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SPECIAL REPORT
from THE RICHARD AND HELEN DEVOS CENTER *for* RELIGION AND CIVIL SOCIETY

No. 112 | JUNE 19, 2012

The Heritage Foundation
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SR-112

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This paper, in its entirety, can be found at:
http://report.heritage.org/sr112

Produced by the Richard and Helen DeVos Center for Religion and Civil Society

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Thomas M. Messner and Edmund F. Haislmaier

On March 21, 2012, the U.S. Department of the Treasury, the U.S. Department of Labor, and the U.S. Department of Health and Human Services (referred to herein, either individually or in any combination of these or certain other federal government sources, as the "Government" or the "Obama Administration") published an Advance Notice of Proposed Rulemaking (ANPRM) in the *Federal Register*.[1] The ANPRM contemplates a potential proposed amendment to the final rule published in the *Federal Register* by the Government on February 15, 2012, that forces health care plans to include abortion-inducing drugs, sterilization procedures, contraceptives, and related education and counseling.[2]

With the ANPRM, the Government continues to unjustifiably burden the freedom of individuals and institutions that, for religious or moral reasons, object to paying for, providing, facilitating, or participating in health insurance plans that include or facilitate access to these services. First, the ANPRM represents a fundamentally flawed approach to religious freedom where one class of religious institutions will receive one level of protection under the final rule published February 15, 2012, and another class of religious institutions will receive a different level of protection under the potential proposed accommodation discussed in the ANPRM. Second, the ANPRM fails to comprehend the full scope of beliefs and stakeholders requiring protection. Third, the ANPRM completely ignores important objections of certain stakeholders. Fourth, for those who would actually qualify, the potential proposed accommodation envisioned by the ANPRM is riddled with problems.

As the Government itself states, it is "essential" that plan sponsors and issuers have "certainty" about their "rights" and "responsibilities."[3] Not only does the ANPRM fail to provide such certainty,[4] it actually increases uncertainty by raising more questions than it answers about a variety of unworkable and otherwise defective proposals that represent a fundamentally flawed approach to protecting religious and moral conscience and fail even to address certain core objections of many stakeholders. In the meantime, the final rule published by the Government on February 15, 2012, remains in effect, the so-called safe harbor fails to resolve the fundamental problem,[5] and already 56 parties have been forced to resort to litigation in federal courts to clarify their obligations and protect their freedom.[6]

The Government should not promulgate regulations that trample religious or moral objection to paying for, providing, facilitating, or participating in health insurance plans that include or facilitate access to abortion-inducing drugs, sterilization services, contraceptives, and related education and counseling. The Government should change course now by withdrawing the ANPRM and replacing it with a rule that would suspend the mandate as to these services while the Government figures out how to fully protect the

religious and moral conscience of all Americans.

Background

The advance notice of proposed rulemaking published on March 21, 2012, is just the latest in a series of actions taken by the Government with respect to forcing health care plans to include abortion-inducing drugs, sterilization services, contraceptives, and related education and counseling.

March 2010—Congress Enacts and President Obama Signs the Patient Protection and Affordable Care Act. In March 2010, Congress enacted, and President Obama signed, the Patient Protection and Affordable Care Act (PPACA).[7] The PPACA added to federal law a requirement that group health plans and health insurance issuers offering group or individual health coverage provide coverage for and not impose cost sharing for preventive services.[8]

This government intrusion into private choice in health care, combined with the enormous discretion afforded to federal agencies in implementing it, is the root of various problems, including the violations of religious and moral conscience at issue in the ANPRM.

July 2010—Obama Administration Issues the Preventive Services Mandate. In July 2010, the Government published an interim final rule to implement the PPACA provision that forces health care plans to include certain preventive services without cost sharing.[9] This interim final rule assumed that "increases in insurance benefits will be directly passed on to the consumer in the form of higher premiums."[10]

The interim final rule did not identify the preventive services for women that must be covered by health insurance policies and employer health plans subject to the mandate. Rather, consistent with the PPACA, it stated that those services would be identified in guidelines "develop[ed]" by the Department of Health and Human Services, "supported" by the Health Resources and Services Administration (HRSA), and expected to be issued "no later than August 1, 2011."[11]

August 2011—Obama Administration Discretionarily Includes Abortion-Inducing Drugs, Sterilization Procedures, and Contraception Services in the Mandate. The Obama Administration was not required by the text of the PPACA statute to include abortion-inducing drugs, sterilization procedures, and contraceptives in the preventive services mandate. Nevertheless, on August 1, 2011, the Obama Administration did just that: Preventive services for women identified by the HRSA "guidelines" include "[a]ll Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity."[12] Several parties have since explained that "Food and Drug Administration approved contraceptive methods" include certain abortion-inducing drugs.[13]

On August 3, 2011, the Government published amendments to the interim final rule of July 19, 2010. The amendments gave HRSA "discretion" to include in its guidelines an exemption for "religious employers,"[14] and HRSA exercised this discretion by including an exemption for religious employers in the guidelines.[15] However, those amendments to the interim final rule gave HRSA no discretion regarding the scope of who would qualify for the "religious employer" exemption. Instead, they defined a religious employer as one that:

1. Has the inculcation of religious values as its purpose;

2. Primarily employs persons who share its religious tenets;

3. Primarily serves persons who share its religious tenets; and

4. Is a non-profit organization under section 6033(a)(1) and section 6033(a)(3)(A)(i) or (iii) of the [Internal Revenue] Code.[16]

According to the Government, "Section 6033(a)(3)(A)(i) and (iii) refer to churches, their integrated auxiliaries, and conventions or associations of churches, as well as to the exclusively religious activities of any religious order."[17] This is a much narrower standard than the standard for tax-exempt entities in general.[18]

February 2012—Obama Administration Finalizes the Mandate Without Adequate Protections for Religious and Moral Conscience. The "religious employer" exemption set forth in the August 2011 amendments to the interim final rule was extremely narrow and widely criticized. The Becket Fund for Religious Liberty explained that the exemption includes only a "vanishingly small" class of religious employers.[19] The Alliance Defense Fund called the exemption "insulting," and stated that no federal rule has defined "being 'religious'" in such a "narrow[] and discriminator[y]" way.[20] The U.S. Conference of Catholic Bishops described the exemption as "exceedingly crabbed."[21] For its own part, The Heritage Foundation explained that the exemption was so narrow that it could be viewed as no

less than a "premeditated squeeze on conscience."[22]

Despite these criticisms, the Obama Administration announced that it would finalize the mandate without budging an inch on freedom of religious and moral conscience.[23] And on February 15, 2012, the Obama Administration did just that—it published the rule mandating abortion-inducing drugs, sterilization procedures, and contraceptives "without change."[24] What one law firm has called "the stingiest definition of a 'religious' organization ever to appear in federal law" is now the law of the land.[25]

March 2012—Obama Administration Publishes Advance Notice of Proposed Rulemaking Seeking Comments on the "Accommodation" Proposed by the President. At the same time that it announced it would finalize the preventive services mandate rule without change the Obama Administration also stated that, for one year, it would not enforce the requirement in certain cases. The stated purpose of this temporary "safe harbor" was to give nonprofit employers who, based on religious beliefs, do not currently provide contraceptive coverage in their insurance plans, "an additional year" to "adapt" to the mandate.[26]

Some stakeholders in this debate were dissatisfied with being told by the Obama Administration that they could have an extra year to figure out how to violate their religious or moral beliefs.[27] The Government's next step led directly to the ANPRM. Faced with intensifying public opposition, President Obama announced that he would create an "accommodation" for some of the objectors who did not qualify for the narrow religious employer exemption established in the final rule.[28] This so-called accommodation would not replace or expand the narrow religious employer exemption in the final rule. Rather, it would create a different set of requirements for some, but not all, of those who objected to being excluded from the narrow religious employer exemption.

On March 21, 2012, the Obama Administration issued an advance notice of proposed rulemaking seeking public comment on various ideas for implementing the proposed "accommodation" announced by the President.[29]

Thus, the ANPRM is not a rule. It is not even a proposed rule. The ANPRM is only a request for comments on a *potential* new rule. The final rule published on February 15, 2012, remains in effect.

The ANPRM Offers a Fundamentally Flawed Approach to Protecting Religious Freedom and Should Be Withdrawn Immediately

Though actually the starting point for a new rulemaking process, the stated purpose of the ANPRM is to "develop and propose changes to the final regulations" published on February 15, 2012.[30] However, the ANPRM does not propose to replace the extremely narrow religious employer exemption finalized in that rule. Rather, the ANPRM proposes to develop an entirely different "accommodation" that will apply to an entirely different class of religious institutions that do not qualify for the extremely narrow exemption included in the final rule.[31]

Such a "religious caste system"[32] approach to religious freedom is unacceptable. It is "patently wrong," as the U.S. Conference of Catholic Bishops has stated, 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 co-religionists."[33] This approach discriminates against "the many religious organizations" that serve needy people outside their own worship communities.[34]

They, and numerous other affected organizations, rightly reject the view that religious and moral beliefs are worthy of full protection only when expressed by co-religionists in houses of worship, and the Government should to do the same. The Government should not engage in "religious gerrymanders" where some religious institutions "are 'in' and others are 'out'" based on "who their teaching calls them to serve, how they constitute their workforce, or whether they engage in 'hard-nosed proselytizing.'"[35]

The ANPRM Contemplates an Inadequate Scope of Protection

The ANPRM also fails to comprehend the full scope of beliefs and stakeholders requiring protection.

First, the ANPRM fails to contemplate protection for conscientious objections based on moral beliefs. Unlike situations presenting issues of freedom with respect to uniquely religious matters, health care issues present a broad range of issues that

require moral consideration by religious and nonreligious individuals and institutions alike. Some of this moral consideration will be informed by religious beliefs, some of it will stem from reflections of a different nature, and some of it will involve both types of reasoning. In the context of health care, it makes sense to protect conscientious objection based on moral beliefs as well as conscientious objection based on religious beliefs, and federal law includes precedent for doing just that.[36]

Second, the ANPRM fails to contemplate protections for various stakeholders. For example, the ANPRM fails to contemplate protections for nonreligious businesses owned or operated by individuals with religious or moral objections to complying with the mandate,[37] individuals who will be forced to subsidize the use of goods and services by others that they do not use themselves for reasons of religious or moral conscience,[38] and nonreligious insurance issuers who might object for any reason to being forced to participate in a scheme that violates the religious or moral beliefs of some of their customers. Some questions of freedom present concerns unique to religious institutions,[39] but religious institutions are not the only stakeholders in this country with an interest in the freedom to operate according to their religious and moral beliefs. Religious and moral objections to paying for, providing, facilitating, or otherwise participating in health insurance plans that include or facilitate access to abortion-inducing drugs, sterilization procedures, contraceptives, and related education and counseling are just as honestly held by individuals and nonreligious enterprises as they are by religious institutions. They too deserve protection.

The ANPRM Completely Ignores Certain Objections Raised by Many Stakeholders

For some individuals or institutions, their religious or moral objection to the mandate might be limited to paying for or directly providing some or all of the mandated abortion-inducing drugs, sterilization services, contraceptives, and related education and counseling. For other stakeholders, however, objectionable cooperation would also include conduct such as "providing," "facilitating," or "participating in" health insurance plans that include or facilitate access to these goods or services.[40]

The ANPRM fails to contemplate protections for such objections. The Government states that its potential proposed policy is designed to protect religious institutions that object to having to "contract," "arrange," and "pay for" abortion-inducing drugs, sterilization procedures, contraception, and related education and counseling.[41] However, the Government makes clear that it is "particularly" interested in addressing objections to "funding" such services,[42] and the ANPRM includes no discussion of how the Government's proposed "accommodation" would accommodate objections to "providing," "facilitating," or "participating in" health insurance plans that include or facilitate access to such services. Failure even to consider objections to "providing," "participating in," or "facilitating" health care plans that include or facilitate access to abortion-inducing drugs, sterilization procedures, and contraceptives provides yet another reason to immediately withdraw the ANPRM and replace it with a rule that would suspend the mandate as to these services until the Government is prepared to address questions of religious and moral conscience in a more serious way. The ANPRM cannot "accommodate" religious and moral objections that it fails to even recognize or consider.

The Limited "Accommodation" Envisioned by the ANPRM Is Riddled with Problems

For those limited number of stakeholders who would qualify, the Government envisions a narrow "accommodation" focused on objections to paying for, or directly providing, abortion-inducing drugs, sterilization procedures, and contraceptives. As set forth in the ANPRM, "an independent entity," separate from the religious institution,[43] would "provide contraceptive coverage directly to the participants and beneficiaries covered under the organization's plan with no cost sharing."[44] Under this approach, the independent entity would be prohibited from imposing cost sharing measures such as deductibles, co-insurance, or co-payments.[45] The independent entity would also be prohibited from imposing a "premium charge" for the separate contraceptive coverage,[46] even though the Government does not prohibit imposing premium charges with respect to any other preventive service subject to the mandate and even assumes that such charges will be imposed.[47] In fact, the statutory phrase "shall not impose any cost sharing requirements" is interpreted by the Government in its implementing regulation as "must provide

coverage for all of the following items and services, and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services," with no mention of premiums.[48]

The ANPRM envisions two different situations under which the potential proposed accommodation would be implemented. The first involves religious institutions that arrange for health insurance coverage through an insurance issuer that collects premiums and issues insurance coverage. The second involves religious institutions that self-insure and contract with third party administrators (TPAs) to manage their self-insured plans. With respect to both situations, the potential proposed "accommodation" fails.

Problems with Providing and Funding Abortion-Inducing Drugs, Sterilization Procedures, and Contraceptives Through Insurance Issuers. The potential proposed accommodation fails to satisfy objections to funding abortion-inducing drugs, sterilization procedures, and contraceptives in health insurance plans issued by insurance issuers. Though the ANPRM states that insurance issuers would be prohibited from charging a premium for the separate contraceptive coverage, there is no reason to believe that insurance issuers would not raise premiums on other services to compensate for the coverage they are forced to provide for "free." Indeed, state-level insurance regulation is properly focused on ensuring that issuers charge enough in premiums to cover expected claims costs, and failing to adjust premiums to pay for mandated services could undermine the financial solvency of insurers, potentially harming policyholders who bought protection against loss. Increases in premium costs might be related only indirectly to the services objected to, but such costs would pass directly to individuals and institutions that hold those objections.

The Government anticipates this objection by stating that contraceptive coverage "is at least cost neutral" and might even "save money."[49] The economics of this assertion are highly suspect, but even accepting them for the purpose of argument only, the potential proposed accommodation still fails to satisfy the concerns of religious institutions that object to "funding" contraception. Even if providing contraceptives results in no net increase in cost to the insurance issuer, plan sponsor, or enrollee, funds must still be used to pay for contraceptives and those funds come from premiums. In this sense, for any premium-based insurance plan where abortion-inducing drugs, sterilization procedures, and contraceptives are provided as part of that plan, the aggregation of the funding involved, and the fungibility of those funds, means that the very first premium dollar contributes to "funding" such services—even if providing such services results in a net decrease in overall costs to the insurance issuer, plan sponsor, or enrollee. The principle involved is the same as that for the analogous hypothetical situation of a plan paying physicians to euthanize terminally ill patients wishing to end their lives. Were a health plan to pay for such "services" it might very well have the economic effect of reducing aggregate plan costs and premiums, but that would not make physician-assisted suicide a "free" plan "benefit," nor would it absolve those sponsoring or funding the plan from complicity in what many would view as an immoral practice.

Problems with Providing and Funding Abortion-Inducing Drugs, Sterilization Procedures, and Contraceptives Through Third-Party Administrators (TPAs). The proposal is even more defective when it comes to providing contraceptive coverage in self-insured plans managed by third-party administrators (TPAs). Unlike insurance issuers, TPAs assume "no responsibility for funding claims" and do not receive "any premium to be used to fund claims."[50] Rather, "TPA pricing is based on the cost of providing claims administration and other ministerial services."[51] Forcing TPAs to pay for contraceptive coverage would mean that "the cost of administrative services across all clients will likely have to rise,"[52] with the result that religious institutions would end up paying for these services directly.

The Government implicitly acknowledges this problem by suggesting a variety of alternative ways that TPAs might provide contraceptives "without using funds provided by the religious organization."[53] Comments filed in response to the ANPRM by the Self-Insurance Institute of America, Inc. (SIIA) explain the defects with the Government's suggested mechanisms for implementing the proposed accommodation with respect to employer self-insured plans and the TPAs that those employers contract with to administer their plans.[54] The SIIA is a trade association representing third-party administrators

of employer self-insured plans, and the Government should give serious consideration to their expert comments.

Even the Government appears to acknowledge the problems with providing abortion-inducing drugs, sterilization services, and contraceptives through TPAs when it states 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 third-party administrator is responsible for providing the contraceptive coverage."[55] But this is no solution. As explained above, the potential proposed accommodation fails to protect religious and moral conscience in the context of plans issued by insurance issuers. Further, self-insuring provides "many cost and coverage advantages," such as the ability to "better control costs and customize health plans to better meet the needs of [an employer's] workforce."[56] Forcing religious institutions to choose between these benefits and their conscience is no accommodation at all. On top of this, as the Government itself acknowledges,[57] self-insured plans are not subject to state insurance laws, and some religious institutions might opt to self-insure precisely to avoid religious freedom conflicts with state mandates that require insurance issuers to provide morally objectionable services in health insurance plans.[58] Suggesting that religious institutions should switch from a plan that helps to protect their religious freedom to one that could actually burden it more is simply insulting and further demonstrates the Government's failure to address burdens on religious and moral conscience freedom in a meaningful way.

Conclusion

The Government could not be on greater notice that its actions substantially burden religious freedom. Numerous stakeholders have submitted comments informing the Government that its actions burdened religious freedom,[59] Congress has held multiple hearings on the issue,[60] protesters have demonstrated at the Department of Health and Human Services and throughout the nation,[61] and to date 56 stakeholders have filed 23 federal lawsuits against the Government,[62] with nine of these suits being filed before the ANPRM was published.[63] Despite this outpouring of objection, the Government continues down a path that unjustifiably burdens religious and moral conscience.

The Government's misguided policies will have unfortunate consequences even apart from harms inflicted on religious and moral conscience. Faced with laws that force them to violate conscience, at least two institutions have already announced they will drop health insurance and more could follow.[64] For individuals enrolled in these plans, this means they will have to find health insurance elsewhere. For the organizations that sponsor these plans, this could mean paying significant federal fines.[65] How any of these results advance the purposes of a law purportedly designed to increase access to health care is beyond comprehension.

Even if those individuals who lose health insurance find coverage elsewhere, and even if those institutions that drop insurance plans find the funds to pay their fines and keep their doors open, the mandate still creates a set of irrational and socially counterproductive costs. Money that will be spent on federal fines could be spent on educating students and serving the poor. Many religious institutions already have been forced to expend resources informing the Government that the mandate violates their religious or moral conscience. On top of all this, more than 50 parties already have found it necessary to seek redress in federal courts, and the day is still young.

The Government should change course—now—by immediately withdrawing the ANPRM and replacing it with a rule that would suspend the mandate as to abortion-inducing drugs, sterilization procedures, contraceptives, and related education and counseling while the Government figures out how to fully protect religious and moral conscience.

Endnotes

1. Advance Notice of Proposed Rulemaking (ANPRM), 77 Fed. Reg. 16,501 (Mar. 21, 2012).
2. *See* Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8725 (Feb. 15, 2012) (final rule); 77 Fed. Reg. at 16,503 (discussing the Government's plans to "develop and propose changes to the final regulations" and stating that the ANPRM is the "first step toward promulgating these amended final regulations").
3. Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41,726, 41,730 (July 19, 2010).
4. *See id.* (admitting that even "[p]roposed regulations are not binding and cannot provide the necessary certainty").
5. *See, e.g.*, Complaint ¶¶ 71–74, Nebraska v. U.S. Dep't of Health & Human Servs., No. 4:12-cv-03035 (D. Neb. Feb. 23, 2012) (explaining that the so-called safe harbor is time limited and "[n]o discernible statutory or regulatory obstacle exists barring the Federal Government from unilaterally *withdrawing* its promise of a 'one-year safe harbor from enforcement' of the Rule").
6. *See HHS Mandate Information Central*, Becket Fund for Religious Liberty, http://www.becketfund.org/hhsinformationcentral/ (last visited June 10, 2012).
7. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of the U.S. Code).
8. *See id.*, tit. I, subtit. A, § 1001 (adding section 2713(a)(4) to Part A of Title XXVII of the Public Health Service Act, as codified at 42 U.S.C. § 300gg-13(a)(4)).
9. *See* 75 Fed. Reg. 41,726.
10. *Id.* at 41,737; *see also id.* at 41,730 (stating that group health plans and health insurance issuers required to provide preventive services with no cost sharing "have to be able to take these changes into account in establishing their premiums").
11. *Id.* at 41,728.
12. Health Res. & Servs. Admin., Women's Preventive Services: Required Health Plan Coverage Guidelines [hereinafter Guidelines], *available at* http://www.hrsa.gov/womensguidelines/; *see Fact Sheet: Affordable Care Act Rules on Expanding Access to Preventive Services for Women*, HealthCare.Gov (stating that HHS adopted Guidelines for Women's Preventive Services, "including . . . contraception," on August 1, 2011), http://www.healthcare.gov/news/factsheets/2011/08/womensprevention08012011a.html (last updated Feb. 15, 2012).
13. *See, e.g.*, Complaint ¶¶ 64, 86, Belmont Abbey Coll. v. Sebelius, No. 1:11-cv-01989-JEB (D.D.C. Mar. 19, 2012) (explaining that "FDA-approved contraceptive methods include . . . Plan B, also known as the 'morning-after pill'; and ulipristal, also known as 'ella' or the 'week-after pill'," and that "Plan B and ella can cause the death of the embryo"); Complaint ¶¶ 61, 82, Colo. Christian Univ. v. Sebelius, No. 1:11-cv-03350-CMA-BNB (D. Colo. Dec. 21, 2011) (explaining that "FDA-approved contraceptive methods include . . . Plan B, also known as the 'morning-after pill'; and ulipristal, also known as 'ella' or the 'week-after pill'," and that "Plan B and *ella* can cause the death of the embryo"); Comments, Alliance Defense Fund on Behalf of Several Catholic Entities 20 (May 30, 2012) [hereinafter ADF 2012 Comments] (explaining that "the Mandate includes drugs that cause early abortions"), *available at* http://www.cardinalnewmansociety.org/LinkClick.aspx?fileticket=OumXvpMXLZk%3D&tabid=707.
14. Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 Fed. Reg. 46,621, 46,623 (Aug. 3, 2011).
15. Guidelines, *supra* note 12.
16. 76 Fed. Reg. at 46,623.
17. 76 Fed. Reg. at 46,623.
18. *See* 26 U.S.C. § 501(c)(3).
19. Comments, The Becket Fund for Religious Liberty 4 (Sept. 30, 2011), *available at* http://www.becketfund.org/wp-content/uploads/2011/09/BF-Comments-to-HHS-on-Contraception-Mandate-9-30-11.pdf.
20. Comments, Alliance Defense Fund on Behalf of Several Catholic Entities 2 (Sept. 29, 2011), *available at* http://www.cardinalnewmansociety.org/LinkClick.aspx?fileticket=3mLIxfWWkTY%3D&tabid=36.
21. Comments, U.S. Conference of Catholic Bishops 19 (Aug. 31, 2011) [hereinafter USCCB 2011 Comments], *available at* http://usccb.org/about/general-counsel/rulemaking/upload/comments-to-hhs-on-preventive-services-2011-08.pdf.
22. Comments, The Heritage Foundation, app. at 2 (Aug. 9, 2011), *available at* https://thf_media.s3.amazonaws.com/2012/pdf/religiouslibertycontraceptiveservicesCMS-9992-IFC2.pdf.
23. News Release, U.S. Dep't of Health & Human Servs., A Statement by U.S. Department of Health and Human Services Secretary Kathleen Sebelius (Jan. 20, 2012) [hereinafter Jan. 20, 2012 HHS News Release], *available at* http://www.hhs.gov/news/press/2012pres/01/20120120a.html.
24. Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8725 (Feb. 15, 2012).
25. Comments, The Becket Fund for Religious Liberty, *supra* note 19, at 3; *see* 77 Fed. Reg. at 8725 (stating that "[t]hese final regulations are effective on April 16, 2012").

26. Jan. 20, 2012 HHS News Release, *supra* note 23. *See* U.S. Dep't of Health & Human Servs., Guidance on the Temporary Enforcement Safe Harbor for Certain Employers, Group Health Plans and Group Health Insurance Issuers with Respect to the Requirement to Cover Contraceptive Services Without Cost Sharing Under Section 2713 of the Public Health Service Act, Section 715(a)(1) of the Employee Retirement Income Security Act, and Section 9815(a)(1) of the Internal Revenue Code 2 (Feb. 10, 2012) (stating that "this bulletin" describes the "temporary enforcement safe harbor" announced by the Secretary of the U.S. Department of Health and Human Services on January 20, 2012), *available at* http://cciio.cms.gov/resources/files/Files2/02102012/20120210-Preventive-Services-Bulletin.pdf.
27. *See Lines Crossed: Separation of Church and State. Has the Obama Administration Trampled on Freedom of Religion and Freedom of Conscience?: Hearing Before H. Comm. on Oversight and Government Reform*, 112th Cong. 2 (Feb. 16, 2012) (testimony of William K. Thierfelder) (stating opposition to abandoning religious beliefs and principles "in a year's time because the government says we have to"), *available at* http://oversight.house.gov/wp-content/uploads/2012/02/2-16-12_Full_HC_Mandate_Thierfelder.pdf; Timothy M. Dolan, Op-Ed., *Obamacare and Religious Freedom*, Wall St. J., Jan. 25, 2012, *available at* http://online.wsj.com/article/SB10001424052970203718504577178833194483196.html.
28. Press Release, The White House, Fact Sheet: Women's Preventive Services and Religious Institutions (Feb. 10, 2012), *available at* http://www.whitehouse.gov/the-press-office/2012/02/10/fact-sheet-women-s-preventive-services-and-religious-institutions.
29. 77 Fed. Reg. 16,501.
30. *Id.* at 16,503.
31. *Id.*; *see* 76 Fed. Reg. at 46,623.
32. ADF 2012 Comments, *supra* note 13, at 13.
33. Comments, U.S. Conference of Catholic Bishops 8 (May 15, 2012), *available at* http://www.usccb.org/about/general-counsel/rulemaking/upload/comments-on-advance-notice-of-proposed-rulemaking-on-preventive-services-12-05-15.pdf.
34. Letter from Leaders and Supporters of Faith-Based Service Organizations to Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs. (June 11, 2012), *available at* http://irfalliance.org/images/stories/pdf/letter-to-hhs-secretary-signed-6112012.pdf.
35. USCCB 2011 Comments, *supra* note 21, at 19.
36. ADF 2012 Comments, *supra* note 13, at 21–23 (stating that contraception mandate "breaks with practically universal statutory tradition in federal health law by not only compelling violations of religious beliefs but also by forcing the violation of moral convictions" and providing federal law citations in support of the claim that "[s]ince 1973 Congress has repeatedly enshrined conscience protections in federal health law for 'religious beliefs and moral convictions'").
37. *See, e.g.*, First Amended Complaint ¶ 3, Geneva Coll. v. Sebelius, No. 2:12-cv-00207 (W.D. Pa. May 31, 2012) (plaintiff business owners "are practicing Catholic Christians" who "adhere to Catholic Church teachings" in their operation of their businesses and, "[f]ollowing these beliefs," have "for multiple years omitted abortifacients, contraception, sterilization, and related education and counseling from their health insurance plan covering themselves and their employees and family members"); Complaint ¶¶ 44–46, Legatus v. Sebelius, No. 2:12-cv-12061 (E.D. Mich. May 7, 2012) (stating that plaintiff and company where he is president ensured that their insurance policy excluded contraception and abortion "to reflect their deeply held religious beliefs"); Verified Complaint ¶¶ 2–3, Newland v. Sebelius, No. 1:12-cv-01123 (D. Colo. Apr. 30, 2012) (plaintiff business owners seek to run their business "in a manner that reflects their sincerely held religious beliefs" and, applying certain religious and moral teachings of the Catholic Church, "have concluded that it would be sinful and immoral for them to intentionally participate in, pay for, facilitate, or otherwise support abortifacient drugs, contraception, or sterilization, through health insurance coverage they offer at [their company]"); Complaint ¶¶ 3–4, O'Brien v. U.S. Dep't of Health & Human Services, No. 4:12-cv-00476 (E.D. Mo. Mar. 15, 2012) (alleging that plaintiff with the controlling interest in the business and its subsidiaries "is an adherent of the Catholic religion," "wishes to conduct his business in a manner that does not violate the principle of his religious faith," and "has concluded that complying with the Mandate would require him to violate his religious beliefs because it would require him and/or the corporations he controls to pay for, not only contraception and sterilization, but also abortion"). The ANPRM states that one option for defining a religious organization would be to adopt the definition of religious organization "used in one or more State laws to afford a religious exemption from a contraceptive coverage requirement." 77 Fed. Reg. at 16,504. If one of those laws includes protections for nonreligious businesses, the ANPRM gives no reason to even remotely suspect the Government is prepared to follow such a precedent. Further, we assume that the reference in the ANPRM to "for-profit religious employers,"*id.*, does not include nonreligious businesses owned by religious individuals.
38. *Compare* 75 Fed. Reg. at 41,730–31 (Table I) (stating that interim final rules create a "transfer from those paying premiums in the group market utilizing less than the average volume of preventive services in their risk pool to those whose utilization is greater than average"), *with* 77 Fed. Reg. at 8728 (assuming that employees who with religious objections to contraception are "less likely" to use contraceptives than employees without such objections).
39. *See, e.g.*, Hosanna-Tabor Evangelical Lutheran Church & School v. EEOC, 132 S. Ct. 694 (2012) (deciding issue involving employment relationship between a religious institution and one of its ministers).

40. *See, e.g.*, First Amended Complaint ¶ 185, Geneva Coll. v. Sebelius, No. 2:12-cv-00207 (W.D. Pa. May 31, 2012) (alleging that Christian college's "sincerely held religious beliefs prohibit it from providing or facilitating coverage for abortion, abortifacients, embryo-harming pharmaceuticals, and related education and counseling, or providing or facilitating a plan that causes access to the same through an insurance company"); *id.* ¶ 80 (alleging that plaintiffs "believe that it would be immoral and sinful for them to intentionally participate in, pay for, facilitate, or otherwise support abortifacient drugs, contraception, sterilization, and related education and counseling, through the inclusion of such items in health insurance coverage they offer at their businesses or participate in for their own individual families"); Complaint ¶ 132, Roman Catholic Archbishop of Wash. v. Sebelius, No. 1:12-cv-00815 (D.D.C. May 21, 2012) (alleging that the mandate "severely burdens" firmly held religious beliefs of various Catholic institutions by requiring them "to provide, pay for, and/or facilitate access to services that are contrary to their religious beliefs"); Complaint ¶ 85, Legatus v. Sebelius, No. 2:12-cv-12061 (E.D. Mich. May 7, 2012) (alleging that business and president of business "cannot provide, fund, or participate in health care insurance which covers artificial contraception, abortion, or abortifacients, or related education and counseling, without violating their deeply held religious beliefs"); *id.* ¶ 68 (alleging that Catholic organization "cannot provide, fund, or participate in health care insurance which covers artificial contraception, abortion, or abortifacients, or related education and counseling, without violating its deeply held religious beliefs"); Verified Complaint ¶ 32, Newland v. Sebelius, No. 1:12-cv-01123 (D. Colo. April 30, 2012) (alleging that owners of HVAC manufacturing business "believe that it would be immoral and sinful for them to intentionally participate in, pay for, facilitate, or otherwise support abortifacient drugs, contraception, sterilization, and related education and counseling, as would be required by the Mandate, through their inclusion in health insurance coverage they offer at [the business they own]"); First Amended Complaint ¶ 30, Belmont Abbey Coll. v. Sebelius, No. 1:11-cv-01989 (D.D.C. Mar. 19, 2012) (alleging that Belmont Abbey College's religious beliefs would not "permit it to deliberately provide health insurance that would facilitate access to artificial contraception, sterilization, abortion, or related education and counseling—even if those items are paid for by an insurer and not by Belmont Abbey College"); Complaint ¶ 5, Ave Maria Univ. v. Sebelius, No. 2:12-cv-00088 (M.D. Fla. Feb. 21, 2012) (alleging that the mandate "subverts the expression of the University's religious beliefs, and the beliefs of millions of other Americans, by forcing the University to fund, promote, and assist others to acquire services which it believes involve gravely immoral practices").
41. 77 Fed. Reg. at 16,503.
42. *Id.*
43. *Id.*
44. *Id.*
45. Guidelines, *supra* note 12.
46. 77 Fed. Reg. at 16,503.
47. *See* Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41,726, 41,737 (July 19, 2010) (stating that transferring costs from individuals using preventive services to plans and issuers "could be expected to lead to an increase in premiums").
48. 45 C.F.R. § 147.130(a)(1).
49. 77 Fed. Reg. at 16,503.
50. Comments, Self-Insurance Institute of America, Inc. 2 (May 7, 2012) [hereinafter SIIA Comments], *available at* http://www.freedom2care.org/docLib/20120612_SelfInsuranceInstituteofAmericaANPRMcomments.pdf.
51. *Id.* at 1.
52. *Id.* at 2.
53. 77 Fed. Reg. at 16,507.
54. *See* SIIA Comments, *supra* note 50, at 2.
55. 77 Fed. Reg. at 16,507.
56. SIIA Comments, *supra* note 50, at 2.
57. 77 Fed. Reg. at 16,505 (stating that "[b]ecause there is no insurance provided by a health insurance issuer, self-insured plans are not subject to State insurance laws").
58. *See* USCCB 2011 Comments, *supra* note 21, at 4 (explaining that state contraceptive mandates "generally exclude" self-insured plans).
59. *See, e.g.*, Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8725, 8726 (Feb. 15, 2012) (stating that the Government received "over 200,000 responses" to the request for comments on the amended final rule published August 3, 2011).
60. *See Executive Overreach: The HHS Mandate Versus Religious Liberty: Hearing Before the H. Comm. on the Judiciary*, 112th Cong. (2nd Sess., Feb. 28, 2012), *available at* http://judiciary.house.gov/hearings/Hearings%202012/hear_02282012.html; *Lines Crossed: Separation of Church and State. Has the Obama Administration Trampled on Freedom of Religion and Freedom of Conscience?: Hearing Before the H. Comm. on Oversight and Government Reform*, 112th Cong. (2nd Sess., Feb. 16, 2012), *available at* http://oversight.house.gov/hearing/lines-crossed-separation-of-church-and-state-has-the-obama-administration-trampled-on-freedom-of-religion-and-freedom-of-conscience/; *Do New Health Law Mandates Threaten Conscience Rights and Access to Care?: Hearing Before the Subcomm. On Health of the H. Comm. on Energy and Commerce*, 112th Cong. (2nd Sess., Nov. 2, 2011), *available at* http://energycommerce.house.gov/hearings/hearingdetail.aspx?NewsID=9048.

61. *See, e.g.*, *On 2nd Anniversary, GOP Says Health Care Law Bad Prescription*, CNN (Mar. 23, 2012), http://articles.cnn.com/2012-03-23/politics/politics_health-care-law-anniversary_1_health-care-obamacare-massachusetts-governor/2?_s=PM:POLITICS; Posting of Kathryn Jean Lopez to The Corner, *Protesting the HHS Mandate, Standing for Religious Freedom* (Mar. 23, 2012, 4:32 PM), http://www.nationalreview.com/corner/294300/protesting-hhs-mandate-standing-religious-freedom-kathryn-jean-lopez#.
62. *See HHS Mandate Information Central*, *supra* note 6.
63. *See id.*
64. *See Campus Health Insurance Policy*, Franciscan U. of Steubenville (stating that "[d]ue to . . . changes in regulation by the federal government . . . the University . . . will no longer offer a student health insurance plan"), http://www.franciscan.edu/StudentHealthInsurance/ (last visited June 10, 2012); Statement by Jim Towey, President, Ave Maria Univ., Ave Maria University Discontinues Student Health Insurance Because of Federal Government's Mandate 2 (May 21, 2012) (announcing that university "will not offer or pay for health insurance plans that violate our deeply-held religious beliefs"), http://www.avemaria.edu/Portals/0/Images/Kevins'%20Images/statement%20on%20student%20insurance%20-%20may%2021%202012.pdf. *See also* 77 Fed. Reg. at 8727 (stating that "[s]ome religiously-affiliated employers warned that, if the definition of religious employer [set out in the interim final rule published on August 3, 2011] is not broadened, they could cease to offer health coverage to their employees in order to avoid having to offer coverage to which they could object on religious grounds").
65. *See, e.g.*, Brian Blase, *Obamacare and the Employer Mandate: Cutting Jobs and Wages*, Heritage Foundation WebMemo No. 3108 (Jan. 19, 2011) (discussing fines for violating employer mandate), *available at* http://www.heritage.org/research/reports/2011/01/obamacare-and-the-employer-mandate-cutting-jobs-and-wages.

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