The Administration’s assumption under Goal 2 is that the employees of objecting employers were not already using contraceptives. If, for example, they

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<sup>14</sup> Obviously, we do not believe that the first two goals are laudable. Our point is simply that the three goals are in conflict with each other.

<sup>15</sup> In this regard, when Congress, in enacting PPACA, tried to ensure that abortion coverage in health plans receiving federal tax credit subsidies would be “separate” from the part of the plan that receives federal funds, it provided that the plan “may *not* take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care.” PPACA, § 1303(b)(2)(D)(ii)(I), codified at 42 U.S.C. § 18023(b)(2)(D)(ii)(I). We have criticized this approach as completely inadequate, as it still authorizes federal subsidies for private health plans that include elective abortions, contrary to the policy reflected in other federal laws. But even that inadequate separation is absent here. To make the coverage “free,” the ANPRM provides that it will not be “separate” even by PPACA’s own standard.

already were paying for contraceptives with their own financial resources, there would be no reduction in births from making those contraceptives “free.” (The only thing to which this would “increase access” is whatever the employees will now purchase with the money they no longer spend on contraception—and that could be almost anything.) Yet in earlier rulemaking, the Administration tried to justify its narrow and discriminatory definition of an exempt “religious employer” by arguing that any broader class of religious organizations probably has many employees who have no objection to contraception and so will not be seriously impacted by the mandate. 77 Fed. Reg. 8725, 8728 (Feb. 15, 2012).

The Administration faces a dilemma on this point. Is it trying to change these employees’ reproductive behavior, or not? That is, does it assume that its policy will chiefly influence employees of religious employers to increase their use of contraception by removing perceived cost barriers, or that it will merely reduce the out-of-pocket cost of contraception for employees who already use it? If the former, it intrudes into the right of employees and their families to take account of the teaching of their faith without undue influence from government. If the latter, the policy may produce no “savings” that can be applied toward helping to offset the costs of contraceptive coverage, because it is chiefly being applied to people who already accept and use contraceptives anyway.<sup>16</sup> In the very cases where the contraceptive coverage is “free”—that is, where its costs are offset by “savings” in other areas—the Administration would achieve this goal by undermining a far more important freedom.

Finally, Goal 1 may be served by making contraceptive coverage “automatic” for all employees of objecting religious organizations and their

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<sup>16</sup> Of course the policy’s supporters sometimes argue that “free” contraceptive coverage will encourage many women to change their contraceptive method, from cheaper methods to more expensive but more effective methods such as injectable and implantable drugs. But no one has produced evidence that the marginally lower “contraceptive failure” rates of such methods will more than compensate for their greater upfront cost, which could be an order of magnitude greater than the cost of the ordinary oral contraceptive. See Cory L. Richards of the Guttmacher Institute, “Letter to the Editor: Cost a barrier to contraceptives’ effectiveness,” *The Washington Times* (Mar. 30, 2012) (available at [www.washingtontimes.com/news/2012/mar/30/cost-a-barrier-to-contraceptives-effectiveness/](http://www.washingtontimes.com/news/2012/mar/30/cost-a-barrier-to-contraceptives-effectiveness/)). And these long-lasting drugs are favored by population control groups precisely because their effectiveness relies less on a woman’s free choices—in the euphemism preferred by these groups, their effectiveness is said to be “independent of user motivation.” Such an agenda is hardly consistent with the claim that one is advancing women’s autonomy.



dependents, but that is achieved only by abandoning any pretense of advancing Goal 3, that of respecting the religious liberty of either employers or employees (or the parental rights of the latter). If the Administration really believes that the great majority of these employees want contraceptive coverage but have been held back only by the objections of their employer, why is its goal not served by making the coverage voluntary? Instead, it is contradicting its earlier statement that the coverage would be an “offer” for those “who desire it.” *Id.* at 8728.

In short, the various alternatives proposed in the ANPRM are unconvincing because the Administration is trying to achieve incompatible goals. The government cannot remove all costs of the coverage to the employee without forcing other premium-payers to bear some of those costs. The government cannot conscript religious people and groups into a campaign to achieve a goal that the government knows full well they will find morally objectionable, while claiming to be committed to religious liberty. The government cannot suggest there is no meaningful difference between those who are exempt and those who are “accommodated,” and yet treat the distinction between the two as indispensable by categorically refusing to extend the exemption. These are insoluble dilemmas of the government’s own creation.

As we have urged previously, the only complete solution to this set of problems is to rescind the mandate.<sup>17</sup> Failing that rescission, the Administration should adopt an exemption that protects the consciences of all stakeholders with a religious or moral objection to the mandate, consistent with the longstanding federal tradition of strong religious accommodation.<sup>18</sup> Although either of these

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<sup>17</sup> Even if the various approaches suggested for self-insured plans were to resolve the moral problem—which has not been demonstrated, and which appears impossible within the constraints established by the final rule—a number of technical legal questions would remain. For example, there is a question whether the government has the authority to require insurers offering a plan, such as a multi-state plan, to provide contraceptive coverage to persons not actually enrolled in the plan. Requiring a plan to provide abortifacient drugs, in particular, would violate the Weldon amendment, and requiring multi-state plans to provide such contraceptives would also violate PPACA itself, which ensures that at least one multi-state plan will not provide coverage of elective abortions. PPACA, § 1334(a)(6), codified at 18 U.S.C. § 18054(a)(6).

<sup>18</sup> The operative language of the bi-partisan Respect for Rights of Conscience Act, H.R. 1179, S. 1467, is an example of such an exemption. By assuring the right of all stakeholders to participate in the health insurance process in a manner that is “consistent with” or not “contrary to the[ir]... religious beliefs or moral convictions,” the Act draws from a long string of federal

changes would appear to require the re-opening of the final rule, and so to fall beyond the scope of the ANPRM, we continue to urge them in the strongest possible terms.

**6. The ANPRM Raises Various Questions That Should Be Resolved in Favor of More Religious Freedom, Not Less.**

Some of the statements in the ANPRM warrant separate comment.

A. An ambiguous hypothetical should be clarified. In discussing the application of the 4-part exemption for “religious employers,” the ANPRM uses the following illustration:

For example, a Catholic elementary school may be a distinct common-law employer from the Catholic diocese with which it is affiliated. If the school’s employees receive health coverage through a plan established or maintained by the school, and the school meets the definition of a religious employer in the final regulations, then the religious employer exemption applies. If, instead, the same school provides health coverage for its employees through the same plan under which the diocese provides health coverage for its employees, and the diocese is exempt from the requirement to cover contraceptive services, then neither the diocese nor the school is required to offer contraceptive coverage to its employees.

77 Fed. Reg. at 16502 (emphasis added).

We have two comments about this example. First, the unstated problem with the first part of the hypothetical is that it begs the question because many, if not most, religious schools will not meet the 4-pronged definition. Many religious schools do not qualify as a church, convention or association of churches, or integrated auxiliary. Many do not have “the inculcation of religious values” as their purpose (if, as it appears, “the purpose” of the organization means its sole purpose). 76 Fed. Reg. at 46626 (emphasis added). In addition, many religious

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conscience protection statutes dating back to 1973. See USCCB Secretariat of Pro-Life Activities, “Current Federal Laws Protecting Conscience Rights” (2012) (available at [www.usccb.org/issues-and-action/religious-liberty/conscience-protection/upload/Federal-Conscience-Laws.pdf](http://www.usccb.org/issues-and-action/religious-liberty/conscience-protection/upload/Federal-Conscience-Laws.pdf)).

schools do not primarily hire and serve those who share their religious tenets. Indeed, many Catholic schools that are models of outstanding educational service to inner city children enroll vastly more non-Catholic than Catholic students.

Second, the contrasting circumstance described in the example is ambiguous. When the Administration uses the phrase “the same school” (emphasis added), does it mean a school that independently qualifies for the 4-part exemption? If the answer is yes, then the example solves nothing, because then the only schools that can decline contraceptive coverage are precisely those that were independently exempt from the mandate anyway. If the answer is no, and the Administration agrees that the school can offer its employees enrollment in the health plan of an exempt organization that excludes contraceptive coverage, then why can’t the school offer its own plan excluding contraceptive coverage? Or, put another way, what legitimate government interest is served by forbidding the school to do directly what it is permitted to do indirectly?

B. Diversity of religious objections should be respected. The ANPRM requests comment on:

whether the definition of religious organization should include religious organizations that provide coverage of some, but not all, FDA-approved contraceptives consistent with their religious beliefs. That is, under the forthcoming proposed regulations, the Departments could allow religious organizations to continue to provide coverage for some forms of contraceptives without cost sharing, and allow them to qualify for the accommodation with respect to other forms of contraceptives consistent with their religious beliefs.

77 Fed. Reg. at 16505. We believe that the conscience rights of all stakeholders, including those with religious or moral objections only to certain types of contraceptive coverage, should be recognized. For example, some organizations may object only to abortifacient drugs, or only to the use of certain drugs for certain purposes. The best way to avoid a conflict between the mandate and the conscience rights of any and all of these organizations is to rescind the mandate.

C. Past practice should not preclude accommodation. The Administration has already conditioned the availability of certain rights, as in the case of the temporary enforcement safe harbor, upon an organization’s past non-coverage of

contraceptive services. In our view, neither the safe harbor, nor any meaningful accommodation, should exclude organizations that have a sincerely-held religious objection to contraceptive coverage. That includes organizations that have provided such coverage in the past, but perhaps did so mistakenly or unknowingly, and organizations that have newly considered the question and concluded that they can no longer, in conscience, provide such coverage. Indeed, as this issue has gained publicity, it would not be unusual for organizations newly to discover, much to their dismay, that they had mistakenly or unknowingly allowed their insurer or third-party administrator to provide coverage for items to which they had a moral or religious objection. Such organizations should not be precluded from correcting that error.

### **Conclusion**

The final rule continues to keep in place a regulation that defines as “preventive health care” drugs, devices, and procedures that render a woman temporarily or permanently infertile, and that may be associated with serious adverse health outcomes. We believe that this mandate is unjust and unlawful—it is bad health policy, and because it entails an element of government coercion against conscience, it creates a religious freedom problem. These moral and legal problems are compounded by an extremely narrow exemption that intrusively and unlawfully carves up the religious community into those that are deemed “religious enough” for an exemption, and those that are not. Now, the ANPRM has invited comment on a promised future “accommodation” for some (but not all) non-exempt religious organizations—an “accommodation” that would still leave their plan premiums or plans (or both) as the source or conduit for the objectionable “services.” But the use of premiums and plans for that purpose is precisely what is morally objectionable, and having an insurer or third party administer the payments does not overcome the moral objection.

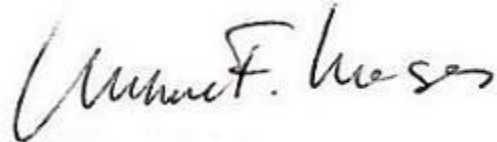
In short, the mandate itself is unjust and unlawful, and it is subject to an unjustly narrow and unlawfully intrusive exemption. These aspects are unchanged from August 2011 and, under the terms of the ANPRM, will remain unchanged: They are enshrined in a final rule and unaffected by the present ANPRM, which instead promises only a future “accommodation” within the constraints of that final rule. Because of those constraints, and under the terms set out in the ANPRM, the “accommodation” cannot provide effective relief even for those few stakeholders that qualify for it.

We again urge the Administration to reconsider and to reverse course.

Respectfully submitted,

A handwritten signature in blue ink that reads "Anthony R. Picarello, Jr." The signature is written in a cursive style with a clear, legible font.

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

A handwritten signature in black ink that reads "Michael F. Moses". The signature is written in a cursive style with a clear, legible font.

Michael F. Moses  
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