DO NEW HEALTH LAW MANDATES THREATEN CONSCIENCE RIGHTS AND ACCESS TO CARE?

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

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C O N T E N T S

DO NEW HEALTH LAW MANDATES THREATEN CONSCIENCE RIGHTS AND ACCESS TO CARE?

WEDNESDAY, NOVEMBER 2, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:05 a.m., in room 2123 of the Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Shimkus, Murphy, Blackburn, Gingrey, Latta, McMorris Rodgers, Lance, Cassidy, Guthrie, Pallone, Dingell, Towns, Engel, Capps, Schakowsky, Baldwin, Matheson, Christensen, and Waxman (ex officio).

Staff present: Carl Anderson, Counsel, Oversight; Marty Dannenfelser, Senior Advisor, Health Policy and Coalitions; Brenda Destro, Professional Staff Member, Health; Andy Duberstein, Special Assistant to Chairman Upton; Paul Edattel, Professional Staff Member, Health; Ryan Long, Chief Counsel, Health; Nika Nour, New Media Specialist; Katie Novaria, Legislative Clerk; John O'Shea, Professional Staff Member, Health; Heidi Stirrup, Health Policy Coordinator; Phil Barnett, Democratic Staff Director; Alli Corr, Democratic Policy Analyst; Ruth Katz, Democratic Chief Public Health Counsel; Karen Lightfoot, Democratic Communications Director and Senior Policy Advisor; Elizabeth Letter, Democratic Assistant Press Secretary; Anne Morris Reid, Democratic Professional Staff Member; and Tim Westmoreland, Democratic Consulting Counsel.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The subcommittee will come to order. The Chair recognizes himself for 5 minutes for an opening statement.

On August 3, 2011, the Department of Health and Human Services issued an interim final rule that would require nearly all private health plans to cover contraception and sterilization as part of their preventive services for women.

While the rule does include a religious exemption, many entities feel that it is inadequate and violates their conscience rights by forcing them to provide coverage for services for which they have a moral or ethical objection.

The religious employer exemption allowed under the preventive services rule—at the discretion of the HRSA—is very narrow. And

the definition offers no conscience protection to individuals, schools, hospitals, or charities that hire or serve people of all faiths in their communities.

It is ironic that the proponents of the healthcare law talked about the need to expand access to services but the administration issues rules that could force providers to stop seeing patients because to do so could violate the core tenets of their religion.

I am also concerned about the process HHS used to issue the rule. The interim final rule was promulgated before the proposed rulemaking and the formal comment period were conducted by HHS. In issuing the rule, HHS acknowledged that it bypassed the normal rulemaking procedures in order to expedite the availability of preventive services to college students beginning the school year in August. HHS argued that there would be a year's delay in the receipt of the new benefit if the public comment period delayed the issuance of HRSA guidance for over a month.

I believe that on such a sensitive issue there should have been a formal comment period so that all sides could weigh in on the issue and HHS could benefit from a variety of views. When the healthcare law was being debated last Congress, the proponents adamantly refuted claims that this would be a Federal Government takeover of our healthcare system.

Now, we have the Federal Department of Health and Human Services forcing every single person in this country to pay for services that they may morally oppose. Groups who have for centuries cared for the sick and poor will now be forced to violate their religious beliefs if they want to continue to serve their communities. Whether one supports or opposes the healthcare law, we should universally support the notion that the Federal Government should be prohibited from taking coercive actions to force people to abandon their religious principles.

I look forward to hearing from our witnesses. Thank you all for being here, and I yield the balance of my time to Dr. Gingrey from Georgia.

[The prepared statement of Mr. Pitts follows:]

Opening Statement of the Honorable Joseph R. Pitts
Energy and Commerce Subcommittee on Health
"Do New Health Law Mandates Threaten Conscience Rights and Access to Care?"
November 2, 2011
(As Prepared for Delivery)

On August 3, 2011, the Department of Health and Human Services issued an interim final rule that would require nearly all private health plans to cover contraception and sterilization as part of their preventive services for women.

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When the health care law was being debated last Congress, the proponents adamantly refuted claims that this would be a federal government takeover of our health care system. Now, we have the federal Department of Health and Human Services forcing every single person in this country to pay for services that they may morally oppose. Groups who have for centuries cared for the sick and poor will now be forced to violate their religious beliefs if they want to continue to serve their communities. Whether one supports or opposes the health care law, we should universally support the notion that the federal government should be prohibited from taking coercive actions to force people to abandon their religious principles.

I look forward to hearing from our witnesses and thank them for being here today.

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OPENING STATEMENT OF HON. PHIL GINGREY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. GINGREY. Well, I thank the chairman for yielding to me.

And absolutely the point that he is making in regard to conscience clause, surely, no matter how one may feel about Patient Protection and Affordable Care Act that was passed in March of 2010, whether you are strongly for it, as most Democrats on the committee were and strongly opposed to it, as most Republicans on our committee were, it seems to me that we should agree that conscience clauses should be protected.

Each year, one in six patients in the United States are cared for in a Catholic hospital, and approximately 725,000 individuals work in Catholic hospitals. These hospitals take all who are in need; it doesn't matter their religious background or their ability to pay. Come one, come all. But now, Obamacare would actually require with the rulemaking Catholic hospitals to primarily serve persons who share its religious beliefs or force them to provide benefits like abortion drugs to employees that contradict their faith.

Let me rephrase. The White House is telling Catholic hospitals to deny care for those of other faiths or be forced as employers to provide coverage for services that they object to on religious and moral grounds. Why must President Obama insist that the price for healthcare reform be giving up the civil liberties through an individual mandate and the religious liberties that our Founding Fathers guaranteed us under the Constitution. This Congress can do better than that. Obamacare can do better than that.

And I thank the chairman for yielding and I yield back.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the ranking member of the Subcommittee on Health, Mr. Pallone, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman.

Today's hearing will focus on the implementation of the Affordable Care Act's prohibition of cost-sharing for preventive health services, which will include prescription birth control methods. The rule released by the Department of Health and Human Services would permit certain religious employers to opt out of the requirement of providing contraception. But unfortunately, this is more than an examination of HHS's rule and whether or not it protects conscience rights. It is simply the latest in a series of attacks this year on the healthcare reform and women's health.

The Federal health reform law represents unprecedented efforts to improve women's health and women's access to comprehensive healthcare. In fact, women will gain the most from healthcare reform. First, we must not forget that the ACA makes health insurance a reality for 19 million women in this country who were uninsured.

In addition, it seeks to protect women from many insurance abuses. In the individual insurance market, women were being denied coverage for such preexisting conditions as pregnancy, having had a C-section, or in some cases, breast cancer. The ACA outlaws

such a practice. Women were also often being charged substantially higher premiums than men for the same healthcare coverage, and the ACA outlaws these gender-rating practices.

In many cases, women and children with insurance had not been receiving key preventive care from mammograms to well baby and well childcare visits to family planning services such as birth control because they could not afford the copays. Now, the Affordable Care Act is making groundbreaking strides in care for women by eliminating these copays and deductibles for preventive services.

The new preventative coverage rules announced by HHS remove significant financial obstacles for women seeking preventive reproductive healthcare. These provisions ensure that a woman has access to all preventative services, regardless of who her employer is. And this is critical because it is well known that almost all women—99 percent in fact, including religious devotees—will use contraception at some point during their reproductive lives. Meanwhile, 3 recent studies have found that lack of insurance is significantly associated with reduced use of prescription contraceptives.

But I absolutely support an individual's right to express their religious convictions. Today's hearing has nothing to do with religious rights and conscience protections. In my opinion, this hearing is about women's access to comprehensive healthcare coverage. And whether my colleagues admit it or not, their attempts here today are meant to turn back the clock on the great strides the Affordable Care Act has and will continue to make for women's health. We can't continue to allow obstacles to prevent us from insuring the affordability of family planning service for millions of women.

I would now like to yield 2 minutes from the time I have left, Mr. Chairman, to the gentlewoman from Illinois, Ms. Schakowsky.

OPENING STATEMENT OF HON. JANICE D. SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Ms. SCHAKOWSKY. Thank you for yielding.

The attention this committee has focused on and continues to focus on the private lives of women makes it clear that one of the goals of the majority is to end access not just to abortions but to family planning. I fought for and will continue to fight for the guidelines adopted by the administration.

After an exhaustive and thorough scientific review by the Institutes of Medicine to ensure insurance coverage of preventive services for women, it is no secret that substantial public health benefits and cost savings emerge when preventive services, including family planning, are accessible and affordable.

As patients, caregivers, and as workers who still earn less than men, women have a particular stake in ensuring insurance coverage of prescription contraceptives and other preventive services. The new guidelines on insurance coverage of preventive services for women should apply to all women, regardless of where they work.

Allowing employers to exempt themselves in providing prescription contraceptives for their employees is counterproductive, unfair, and paternalistic. Why should the conscience of an employer trump a woman's conscience? Why should an employer decide for a woman whether she can access the healthcare services that she

and her doctor decide are necessary? Why are we talking about allowing some employers to put up a barrier to access at a time when woman are struggling to afford and access healthcare?

It never used to be that family planning was considered a partisan issue and it never used to be that family planning was equated with abortion. My, how things have changed. Today, the full continuum of reproductive healthcare is under assault. Believe me, these conversations are heard far and wide among women out in the public, women of all ages and races and parties, political parties, who understand that these kinds of assaults on women's right to make a choice about a lot of things, including contraceptive care, and men, too, who want to be able to plan their families. Unacceptable.

I yield back.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes the vice chair of the Subcommittee on Health, Dr. Burgess, for 5 minutes.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. I thank the chairman for the recognition. And once again, we are here learning that those who are driving the regulatory train are in fact making the practice of medicine more difficult through their lack of thought. And we are left with consequences. The decision by Health and Human Services to issue an interim final rule, while that sounds like arcane Washington-speak, what that means is that the transparency and accountability of the normal Federal rulemaking process has now been circumvented, and as a consequence, we have got a rule being put forward that now has the force of law as if it were legislation passed by Congress and signed by the President.

Now, we have got a rule that has the force of law that is unworkable, yes, for faith-based facilities but also was going to have dramatic cost implications across the board for all Americans. A good thing or bad thing, problem is we don't know because we never had the opportunity to explore the possibilities.

So the administration now has singlehandedly rendered faith-based facilities fearful of their ability to continue to serve their patients. The lack of consideration for these organizations has manifested in an extremely narrow and in fact an unworkable exemption.

The interim final rule further expands the power and reach of the Federal Government into the realm of private health insurance without regard for conscience rights to be sure, but also without regard to the bill that must be footed by the taxpayer. The requirement that all, underscore "all," preventive FDA-approved contraceptives must be offered at no copay to all women was never examined for its cost or its practical implications. This policy considers both generic and brand name contraceptives the same, so how in the world do we expect there to be any price sensitivity in the marketplace if we have simply removed that obligation from the marketplace itself?

The interim final rule does violate the conscience protections many healthcare providers rely upon and ultimately leads to di-

minished access of care—as Dr. Gingrey so eloquently pointed out—and also importantly, a rising monthly premium for all Americans.

I yield now to the gentlelady from Tennessee.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mrs. BLACKBURN. Thank you, Mr. Burgess.

And I want to welcome all of our witnesses. We are so pleased that you have taken the time to be here with us today.

President Obama came before Congress and made a statement, "under our plan, no Federal dollars will be used to fund abortions and Federal conscience laws will remain in place." Then, at Notre Dame he said, "let us honor the conscience of those who disagree with abortion." But the truth is this administration, by its actions, calls abortion essential care. Obamacare discriminates against hospitals, insurance plans, and healthcare professionals who don't want to violate what they know in their hearts to be true.

HHS has published this new rule—we have all spoken about this—to force America's doctors and nurses to do the things that otherwise they would not do. Maybe it should be called coercion backed by the taxpayer dollars and that is a little bit of a poisonous medicine to swallow. It is unconstitutional and unethical and cheapens the civil rights of our medical professionals.

Smuggling abortion into PPACA was destructive and it is another big reason why I think we need to repeal Obamacare.

With that, I would like to yield the balance of the time to Dr. Murphy.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Thank you. And thank you, Chairman Pitts.

Since this rule was released, I have heard an outpouring of concern not only from religious leaders like Bishop David Zubik of the Diocese of Pittsburgh, but from over 1,000 individual constituents and a range of employers from the CEOs of multibillion dollar companies to small business owners. I have a hard time explaining to them that the Federal Government is forcing them to choose between their faith and providing health insurance to their employees.

This mandate stands in stark contrast to the stated purpose of healthcare reform expanding access to healthcare. Instead, this mandate will strip countless Americans of their health insurance calling into question President Obama's promise that if you like your health insurance you can keep it. To that I would add a question. If you like your religion, can you keep it?

Almost exactly a month ago, I sent a letter to Secretary Sebelius expressing my concern and that of the thousands I represent in Congress with the blatant disregard for the religious and moral beliefs of millions of Americans displayed in this new "preventative services" mandate. I am still waiting for Secretary Sebelius to respond.

Mr. Chairman, toward that end, I ask for unanimous consent that my letter to Secretary Sebelius be included in the official record. And with that, I yield back.

Mr. PITTS. Without objection, so ordered.

[The information follows:]

TIM MURPHY
18TH DISTRICT, PENNSYLVANIA

COMMITTEE ON ENERGY AND COMMERCE
HEALTH
COMMERCE, TRADE AND CONSUMER PROTECTION

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CO-CHAIR, 21ST CENTURY HEALTH CARE CAUCUS
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SUBURBAN CAUCUS

Congress of the United States
House of Representatives
Washington, DC 20515

WEBSITE: murphy.house.gov

October 4, 2011

Secretary Kathleen Sebelius
Department Of Health And Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

On behalf of employers and religious institutions in my district, I want to share with you my objection to the disregard for religious and moral beliefs displayed by the Department of Health and Human Services in the new preventive services mandate created under the Patient Protection and Affordable Care Act[1]. The new rule will require all health insurance plans to offer contraceptives and abortifacients as free preventive care. While the rule attempts to provide exceptions for 'religious employers', the Department's definition is far too narrow. I urge you to immediately abandon this mandate and rewrite the conscience exemption so that the employers with deeply-held religious beliefs are not forced to violate their faith in order to comply with the law.

Our nation allows individuals of all faiths to practice their beliefs, and this new mandate will force many employers like religious hospitals and universities to violate their moral values and convictions in order to follow the law. To qualify for this exemption Catholic hospitals would be required to treat only patients of the same religious beliefs, and private universities may only hire employees that share the same faith.

As the Most Reverend Donald Zubik, who serves as the Bishop of the Diocese of Pittsburgh, succinctly put it: "This mandate would apply in virtually every instance where the Catholic Church serves as an employer, requiring the Catholic Church to violate its own tenets by forcing Catholic entities to provide contraceptive and sterilization coverage."

While arguing that PPACA will expand access to healthcare, the Department has proposed a rule that will in fact strip it away from thousands of employees across the country. By choosing to stand behind fundamental beliefs and expressing one of America's dearest freedoms, schools, hospitals, charities, and care homes will be conducting an illegal act, and will be forced to pay a large penalty that will all but require them to let go many employees or drop healthcare coverage altogether. This is unacceptable.

[1] Interim rule (76 Fed. Reg. 46621) published on August 3, 2011 by the Department of Health and Human Services in interpretation of section 2713(a)(4) of PL111-148

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Further, implementation of this rule runs counter to the President's oft-repeated claim if you like "If you like your health care plan, you can keep your health care plan."[2] With this latest development, it is clear that simply will not be the case.

Therefore, I ask that the Department discard the preventive services mandate. The Department recognized the need to create an exemption for religious institutions, and I ask that the rule be redrafted to ensure the rights it aims to defend are fully protected.

Sincerely,

Tim Murphy
Member of Congress

[2] "Why We Need Health Care Reform" *New York Times* oped. President Obama. 15 August 2009. http://www.nytimes.com/2009/08/16/opinion/16obama.html?pagewanted=all

Mr. PITTS. The Chair recognizes the ranking member of the full committee, Mr. Waxman, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Mr. Chairman, this is not a hearing about abortion. This is not a hearing about whether people can adhere to their religious beliefs and follow their own individual consciences. This is a hearing about whether the Republicans can have the government intrude to the point where people who buy health insurance could be denied insurance coverage for the preventive service of family planning. Preventing conception is what family planning is all about, and it is a legitimate medical service. In fact, the Institute of Medicine made recommendations to the Department for what would be covered under preventive services, and they recommended that this be a covered preventive service.

So the question is, if somebody doesn't want to provide contraception because it violates their religion or their conscience, would they be required to? Absolutely not. The question then comes down to, what is the scope of the exception that church-provided insurance need not cover family planning? Well, I don't know why that should be even an exception. I disagree with the administration in providing that exception. But the Republicans would like to, first of all, extend that exception to all church-related groups whether it means that the people who are covered are of the same faith or not. But we are going to hear from a witness who would like to have no insurance coverage for contraceptives services because it violates her point of view.

Now, we hear a lot from the other side of the aisle about government intrusion in our private lives. There can be no intrusion more significant than government telling people they cannot get contraception, they cannot get insurance to cover contraception, it should not be a provided service. Well, that is part of what the Republican agenda appears to be, but it is much more than that because what we have is a hearing today that purports to be about the conscience protection, but it is another attempt by the Republicans to undermine and undo the Affordable Care Act's provisions related to women's health. And no single piece of legislation in recent memory has done more to advance women's health and women's access to health services than the Affordable Care Act.

It provides coverage for millions of Americans including 19.1 million women who are uninsured. It makes health insurance coverage more affordable through premium assistance. It stops gender rating. It would no longer be legal to do that where women are charged higher premiums than men for the same insurance coverage. It will be illegal for insurance companies to discriminate against women and others on the basis of preexisting conditions, which by the way may even include history of breast cancer, pregnancy, or experience of domestic violence. And then the cost-sharing requirements under Medicare have been eliminated for women's preventive health services such as mammograms and well women visits. For new private health insurance coverage that prohibition against cost-sharing extends to breastfeeding counseling,

screening, and counseling for domestic violence. And it would include FDA-approved contraceptives in addition to mammograms and well women checkups.

Now, the Republicans would like to take all this away, not just the access to contraceptive services. They would like to repeal the Affordable Care Act. And if they succeed, newly established health benefits and health coverage for women would disappear. And what would they do to replace this? Nothing. They would leave the status quo in place.

Now, let me be clear. I support policies that recognize and protect the right of individuals to express and act on their religious and moral convictions. If you have moral convictions, you can keep them, just don't try to impose them on everybody else. We cannot turn the clock back. We shouldn't let the Republicans confuse the issue.

Deny health insurance coverage that includes contraceptive services to millions of American women, that is wrong. Women who don't want that service don't have to access it if it violates their conscience. A doctor does not have to provide it if it violates his or her conscience. But tell me less about the conscience of the employer or the insurance company and why that should take precedence over all the people who are to be covered that do not share that particular point of view. The Department's position on insurance coverage for family planning is in keeping with this goal and should move forward without delay.

I am going to yield back my time and express a strong support for this preventive service which is now being used widely by people who even are members of a church that in theory and religious doctrine disapprove of the service.

Mr. PITTS. The Chair thanks the gentleman. That concludes the opening statements of the members. The Chair has a UC request to submit for the record a statement by Congressman Jeff Fortenberry; a statement by the Catholic University of America president, John Garvey; some letters from the U.S. Conference of Catholic Bishops; and a letter from the Family Research Council. These have all been provided. Without objection, these will be entered into the record.

[The information follows:]

United States Congressman — First District, Nebraska

JEFF FORTENBERRY

Statement of Congressman Jeff Fortenberry

"Do New Health Law Mandates Threaten Conscience Rights and Access to Care?"

House Energy and Commerce Subcommittee on Health

November 2, 2011

Chairman Pitts, I appreciate the opportunity to submit this statement for the record, and am grateful for your initiative to hold this important dialogue today for the consideration of the American people.

I am not a doctor, nor do I approach this hearing with clinical expertise or experience in the health care industry. I am speaking today as an American, as the representative of the First District of Nebraska, as a husband and father of five who is deeply concerned about the direction of our public policies, and in particular the direction of U.S. health care policy pursuant to the enactment of the health care overhaul last year.

In 2009, I was pleased to hold several Town Hall events on health care, including one on August 27 at the People's City Mission in Lincoln, to discuss the many concerns my constituents sought to raise about access to quality health care. Over the past two years, there has been much debate about improving access

to quality care as well as improving health care outcomes for hard-working Americans. I support the right type of health care reform that improves outcomes while reducing unsustainable costs. It grieves me profoundly that the health care law enacted in 2010 represents the flash point of an ideological agenda that in no small measure threatens to undermine fundamental liberties that have defined the essence of our national character, particularly the foundational liberties of religion and conscience.

In 1809, Thomas Jefferson declared that "[n]o provision in our Constitution ought to be dearer to man than that which protects the rights of conscience against the enterprises of the civil authority." James Madison also spoke to the primacy of conscience in American public life when he stated in one of his amendments to the Constitution that "the civil rights of none shall be abridged on account of religious belief or worship, nor shall any national religion be established, nor shall the full and equal rights of conscience be in any manner, or on any pretext, infringed." Madison, the major architect of our Constitution, also declared "conscience is the most sacred of all property." The right of conscience is clearly a quintessential American tradition.

Yet conscience rights have come under attack. Two years ago, when significant alarms were being raised about the potential for the health care overhaul to serve as a vehicle for forced funding of abortion-on-demand, which 72% of Americans polled oppose[1], I began working on the *Respect for Rights of Conscience Act.* In anticipation of concerns (which have recently been confirmed in the series of administrative actions taken by the Department of Health and Human Services this year) I introduced the measure on March 17, 2011 with my colleague Dan Boren.

H.R. 1179, the *Respect for Rights of Conscience Act of 2011,* sets forth findings that illustrate the fundamental nature of the health care liberties my colleagues and I are working to defend. It seeks to preclude the broad potential for violation of fundamental rights of conscience inherent in new powers granted to the federal bureaucracy through the terms of the 2010 health care law, as interpreted by the Department of Health and Human Services.

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[1] Quinnipac University survey of 1,616 registered voters nationwide, December 15-20, 2009, margin of error +/- 2.4 percentage points.

The federal government crossed a line with the enactment of the 2010 health care law by establishing a framework for imposing coverage requirements that infringe on the rights of health care providers broadly, including insurers, purchasers of insurance, plan sponsors, beneficiaries, and individual or institutional health care providers. Unless adequate conscience and associated non-discrimination protections are enacted, the 2010 health care law effectively bars health care stakeholders from retaining existing insurance arrangements consistent with their moral and ethical convictions.

I believe that it is vital for Americans to understand that the Department of Health and Human Services is interpreting the new health care law in a manner that imposes health care directives and associated conscience concerns that extend well beyond the context of abortion.

While the abortion funding concern remains preeminent, the potential fallout from the Administration's approach to health care reform encompasses a much broader array of conscience concerns related to drugs and procedures that have always been considered elective in nature, and offer no prospect of helping to mitigate chronic diseases such as cancer, heart disease, and stroke – that consume 75 cents of every public health care dollar spent in the United States.

Specifically, on February 18, 2011, the Obama Administration's Department of Health and Human Services rescinded key portions of a regulation issued in 2009 to protect the conscience rights of health care providers. Subsequently, in July 2011, the Institute of Medicine (IOM) issued a recommendation to the Department of Health and Human Services to mandate coverage of certain items and services considered by IOM to qualify under the category of preventive care.

On August 3, 2011, the Department of Health and Human Services issued guidelines flowing from the IOM recommendations that require mandatory coverage of drugs and procedures at no cost to the recipient and fully funded by third party enrollees, regardless of their willingness to pay for items and services many Americans object to in good conscience. It is also disturbing that that the process the Department followed in issuing this mandate short-circuited established rulemaking and comment procedures in a rush to expedite availability of drugs and procedures that are distinctly unrelated to America's health care challenges, over the vigorous objections of Members of Congress, the public, and a wide range of health care providers, including small businesses seeking to provide adequate health care benefits for their employees.

Ironically, the Department's interpretation of the Mikulski Amendment, from which it purports to derive justification for assuming unto itself vast and arbitrary powers which rightfully belong to Americans concerning their private health care decisions, reaches significantly beyond that amendment's stated intent to ensure "that women get the kind of preventive screenings and treatments they may need to prevent diseases particular to women such as breast cancer and cervical cancer."[2]

I also find it peculiar that the Recommendations of the U.S. Preventive Services Task Force for 2010-2011, set forth in The Guide to Clinical Preventive Services, make no mention of the drugs and procedures covered in the HHS directive.

Moreover, the Department's guidelines incorporate such a narrowly construed conscience exception for religious providers as to ensure that the vast majority of faith-based health care providers in the United States, including faith-based plans and employers such as parochial schools and universities, will be forced to either violate their deeply-held beliefs, drop health care coverage, or cease providing health care services to the general public unless they serve or employ persons primarily of their own faith. Such a scenario is discriminatory and insulting. To clarify potential misconceptions about the application of conscience rights to institutional health care providers, it is understood that 'providers' in this context includes entities managed by individuals working together to uphold fundamental moral and ethical convictions in the exercise of their beneficent mission.

For the first time in the history of the U.S. health care system, which owes its success in large measure to the faith-based institutions that continue to serve as a compassionate backstop for the health care needs of our most vulnerable and underserved populations, ill-advised public policies threaten to result in the following adverse consequences: 1) ballooning health care costs, by virtue of the extensive scope of mandated coverage; 2) absent the enactment of adequate conscience protections, the forced violation of deeply held beliefs of health care providers, who will be required by the strong arm of government to choose between their convictions and livelihood; 3) resulting in reduced access to high quality care for vulnerable populations that have traditionally relied on charitable institutions for health care.

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[2] *Congressional Record,* December 3, 2009, S12269.

I find it is deeply troubling that this country, which derived its unique character and strength from inalienable rights, including freedom of conscience, whether exercised in a religious context or otherwise, is increasingly facing the steady erosion of the right of health care providers to exercise deeply held moral and ethical judgments. Americans deserve a health care system that respects their core values and fundamental liberties to negotiate private health care decisions and treatment options, as has always been the case prior to the passage of the new health care law.

United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

"Do New Health Law Mandates Threaten Conscience Rights and Access to Care?"

November 2, 2011

Testimony of
John H. Garvey
President
The Catholic University of America

Federal regulations should not place The Catholic University of America – or any university – in the position of having to choose between the exercise of its religious principles and compliance with an over-reaching government policy. The new HHS women's health mandate puts us in exactly that position. It requires us to include, in our health insurance plans for students and employees, surgical sterilizations and all FDA-approved contraceptives. This includes prescription drugs (like Ella) that cause early term abortions. We might avoid this obligation by refusing to offer health insurance – an option our Catholic faith disdains. In three years we won't even have that option, so far as our employees are concerned. Under the Affordable Health Care Act we will have to pay a $2000 per employee if we do not offer health insurance, and our insurance will have to cover mandated services.

The Catholic University of America pays about 75% of its employees' health insurance costs. Though it does not subsidize its student plan in that way, it does negotiate the terms of the plan and collect payment from the students. By providing, operating, and subsidizing health plans that include sterilization, contraception, and early-term abortions, Catholic University cooperates in activities it views as intrinsically evil. It is a widely accepted moral principle that helping someone else to do wrong is almost as bad as doing wrong oneself.

Forcing The Catholic University of America to comply with this law is wrong for another reason as well. It is our mission, as a Catholic university, to see that our students grow in grace as well as wisdom during the time they study here. This law will force us to help our students do things that we teach them, in our classes and in our sacraments, are sinful . . . sometimes gravely so. A proper respect for religious liberty would warrant an exemption for our university and other institutions like it.

These regulations are so wide-ranging that they apply to virtually all conventional health plans – and to hundreds of Catholic institutions, elementary and secondary schools, hospitals, and social service organizations such as Catholic Charities. The rules purport to offer an exemption for "religious employers," but the term is defined in a way that excludes Catholic universities and most other Catholic

institutions. The rules say: "The inculcation of religious values [must be] *the* purpose of the organization" (emphasis added). That is too narrow to include Catholic universities, which observe norms of academic freedom and teach chemical thermodynamics, aerospace engineering, musical theater, Mandarin Chinese and the Victorian novel along with theology. It's too narrow to include St. Ann's Infant & Maternity Home in Hyattsville, MD, which provides care to abused and neglected children and to pregnant adolescents who need help. Nor does it encompass the Jeanne Jugan Residence for the elderly, run by the Little Sisters of the Poor across the street from our campus.

The rules disqualify any organization that does not also employ and serve "primarily persons who share the religious tenets of the organization." This would require Catholic hospitals and Catholic Charities to abandon their commitment to serve poor people of all faiths. It would disqualify Catholic middle schools such as the Nativity Miguel Network, which educates boys of all faiths tuition-free. And it would exclude any Catholic college or university whose faculty and student body are not majority Catholic.

Even if an organization meets all these criteria, it is still not considered a "religious employer" unless it is one of the few nonprofits that are excused under the tax law from filing an IRS Form 990. This stipulation limits the exemption to churches, their integrated auxiliaries, and religious orders. It is not a serious or meaningful attempt to reconcile such a Draconian mandate with the religious liberties that citizens and institutions should enjoy.

I understand, as do the leaders of other Catholic organizations, that not all citizens share the views that the Catholic Church holds about contraception and sterilization. It is particularly sad that not all Americans share our conviction that abortion is gravely wrong, even in the earliest stages of pregnancy. But in objecting to these regulations, our university only asks for respect for the religious beliefs we try to impart to our students. In offering a requirement, not an option, the government forces employers to choose not how and what procedures to cover, but whether to provide insurance at all. And in 2014 even

that option will be foreclosed for employees. It is distressing that HHS should ignore our nation's historical commitment to religious liberty in deciding what kinds of services to mandate. When the Affordable Health Care Act was under consideration in Congress, the administration promised that Americans who like their current health care coverage could keep it after we enacted the new reform. Employers, employees, and issuers who have moral and religious objections to sterilization, contraception, and abortion are now free to have health care coverage that excludes these practices. If the appeal to religious liberty is not reason enough to provide a liberal exemption, HHS should consider its obligation to keep the President's promises.

It does not take a college education to see the hypocrisy in offering to pay for the very services we condemn in our theology classes and seek forgiveness for in our sacraments. The federal government should not have the power to force Catholic institutions into such a collective violation of our own conscientious beliefs. HHS would do well to bear in mind the words of Justice Robert Jackson, writing almost 70 years ago about a law that forced Jehovah's Witnesses to violate their religious beliefs: "If there is any fixed star in our constitutional constellation, it is that no official, high or petty, can prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion or force citizens to confess by word or act their faith therein."

Secretariat of Pro-Life Activities
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November 1, 2011

The Honorable Joseph Pitts
Chairman, Subcommittee on Health
House Energy and Commerce Committee
Washington, D.C. 20515

Dear Mr. Chairman:

On behalf of the United States Conference of Catholic Bishops, I want to thank you for holding a hearing on November 2 titled, "Do New Health Law Mandates Threaten Conscience Rights and Access to Care?" We would like to ask that you accept this letter and its attachments as our written submission for this hearing.

This issue has been a matter of grave concern to the Catholic bishops of the United States throughout Congress's debate on health care reform. We have long supported the goal of universal access to health care, and encouraged the 111th Congress to advance this goal through morally responsible health care reform. At the same time, we consistently stated that such reform must not become a vehicle for abandoning or weakening longstanding federal policies that respect unborn human life and rights of conscience. Days before final votes on the health care reform bill, Cardinal Francis George as President of the USCCB reaffirmed what we had said many times over the previous year: **"Any final bill, to be fair to all, must retain the accommodation of the full range of religious and moral objections in the provision of health insurance and services that are contained in current law, for both individuals and institutions"** (Statement of March 15, 2010).

The final legislation passed by Congress was flawed in several respects. It fell short of universal access, most notably with respect to immigrants. It allowed for federal funding of elective abortions, and of health benefits plans that cover such abortions, for the first time in decades. It excluded longstanding protections for conscience rights on abortion, by failing to apply the annual Hyde/Weldon amendment to the billions of dollars newly appropriated by the Act. And it created new open-ended mandates for "essential health benefits" and "preventive services" to be included in almost all private health plans, without any provision for individuals or institutions that may have a moral or religious objection to particular items or procedures.

This last deficiency in the statute has now been exploited by the Department of Health and Human Services to impose a nationwide mandate for coverage of all FDA-approved contraceptive drugs (including at least one abortion drug similar to RU-486), sterilization procedures, and education and counseling to promote these to "all women

with reproductive capacity." The HHS rule includes an exemption for "religious employers" so narrowly crafted that many religious organizations cannot fulfill any of its four requirements, let alone all four. Catholic health care providers, educational institutions and social services agencies would have to be listed in the tax code as a church or similar narrowly defined entity, make the inculcation of religious doctrine their organizational purpose, and largely refuse to hire *or serve* non-Catholics to be fully eligible. It has been said that Jesus and the apostles would not be "religious enough" under such a test, as they served and healed people of different religions. Moreover, even Catholic institutions that somehow manage to meet these tests would not be allowed to offer a Catholic health plan to non-employees – for example, to students at a Catholic college, or to members of the public (even if they are fellow Catholics).

Here we see immediately how a failure to respect conscience rights poses a serious threat to the goal we share of expanding access to health care. For under the new HHS mandate, Catholic organizations committed to their moral and religious teaching will have no choice but to stop providing health care and other services to the needy who are not Catholic, or stop providing health coverage to their own employees. This is an intolerable dilemma, and either choice will mean reduced access to health care.

It is especially troubling that this reduction in access to life-saving health care would be done in order to maximize the use of elective drugs and procedures that prevent no illness, are used mainly for personal lifestyle reasons, and can pose their own significant risks to women's life and health. Even recent findings that hormonal contraceptives can heighten women's risk of contracting and transmitting the AIDS virus has not made any difference to this campaign – although the "preventive services" package of benefits is, among other things, supposedly aimed at *preventing* AIDS. Is the drive to maximize contraceptive coverage, even among those who do *not* want it, such an urgent national priority that it transcends concerns about religious liberty, our nation's "First Freedom," as well as concerns about women's health and about access to basic health care for men and women alike?

In this new rule, we have moved very far from the longstanding consensus on respect for rights of conscience that has prevailed in the federal government for decades. To cite just one instance, when Congress decided to require contraceptive coverage in the Federal Employees Health Benefits Program in 1999, there was also a strong bipartisan consensus that any health plan would be exempt if its carrier simply objected on the basis of religious belief – and that individual health care providers in all plans would be protected from being required to violate their religious beliefs or moral convictions. This policy remains in place to this day. So for the past twelve years, a Catholic health system could offer a health plan without contraceptive coverage to anyone who wanted it, including federal employees – yet now it will be prohibited from offering such a plan to *anyone*, even *its own* employees.

This is why congressional approval of the Respect for Rights of Conscience Act (H.R. 1179/S. 1467) is urgently needed. This legislation would not affect any state or federal obligation to provide health coverage, except to provide that new nationwide

mandates under the new health care reform law will not forbid the issuers, sponsors, and beneficiaries of private health plans to negotiate health coverage that is consistent with their moral and religious convictions. Such accommodations have been the norm in federal law for many years, and it is long overdue that they be permitted by the health care reform law as well.

As attachments to this letter, I have provided additional materials: A full-page ad appearing this week in *Politico*, *Roll Call*, *The Hill*, and *CQ Today* signed by the leadership of 22 Catholic organizations concerned about the "preventive services" mandate; my September 7 letter endorsing the Respect for Rights of Conscience Act; and an August 31 press release about our formal comment letter to HHS objecting to this mandate. The comment letter itself, and other materials on this issue, are available at www.usccb.org/conscience.

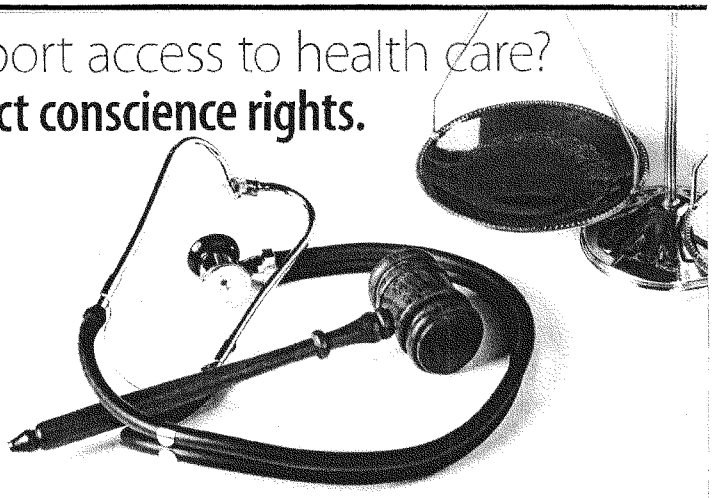
Thank you again for addressing this situation in which religious liberty, freedom of conscience for health care providers, and access to health care for all Americans are very much at stake.

Sincerely,

Cardinal Daniel DiNardo

Cardinal Daniel N. DiNardo
Chairman, Committee on Pro-Life Activities
United States Conference of Catholic Bishops

Support access to health care?
Protect conscience rights.



Catholic Organizations Respond to HHS "Preventive Services" Mandate

We, the undersigned, strongly support access to life-affirming health care for all, and the ability of secular and religious groups and individuals to provide and receive such care. That is why we have raised objections to a rule issued by the U.S. Department of Health and Human Services forcing almost all private health plans to cover sterilization procedures and contraceptive drugs, including drugs that may cause an early abortion.

As written, the rule will force Catholic organizations that play a vital role in providing health care and other needed services either to violate their conscience or severely curtail those services. This would harm both religious freedom and access to health care.

The HHS mandate puts many faith-based organizations and individuals in an untenable position. But it also harms society as a whole by undermining a long American tradition of respect for religious liberty and freedom of conscience. In a pluralistic society, our health care system should respect the religious and ethical convictions of all. We ask Congress, the Administration, and our fellow Americans to acknowledge this truth and work with us to reform the law accordingly.

Robert B. Aguirre
President
Catholic Association of Latino Leaders

Carl A. Anderson
Supreme Knight
Knights of Columbus

F. DeKarlos Blackmon, ObISB
Supreme Knight/CEO
Knights of Peter Claver

Christiane Chagnon
International Regent
Daughters of Isabella

William J. Cox
President/CEO
Alliance of Catholic Health Care

Michael Galligan-Stierle, PhD
President/CEO
Association of Catholic Colleges and Universities

John Garvey, JD
President
The Catholic University of America

Sheila Gilbert
President
National Council of the U.S. Society of St. Vincent de Paul

John M. Haas, PhD, STL
President
National Catholic Bioethics Center

Ken Hackett
President
Catholic Relief Services

Jan R. Hemstad, MD
President
Catholic Medical Association

Cheryl A. Hettman, PhD, RN
President
National Association of Catholic Nurses

Rev. John Jenkins, CSC
President
University of Notre Dame

Patty Johnson
President
National Council of Catholic Women

James G. Lindsay
Executive Director
Catholic Volunteer Network

Stephen L. Mikochik, JD
Chair
National Catholic Partnership on Disability

Karen M. Ristau, EdD
President
National Catholic Educational Association

Geralyn C. Shelvin
Supreme Lady
Knights of Peter Claver Ladies Auxiliary

Rev. Larry Snyder
President
Catholic Charities USA

Joanne Tomassi
National Regent
Catholic Daughters of the Americas

The Most Rev. José Gomez
Archbishop of Los Angeles
Chairman
Migration and Refugee Services

The Most Rev. Timothy Dolan
Archbishop of New York
President
United States Conference of Catholic Bishops

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September 7, 2011

Dear Member of Congress:

While I have written previously to encourage your support for the Respect for Rights of Conscience Act (H.R. 1179, S. 1467), recent events make this request more urgent.

In an interim final rule published August 3, the Department of Health and Human Services (HHS) has established a list of "preventive services for women" to be required in almost all private health plans nationwide, under the authority of the Patient Protection and Affordable Care Act (PPACA). Tragically, HHS missed its opportunity to focus on prevention of diseases and disabling conditions that truly pose serious risks to women's lives. Instead it decided to include mandatory coverage for: surgical sterilization; all prescription contraceptives approved by the FDA, including drugs like Ella (ulipristal) that can cause abortions in the early weeks of pregnancy; and "education and counseling" to promote these to "all women of reproductive capacity."

The new HHS mandate underscores a major deficiency in PPACA – it lacks a conscience clause to prevent the Act itself from being used to suppress the rights and freedoms of those who may have moral or religious objections to specific procedures. This omission is especially glaring in light of the fact that the Act does accommodate the religious beliefs of those who object to participation in government-run benefits programs altogether, those who wish to address illness solely by prayer, and those on Indian reservations who are committed to traditional tribal practices of healing.

As you may know, the nation's largest abortion provider, Planned Parenthood, actively campaigned for the mandate now issued by HHS, and supports mandated coverage of chemical as well as surgical abortion. Planned Parenthood and other pro-abortion groups hope that once there is a national mandate for "prevention" of pregnancy as if it were a disease inimical to women's well-being, this will build their case for promoting abortion as the "cure."

Last fall the United States Conference of Catholic Bishops presented a detailed case against a nationwide contraceptive mandate on several grounds. For example, there are solid reasons to doubt claims that expanded contraceptive programs reduce abortions, or that prescription contraceptives enhance health for women (http://old.usccb.org/ogc/preventive.pdf). In this letter I wish to focus on the threat posed by such a mandate to rights of conscience and religious freedom, as Congress has protected these rights in the past and needs to do so again.

This spring, to address the serious flaw in PPACA regarding lack of conscience rights, Reps. Jeff Fortenberry (R-NE) and Dan Boren (D-OK) introduced the Respect for Rights of Conscience Act (H.R. 1179). This legislation would change no current state or federal mandate for health coverage, but simply prevent any new mandates under PPACA – such as HHS's new set of "preventive services for women" -- from being used to disregard the freedom of conscience that Americans now enjoy. This would seem to be an absolutely essential element of

any promise that if Americans like the health plan they have now, they may retain it. I applaud the August 2 introduction of a Senate version of this legislation (S. 1467) by Senators Roy Blunt (R-MO), Marco Rubio (R-FL) and Kelly Ayotte (R-NH), and I urge members of both parties to add their names as co-sponsors to these urgently needed bills.

Respect for rights of conscience in health care has been a matter of strong bipartisan consensus for almost four decades. Under the Church amendment of 1973, those taking part in a variety of federal health programs may not be discriminated against because they have moral or religious objections to abortion or sterilization, and in some circumstances to any other health service. The Federal Employees Health Benefits Program exempts religiously affiliated health plans from any contraceptive mandate, and protects the conscience rights of health professionals in secular plans. The major federal legislation for combating AIDS in developing nations ensures the full participation of organizations that have a moral or religious objection to particular methods of AIDS prevention. This consensus is reflected in a variety of other federal laws as well (http://old.usccb.org/prolife/issues/abortion/crmay08.pdf).

HHS's new mandate for contraception/sterilization coverage, by contrast, includes an incredibly narrow exemption for "religious employers" that protects almost no one. For example, a Catholic institution serving the poor and needy would have to fire its non-Catholic staff, refuse life-affirming care to non-Catholic people in need, and devote itself instead to "the inculcation of religious values" to qualify for the exemption. Individuals, insurers, and the sponsors of non-employee health plans (e.g., student health plans in Catholic schools) would have no exemption at all. This effort to corral religion exclusively into the sanctuaries of houses of worship betrays a complete ignorance of the role of religion in American life, and of Congress's long tradition of far more helpful laws on religious freedom.

HHS's new list of mandated benefits makes it especially urgent for Congress to bring PPACA into line with the federal government's long legal tradition of respect for the rights of conscience. Those who sponsor, purchase and issue health plans should not be forced to violate their deeply held moral and religious convictions in order to take part in the health care system or provide for the needs of their families, their employees or those most in need. To force such an unacceptable choice would be as much a threat to universal access to health care as it is to freedom of conscience.

Therefore I urge you to support and co-sponsor the Respect for Rights of Conscience Act, to help preserve respect in federal law for the freedom to follow the dictates of one's conscience.

Sincerely,

Cardinal Daniel DiNardo

Cardinal Daniel N. DiNardo
Archbishop of Galveston-Houston
Chairman, Committee on Pro-Life Activities
United States Conference of Catholic Bishops

UNITED STATES CONFERENCE OF CATHOLIC BISHOPS

USCCB> Media > News Releases >

USCCB Urges Rescission Of HHS Contraceptive Mandate, Criticizes 'Inexplicably Narrow' Definition Of Religious Freedom

August 31, 2011

WASHINGTON—The general counsel of the U.S. Conference of Catholic Bishops (USCCB) called on the Department of Health and Human Services (HHS) to rescind its mandate forcing private insurance plans to cover contraception—including abortifacients—and sterilization, calling the mandate "unprecedented in federal law and more radical than any state contraceptive mandate." The comments also criticize the narrow "religious employer" exception to the mandate, explaining that it provides "no protection at all for *individuals* or *insurers* with a moral or religious objection to contraceptives or sterilization," instead covering only "a very small subset of religious employers."

In their August 31 comment to HHS, Anthony Picarello, USCCB general counsel, and Michael Moses, associate general counsel, noted that the mandate to cover "all FDA-approved contraceptives" and "emergency contraceptives," including at least one drug called Ella that can cause abortions, entails "nationwide government coercion of religious people and groups to sell, broker or purchases 'services' to which they have a moral or religious objection." This represents "an unprecedented attack on religious liberty," they wrote.

As to the exemption, the comments detail how it "is narrower than any conscience clause ever enacted in federal law, and narrower than the vast majority of religious exemptions from state contraceptive mandates," wrote Picarello and Moses. "By failing to protect insurers, individuals, most employers, or any other stakeholders with a religious objection to such items and procedures, the HHS exemption, like the mandate itself, violates" the U.S. Constitution and various federal statutes.

According to Picarello and Moses, the mandate violates the Weldon amendment and the Patient Protection and Affordable Care Act (PPACA, commonly known as the health care reform law), as well as the Administration's own stated policy to exclude from the mandate any drug that can cause an abortion. Both the mandate and the narrow exception violate various protections of religious freedom under the First Amendment.

"Until now, no federal law has prevented private insurers from accommodating purchasers and plan sponsors with moral or religious objections to certain services," they wrote. "Plans were free under federal law to accommodate those objections by allowing purchasers to choose not to buy coverage for gender change surgery, contraceptives, in vitro fertilization, or other procedures that the purchaser or sponsor found religiously or morally problematic. Likewise, federal law did not forbid any insurer, such as a religiously-affiliated insurer, to exclude from its plans any services to which the insurer itself had a moral or religious objection. Indeed, the freedom to exclude morally objectionable services has sometimes been stated affirmatively in federal law."

Under the mandate, they wrote, this will end. "Individuals with a moral or religious objection to these items and procedures will now be affirmatively barred by the HHS mandate from purchasing a plan that excludes [contraception and sterilization]. Religiously-affiliated insurers with a moral or religious objection likewise will be affirmatively barred from offering a plan that excludes them to the public, even to members of their own religion. Secular organizations (insurers, employers, and other plan sponsors) with a moral or religious objection to coverage of contraceptives or sterilization will be ineligible for the exemption."

Religious employers that do not meet HHS's narrow definition will also be subject to the mandate. "HHS

has concluded, for example, that a church is not a religious employer if it (a) serves those who are not already members of the church, (b) fails to hire based on religion, or (c) does not restrict its charitable and missionary purposes to the inculcation of religious values. Under such inexplicably narrow criteria—criteria bearing no reasonable relation to any legitimate (let alone compelling) government purpose—even the ministry of Jesus and the early Christian Church would not qualify as 'religious,' because they did not confine their ministry to their co-religionists or engage only in a preaching ministry. In effect, the exemption is directly at odds with the parable of the Good Samaritan, in which Jesus teaches concern and assistance for those in need, regardless of faith differences."

Though the problems with this exemption are serious and need to be addressed, the comments emphasize that the fundamental problem lies in the mandate itself, which must be rescinded: "Only rescission will eliminate all of the serious moral problems the mandate creates; only rescission will correct HHS's legally flawed interpretation of the term 'preventive services.'"

The full comment can be found online:
www.usccb.org/about/general-counsel/rulemaking/upload/comments-to-hhs-on-preventive-services-2011-08.pdf

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Keywords: Department of Health and Human Services, HHS, United States Conference of Catholic Bishops, USCCB, General Counsel, preventive services, mandate, interim rule, comment, U.S. bishops, Anthony Picarello, Michael Moses, contraceptives, sterilization, abortion, religious freedom, conscience

November 2, 2011

The Honorable Joe Pitts
Chairman, Subcommittee on Health
House Committee on Energy and Commerce
420 Cannon House Office Building
House of Representatives
Washington, DC 20515

Dear Chairman Pitts:

We thank you for holding a hearing, "Do New Health Law Mandates Threaten Conscience Rights and Access to Care?" As you are aware, the administrative action taken by the Department of Health and Human Services on August 1, 2011, to cover contraceptives and sterilization services is an unprecedented mandate which directly conflicts with the religious freedom and conscience rights of the American people.

Additionally, the August 1, 2011 interim final rule "allowing," but not requiring, the Health Resources and Service Administration (HRSA) to consider exempting certain religious employers is a grossly inadequate regulation. The exemption for religious employers is so narrow that it only covers a small subset of religious organizations, specifically churches. It does not include the vast majority of religious organizations and employers. This exemption reveals a profound disrespect and lack of concern for those with moral and religious objections to certain medical procedures.

The Family Research Council (FRC) opposes this mandate because: 1) contraceptives and sterilization procedures do not constitute a form of preventive medicine since they do not prevent any disease; 2) access to contraception is already widely available in the U.S., bringing into question the practical need for this mandate; 3) the mandate includes drugs that have abortifacient modes of action, thereby forcing all health plans to cover abortion; 4) the required inclusion of contraceptives and sterilization procedures in health plans will violate the consciences of millions of Americans who object morally to "contraceptives" per se as well as drugs and devices that can act as abortifacients (*i.e.*, they can be embryocidal).

Furthermore, the "religious employer" definition issued by HHS as an allowable exemption to this mandate protects so few religious groups that most religious employers will be faced with either violating their consciences or dropping health coverage. Choosing the second option will undermine the stated goal of the Affordable Care Act. FRC represents a large Christian community of concerned citizens, at least 12,000 of whom submitted comments to the government via our website disagreeing with this mandate and the religious exemption. We join together with Daniel Cardinal DiNardo representing the Catholic Church in the U.S., who recently stated, "Jesus himself, or the Good Samaritan of his famous parable,

would not qualify as 'religious enough' for the exemption, since they insisted on helping people who did not share their view of God."[1]

This Administration is either unconcerned about forcing religious groups and individuals to violate their consciences under the new mandate, or it is unaware that tens of millions of Americans have grave concerns with the use of contraceptives and sterilization procedures. The Administration's minimal attempt to meet the objections raised by the mandate leads us to question whether there has been a serious effort to protect conscience rights by the federal government. The coercive policy that will be forced upon millions by HHS is not only bad health policy, but also conflicts directly with several federal conscience protection laws in so far as it mandates the use of drugs that have abortifacient properties.

Your hearing on this unprecedented mandate and conscience rights is critically important. The mandate flies in the face of long-standing conscience protection norms and statutes while acquiescing to the demands of extreme proponents of contraception, sterilization, and abortion. For further information, please see the attached and more comprehensive comments we have submitted to HHS laying out in greater detail the numerous problems with the contraceptive mandate and its undermining of conscience rights.

Thank you for your consideration.

Sincerely,

/s/ Jeanne Monahan
Director, Center for Human Dignity

/s/ Chris Gacek, J.D., Ph.D.
Senior Fellow for Regulatory Policy

[1] "Statement for Respect Life Month," Cardinal Daniel N. DiNardo, Chairman, Committee on Pro-Life Activities United States Conference of Catholic Bishops (Sept. 26, 2011).

September 30, 2011

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-9992-IFC2,
P.O. Box 8010,
Baltimore, MD 21244-8010

Submitted Electronically Via Email
Re. File Code CMS-9992-IFC2

Dear Sir or Madam,

On August 3, 2011 the Department of Health and Human Services (HHS) issued an interim final rule for individual and group health plans related to women's preventive services coverage under the Patient Protection and Affordable Care Act (PPACA).[2] 76 Fed. Reg. 46621 (Aug. 3, 2011). In it HHS specified Health and Research Services (HRSA) guidelines that must be covered by individual and group health plans under the PPACA, including contraceptives and sterilization procedures, among other "preventive services" for women. The regulation also requested comments related to its definition for "religious employers" that may be eligible to receive an exemption from this coverage mandate.

On behalf of the Family Research Council (FRC), which represents hundred of thousands of American families, we oppose strongly the decision to include, with no cost sharing, "all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling"[3] in the list of mandated services which all individual and group health plans will be required to cover. We oppose this mandate because: 1) contraceptives and sterilization procedures do not constitute a form of preventive medicine since they do not prevent any disease; 2) access to contraception is already widely available in the U.S. bringing into question the practical policy need of this mandate; 3) the mandate includes drugs that have abortifacient modes of action thereby forcing all health plans to cover abortion; 4) the required inclusion of contraceptives and sterilization procedures in health plans will violate the consciences of millions of Americans who object morally to

[2] PPACA, P.L. 111-148 as enacted contains a provision on preventive health services in Section 1001, which created a new section 2713 of the Public Health Service Act (PHSA) to mandate that all individual and group health plans provide coverage for preventive care in accordance with guidelines offered by the U.S. Preventive Services Task Force (USPSTF). Section 2713(a)(4) of PHSA would extend the coverage mandate to include, with no cost sharing requirements, the following: "(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration." Paragraph (1) would include all "items or services" that are currently recommended by the USPSTF. Paragraph (4) therefore would add to that mandate coverage of items and services not recommended by the USPSTF, but which would be provided for by the Health Resources and Services Administration (HRSA).

[3] U.S. Department of Health and Human Services Health Resources Services Administration, "Women's Preventive Services: Required Health Plan Coverage Guidelines," August 1, 2011, p 1. http://www.hrsa.gov/womensguidelines/.

"contraceptives" per se as well as drugs and devices that can act as abortifacients (*i.e.*, they can be embryocidal).

We also comment negatively on the excessively narrowly defined "religious employer" exemption to this mandate. Under the exemption as drafted, so few religious groups will be eligible for the exemption's protection that, in reality, most religious employers will be faced with either violating their consciences or dropping health coverage. We conclude by discussing how this unprecedented mandate conflicts with conscience and religious freedom protections currently in place to protect the American people from government interference.

I. Contraceptives Are Not Properly Classified as Preventive Medicines.

At a most basic level, the mandate to include the full range of FDA-approved contraceptives as necessary preventive medicine defies common sense because pregnancy is not a disease or disabling condition. Pregnancy is a beneficial, temporary condition that not only indicates a condition of good health on the part of the woman who is pregnant, but is a benefit to society in that this healthy condition is necessary for the propagation of the human race. To the contrary it is the woman who has difficulty becoming pregnant who experiences a medical complication and will likely seek medical services to reverse that medical condition. Pregnancy is a normal medical condition from which serious medical complications can arise but typically do not. Diseases or complications *related* to pregnancy are to be treated, but pregnancy itself is not a disease or illness.

Because they prevent the body from a normal healthy function, contraceptive services are by their nature elective and are not medically necessary. They should not be placed in the same category as other basic types of preventive medical care.

Additional concerns exist regarding contraceptives because FDA has approved several drugs and devices as "contraceptives" that can act destructively on the embryo after fertilization as well as post-implantation.[4] The termination of a pre-born baby through early chemical abortion obviously would "prevent" bringing a child to term. However, since pregnancy is not a disease, the provision of contraceptives that function as abortifacients should not be required as "preventive care for women." By destroying that which is both healthy and alive in a woman, abortion contradicts the very definition of a preventive service for women.

II. Contraceptives Are Readily Available in the United States.

Arguments favoring increasing access to contraceptives as a way of reducing sexually transmitted diseases (STD), "unwanted pregnancies," or abortion are flawed. Contraceptives are widely available in the U.S. and already are heavily subsidized by the federal government; total public expenditures for contraceptive services were $1.85 billion in 2006.[5] Medicaid family planning costs during

[4] It is a scientifically valid belief that conception occurs at fertilization and that pregnancy begins with fertilization and not with implantation. This analysis is supported by a recent survey of the four American medical dictionaries showing that three of the four back this position to some extent. Christopher M. Gacek, "Conceiving 'Pregnancy': U.S. Medical Dictionaries and Their Definitions of 'Conception' and 'Pregnancy,'" *National Catholic Bioethics Quarterly* (Autumn 2009): 542-557.

[5] A. Sonfield, C. Alrich, and R.B. Gold, "Public Funding for Family Planning, Sterilization and Abortion Services, FY 1980–2006," *Occasional Report* 38 (Jan 2008): 28-33.

that time totaled $1.3 billion[6]. States additionally contributed $241 million for family planning in fiscal year 2006. Also in the same fiscal year, Title X, an additional funding stream for family planning, contributed another $215 million of taxpayer dollars for family planning services.[7] In more recent years, Title X costs have been as high as $317 million annually.[8]

Contraceptives are also covered by most insurance plans; nine out of ten employer-based insurance health plans cover the full range of contraceptives.[9] Additionally, there is no good evidence to suggest that women who choose not to contracept are making that decision due to financial need. A survey of sexually active women conducted by the Guttmacher Institute shows only that 12 percent report "lacking access to contraceptives due to financial or other reasons."[10] This survey leaves open the possibility that the lack of access for all such women is due to other reasons, not financial.

Moreover, increased contraception does not necessarily correlate with a decrease in unintended pregnancies or sexually transmitted diseases. Recent peer reviewed studies from Sweden,[11] the United Kingdom,[12] and Spain[13] agree that increased use of contraceptives coincides with an increase in abortions and STDs. In the United States, lower contraceptive use correlates with fewer abortions. From 1995 to 2002, the rate of contraceptive use decreased from 64 percent to 62 percent[14] and abortion numbers decreased from 1,359,400 to 1,269,000.[15]

A Federal mandate on a significant portion of the American population is unwarranted given the lack of need in addition to the profound implications that will arise for those who

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[6] Guttmacher Institute, "Facts on Contraceptive Use in the United States" (August 2011): p. 1 (http://www.guttmacher.org/pubs/fb_contraceptive_serv.html).

[7] *Ibid.*

[8] Title II of Division D of The Consolidated Appropriations Act, 2010 (P.L. 111-117), 123 STAT 3239.

[9] Guttmacher Institute, "Facts on Contraceptive Use in the United States" (June 2010): p. 1 (http://www.guttmacher.org/pubs/fb_contr_use.html).

[10] R. Jones, J. Darroch and S.K. Henshaw "Contraceptive Use Among U.S. Women Having Abortions," *Perspectives on Sexual and Reproductive Health 34* (Nov/Dec 2002): 294-303

[11] K. Edgardh, et al., "Adolescent Sexual Health in Sweden," *Sexual Transmitted Infections* 78 (2002): 352-6 (http://sti.bmjjournals.com/cgi/content/full/78/5/352).

[12] Sourafel Girma, David Paton, "The Impact of Emergency Birth Control on Teen Pregnancy and STIs," *Journal of Health Economic,* (March 2011): 373-380. *See also* A. Glasier, "Emergency Contraception," *British Medical Journal* (Sept 2006): 560-561.

[13] J.L. Duenas, et al., "Trends in the Use of Contraceptive Methods and Voluntary Interruption of Pregnancy in the Spanish Population During 1997–2007," *Contraception* (January 2011): 82-87.

[14] Guttmacher Institute, "Facts on Contraceptive Use in the United States" (June 2010): p.1 (http://www.guttmacher.org/pubs/fb_contr_use.html). These numbers represent use among all women age 15-44, and thus, because many women in this age group would not be sexually active, the rate of use among sexually active women would be higher.

[15] R.K. Jones, M. Zolna, L.B. Finer, and S.K. Henshaw, "Abortion in the United States: Incidence and Access to Services, 2005" *Perspectives on Sexual and Reproductive Health* (2008): p. 9 (http://www.guttmacher.org/pubs/psrh/full/4000608.pdf).

fundamentally object to covering, providing for, or paying for contraception and sterilization.

III. The Mandate Including Provision of the Full Range of FDA-approved Contraceptives Includes Abortifacient Drugs and Services.

The "Food and Drug Administration-approved contraceptive methods" required by the contraceptive mandate include a variety of drugs and devices whose modes of action can be destructive rather than preventive. There is substantial evidence that some of the included drugs and devices can be destructive to a newly forming human embryo. However the Institute of Medicine (IOM) committee tasked with providing recommendations for inclusion of services in the mandate actively ignored and overlooked the available research and ethical concerns regarding this critical issue. A spokesperson for the IOM brushed aside such research as "personal opinions" during the question and answer portion of the press conference coinciding with the release of the IOM report. HHS then in turn also ignored numerous peer-reviewed research studies indicating that certain drugs have abortifacient properties. Despite the fact that the difference between the prevention and destruction of life is vast in the eyes of most Americans, rather than erring on the side of science, evidence and caution on this critical issue, HHS chose to mandate the provision of drugs that likely have embryo destructive modes of action.

The first of these drugs is Levonorgestral, or Plan B. Plan B possesses a number of mechanisms of action which can prevent a newly formed embryo from implanting in the uterine wall. One extensive review of the available literature on Levonorgestral revealed as many as seven mechanisms of action that could potentially prevent implantation of an embryo.[16] In another literature review of the mechanisms of action of Levonorgestral, the authors concluded, "The evidence to date supports the contention that use of EC does not always inhibit ovulation even if used in the preovulatory phase, and that it may unfavorably alter the endometrial lining regardless of when in the cycle it is used, with the effect persisting for days."[17] Plan B's labeling information also admits this scientific reality. "[Plan B] may inhibit implantation (by altering the endometrium)."[18]

The second problematic FDA-approved drug covered by the mandate is ulipristal acetate, marketed as Ella® by Watson Pharmaceuticals. To be clear, including Ella in the mandatory category of "preventive care service for women" means that HHS is requiring each health insurance plan to cover a drug with the ability to kill an implanted embryo. Causing the demise of an embryo post-implantation is agreed by all to be an abortion. FDA approved Ella as an "emergency contraceptive," but Ella is chemically and functionally similar to the

[16] H. Croxatto, et al., "Mechanism of Action of Hormonal Preparations Used for Emergency Contraception: a Review of the Literature," *Contraception* 63 (2001): 111.

[17] C. Kahlenborn, et al., "Postfertilization Effect of Hormonal Emergency Contraception," *Annals of Pharmacotherapy* (2002): 468.

[18] U.S. Department of Health and Human Services Food and Drug Administration, "Plan B One Step Labeling Information" (July 2009): p. 4 http://www.accessdata.fda.gov/drugsatfda_docs/label/2009/021998lbl.pdf.

FDA-approved abortifacient, RU-486.[19] Even Ella's label states that the drug is contra-indicated for pregnancy.[20]

A recent article published in *Annals of Pharmacotherapy* stated "[t]he mechanism of action of ulipristal in human ovarian and endometrial tissue is identical to that of its parent compound, mifepristone."[21] Numerous other research studies confirm ulipristal's abortifacient mechanism of action.[22] In one such study involving ulipristal's action in macaques (monkeys), 4 out of 5 fetuses were aborted.[23]

In paperwork filed for the approval of ulipristal in Europe, the European Medicines Agency noted that "Ulipristal, mifepristone and lilopristone were approximately equipotent at the dose levels of 10 and 30 mg/day in terminating pregnancies in guinea-pigs..."[24] The authors of the *Annals* article noted: "[E]xisting studies in animals are instructive in terms of the potential abortive effects of the drug in humans."[25] Their analysis led them to conclude "it can be reasonably expected that the prescribed dose of 30 mg of ulipristal will have an abortive effect on early pregnancy in humans."[26] Thirty milligrams is the precise dose of ulipristal now provided in a single package of Ella when purchased as an emergency contraceptive in the United States.[27]

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[19] RU-486 (mifepristone; Mifeprex®) was approved in 2000 by the FDA as an "abortifacient."

[20] U.S. Department of Health and Human Services Food and Drug Administration, "Ella Labeling Information" (August 2010): p.1 (http://www.accessdata.fda.gov/drugsatfda_docs/label/2010/022474s000lbl.pdf).

[21] D. Harrison and J. Mitroka, "Defining Reality: The Potential Role of Pharmacists in Assessing the Impact of Progesterone Receptor Modulators and Misoprostol in Reproductive Health," *Annals of Pharmacotherapy 45* (Jan. 2011): 115-9.

[22] Reel et al., "Antiovulatory and Postcoital Antifertility Activity of the Antiprogestin CDB-2914 When Administered as Single, Multiple, or Continuous Doses to Rats," 58 *Contraception* (1998): 129-136, p. 129; VandeVoort et al., "Effects of Progesterone Receptor Blockers on Human Granulosa-Luteal Cell Culture Secretion of Progesterone, Estradiol, and Relaxin," 62 *Biology of Reproduction* (2000): 200-205, 200. In this article, ulipristal is referred to as "HRP-2000," Hild et al., "CDB-2914: Anti-progestational/antiglucocorticoid Profile and Post-coital Anti-fertility Activity in Rats and Rabbits," 15 *Human Reproduction* (2000): 822-829, 824; G. Teutsch and D. Philibert, "History and Perspectives of Antiprogestins from the Chemist's Point of View," 9 *Human Reproduction* (1994)(suppl 1):12-31; B. Attardi, J. Burgenson, S. Hild, and J. Reel, "In vitro Antiprogestational/Antiglucocorticoid Activity and Progestin and Glucocorticoid Receptor Binding of the Putative Metabolites and Synthetic Derivatives of CDB-2914, CDB-4124, and mifepristone," *Journal of Steroid Biochemistry and Molecular Biology* 88 (2004): 277-88.

[23] A.F. Tarantal, A.G. Hendrickx, S.A. Matlin, et. al., "Effects of Two Antiprogestins on Early Pregnancy in the Long-tailed Macaque (*Macaca fascicularis*)," 54 *Contraception* 1996: 107-15; European Medicines Agency, "CHMP Assessment Report for EllaOne," (Doc.Ref.: EMEA/261787/2009).

[24] European Medicines Agency, "CHMP Assessment Report for EllaOne," (Doc.Ref.: EMEA/261787/2009): p. 10.

[25] Harrison and Mitroka, *supra, n.20.*

[26] *Ibid.*

[27] Plan B and Ella are not the only FDA-approved contraceptive drugs or devices (e.g., IUDs) that are potentially embryocidal. However, we have focused on them because the medical evidence is most clear in these two cases that HHS's regulatory mandate includes embryo destructive items. Therefore, it is clear that the mandate will create a conflict with the moral and religious beliefs of individuals and organizations who will be forced to provide such coverage or participate in such plans.

Without a doubt the full range of FDA-approved contraceptives included in this mandate will involve a variety of drugs and devices with mechanisms of action that can destroy life rather than prevent life.

IV. Requiring Contraceptives in Health Plans Will Violate the Consciences of Millions of Americans.

Regardless of the Administration's position on the question of when life begins (*e.g.*, before or after implantation), it is not the role of the Secretary of Health and Human Services or any elected or appointed federal official to dictate what does or does not violate another person's conscience. Conscience is about choice. Insurance plan providers and participants should not be forced to engage in an action that they believe is the taking of a human life through the coverage of, and payment for, drugs they regard to be abortifacients, regardless of whether this or any Administration agrees.

This type of mandate is not popular with the American people. A poll published April 8, 2009 by the Polling Company showed that 87% of Americans believe that, generally, the conscience rights of health care professionals should be protected. More specifically, an August 4, 2011 Rasmussen poll showed that only 39% believe health insurance companies should be required to cover all government approved contraceptives for women, while 46% of respondents do not think they should be covered. Fifteen percent are undecided.[28] As the government agency implementing PPACA and its mandatory preventive care services provision, it is not the role of HHS to force Americans to participate in services that violate their essential right of conscience.

With this mandate, accompanied by its narrow exemption for certain religious employers (discussed in Section V), the Obama Administration will deny many Americans a most basic right: freedom from government interference in religious and moral matters. As a result many religious businesses or non-profit organizations, as well as Americans with insurance in the individual market, will be forced to violate their consciences on the issues they hold most profoundly. Employers will be forced to deny healthcare to their employees or violate their consciences. Individuals will be unable to purchase health plans without contraceptives and sterilization procedures.[29] Individuals will be forced to subsidize services to which they have ethical objections. The cost of such drugs and devices will be shifted from the patients to other plan participants' premiums. Individuals wanting to drop insurance coverage will be subject to PPACA's individual mandate requiring all individuals to purchase health insurance.[30]

V. The Definition of "Religious Employer" in the Proposed Exemption.

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[28] Rasmussen Reports, "Health Insurance" August 2011. (http://www.rasmussenreports.com/public_content/politics/current_events/healthcare/august_2011/39_say_health_insurance_companies_should_be_required_to_cover_contraceptives).

[29] This excludes those who are covered by "grandfathered" plans that do not cover contraceptives.

[30] PPACA, Section 1501(b) as amended by Section 10106, 124 Stat. 907 (P.L. 148-111).

The new HHS regulation purports to provide a possible exemption, depending on HRSA, for "religious employers" but in fact exempts only places of worship. To summarize, the regulation limits a "religious employer" to an organization that a) has the "inculcation of religious values as its purpose," b) primarily employs persons who share its religious tenets, c) primarily serves persons who share its religious tenets, and d) is a non-profit organization which under 26 U.S.C. §§ 6003(a)(1) and 6033(a)(3)(A)(i) or (iii) is exempt from filing annual tax returns.

This narrow exemption will not cover most religious non-profit organizations which employ people of different faiths or which provide social services to people of other faiths. Additionally, this exemption will not protect religious entities providing health care services to the poor or those who perform missionary work in the United States or abroad. It will not include religious businesses, for-profit or non-profit health care insurers, hospitals, or even many institutions of higher education. Religiously affiliated health care issuers in the individual market are not exempted and the regulation does not allow HRSA the option of considering an exemption for such employers. In short, the exemption excludes most religious employers in both markets.

Many religious employers will be forced to choose between offering health insurance for employees and violating their consciences on issues as critical as the destruction of life. In the end, conscientious employers will be forced to withdraw health benefits.

While one of the much-discussed purposes for passing PPACA was to increase "access" to health care insurance for more Americans, the contraceptive mandate ultimately will do the very opposite. Religious employers will be forced to withdraw insurance so as to not violate their consciences on issues related to life and death. It can not be denied that the issue of the sanctity of unborn life was a major obstacle to the passage of PPACA. With the promulgation of this mandate the Administration demonstrates a blatant disregard for the deeply held opinions of most Americans.

VI. The Contraceptive Mandate Violates Current Conscience Laws and PPACA's Abortion Anti-mandate Provision.

The HHS contraceptive mandate violates the spirit and, in some cases, the letter of long-standing federal conscience laws meant to protect people and groups from government discrimination in health care. In the past 35 years, Congress has passed a number of laws (notably, the Church Amendments[31] and the Hyde-Weldon Amendment[32]) related to protecting the conscience rights of healthcare workers from government discrimination with regard to abortion or any service in a federally funded or administered program.[33] These laws

[31] 42 U.S.C. § 300a-7.

[32] Hyde-Weldon is currently contained in Section 508(d) of Division D of the Consolidated Appropriations Act, 2010 (P.L. 111-117), 123 Stat. 3280 (2009) which was renewed through the Department of Defense and Full Year Continuing Appropriations Act of 2011 (P.L. 112-10).

[33] The HHS contraceptive mandate also clearly violates the principle contained in the Coats Amendment (42 U.S.C. § 238N). It also violates the conscience measure in current law governing health contracts through the Federal Employee Health Benefits Program. A provision mandating coverage of contraceptives is qualified to prevent it from applying to "religious plans," or if "the carrier for the plan objects to such coverage on the basis of religious beliefs." *See* Section 728, Division C, the Consolidated Appropriations Act, 2010 (P.L. 111-117) which was renewed through the Department of Defense and Full Year Continuing Appropriations Act of

forbid discrimination in federally funded or administered programs. The HHS contraceptive mandate extends discrimination even further by mandating insurance coverage in the private market in such a way as to violate the consciences of insurers, providers, and plan participants who have moral or religious objections.

First, the contraceptive mandate violates the principles contained in the Church Amendments. The Church Amendments offer various protections in federally funded programs against discrimination on the basis that a participant objects to abortion or other services to which they have a moral or religious objection. "Church (d)" forbids the government from discriminating against an individual who objects to any service in a program funded by HHS. It states: "No individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions."[34]

Clearly the law protects against forcing an individual to participate in any "program" or "research activity" contrary to his/her moral or religious beliefs under a program funded by the Secretary of HHS. Such protected parts of a program or activity would include the types of services included in HHS's contraceptive mandate. Church (d) might well apply to PPACA's "preventive services" mandate and the HHS contraceptive mandate regulation where a health plan is part of the state exchange program funded by HHS. However, the Church (d) provision clearly demonstrates the principle in law that the government should not require individuals to participate in health services that provide contraceptives, abortion, sterilization and other services to which individuals have moral or religious objections. The HHS contraceptive mandate openly violates this principle and may violate the letter of Church(d) as well.

Second, the contraceptive mandate violates the Hyde-Weldon Amendment by mandating the provision of contraceptive drugs that can function as abortifacients even if they are FDA-approved under the category of "emergency contraceptives." The Hyde-Weldon Amendment in current law forbids the government under the Labor, Health and Human Services Act (LHHS Act) from discriminating against an individual on the basis of objections to abortion.[35] Hyde-Weldon specifically states that the federal government, or any state or local government funded under the LHHS Act, may not subject a "health care entity" to "discrimination" on the basis that, among other things, it does not "provide coverage of....abortions." The term "health care entity" is defined to include "an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan."

The Hyde-Weldon Amendment does not even qualify that those who object to abortion do so on the basis of religious or moral grounds. It categorically prohibits government

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2011 (P.L. 112-10).

[34] 42 U.S.C. § 238N.

[35] Hyde-Weldon is currently contained in Section 508(d) of Division D of The Consolidated Appropriations Act, 2010 (P.L. 111-117), which was renewed through the Department of Defense and Full Year Continuing Appropriations Act of 2011 (P.L. 112-10).

discrimination for those who refuse, for whatever reason, to participate in or cover abortion. As discussed in Section III some drugs and devices approved as "contraceptives" and included in the HHS mandate can function as abortifacients. Therefore, the contraceptive mandate violates the Hyde-Weldon provision by requiring entities that do not cover these drugs to do so.

HHS does not need to adopt a specific view of the term "abortion" for the sake of interpreting various Federal laws regarding abortion, but it should extend protections for those who have various views on "abortion" as it relates to their conscience rights. Many believe that the use of "emergency contraceptives," such as Plan B and Ella, end the lives of embryos by preventing implantation or destroying those already implanted. As previously stated there is medical evidence that these drugs can harm an embryo by preventing implantation, and that Ella can cause an abortion after implantation. Since an induced abortion is a humanly caused interruption of pregnancy, an abortion can take place at any point after fertilization.[36]

The underlying question of the Administration's view on when life begins and, therefore, when a termination can appropriately be labeled an "abortion" is not at issue. Rather, the salient issue is whether the Obama Administration should, contrary to the Hyde/Weldon amendment, be able to discriminate against individuals who hold traditional and/or scientific opinions concerning the beginning of life differing from its own. In this context, HHS need only recognize that the reasonable subjective view of the individual or institution should govern any assessment of that individual's or institution's invocation of religious beliefs or moral convictions.[37] The contraceptive mandate, therefore, diminishes the conscience rights protected under Hyde/Weldon by assuming a narrow view of "abortion" and "pregnancy." Even with a narrow definition of abortion, the contraceptive mandate includes a drug that can function after implantation (*e.g.,* Ella). In doing so, the contraceptive mandate violates Hyde-Weldon.

In either case, the HHS contraceptive mandate clearly raises the possibility of conscience rights violations. Because employers under PPACA are required to offer health insurance with contraceptive coverage according to HHS regulations, there is no question that employers who have moral or religious objections to such services will be forced to violate their consciences or drop coverage despite penalties.[38] HHS clearly recognized the conscience conflict this mandate would generate by issuing an exemption for certain religious employers. As stated earlier, HHS chose only to protect the conscience of a tiny minority of "religious employers," rather than provide protection for the typical religious employer that exists in America.

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[36] Gacek, *supra*, n.2.

[37] The term "pregnancy" in the human subject protections, 45 C.F.R. § 46.202(f) defines pregnancy starting at implantation. However, this definition is relevant to "this subpart" only as it relates to research on fetuses and pregnant women. This definition does not apply to the term "abortion" in Hyde/Weldon or other federal statues.

[38] The employee penalties are contained in Section 1513 and 10106 of PPACA (P.L. 111-148), as amended by Section 1003 of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

Third, the contraceptive mandate violates the supposed "abortion compromise" in Section 1303, as amended, of PPACA.[39] This section contains a provision that prevents the law from being used to mandate abortion coverage. It specifically states that "nothing in this title," which includes the section authorizing preventive care services for women, "shall be construed to require a qualified health plan to provide coverage of" abortion services. It also grants the decision over coverage of abortion to the issuer of the qualified health plan. While FRC believes that PPACA allows for federal funding for abortion, and does not accept that Section 1303 maintains the long-established Hyde Amendment, this specific provision does prevent HHS from using PPACA to mandate abortion as an essential benefit. It also clearly grants the decision about abortion coverage to the insurance issuer. Since the HHS contraceptive mandate on private insurance includes drugs such as Plan B and Ella, it violates Section 1303 of PPACA.

Indeed, the HHS contraceptive mandate also violates the statement of President Barack Obama in Executive Order 13535 (EO). In his EO, President Obama states that "long standing laws to protect conscience" such as the "Church Amendment" and the "Weldon Amendment" will "remain intact." The contraceptive mandate violates the EO which references the entire Church Amendment that, as stated above, includes conscience protections for services beyond abortion. The HHS contraceptive mandate, therefore, undermines PPACA provisions with respect to abortion coverage and contradicts the EO which claims that it covers the Church Amendment and Hyde-Weldon Amendment.

VI. The Contraceptive Mandate Violates the Religious Freedom Restoration Act.

An additional question before us is whether the HHS contraceptive mandate impinges upon or burdens a person's exercise of his or her religion. In 1993, Congress enacted the Religious Freedom Restoration Act ("RFRA").[40] Under RFRA, the federal government "shall not substantially burden a person's exercise of religion even if the burden results from a rule of general applicability."[41] In order for a substantial burden on religious exercise to be permissible the government must be able to show that the law being enforced or observed is such that the government can "demonstrate that application of the burden to the person – (1) is in furtherance of a compelling government interest; and (2) is the least restrictive means of furthering that compelling government interest."[42]

The contraceptive mandate will require insurance plans to offer contraceptives and intra-uterine devices free of charge to the recipient. A number of religious faiths and denominations, the Catholic Church being the largest, have expressed moral objections to the use of such contraceptives for many decades. As extensively discussed above, some organizations and individuals believe that contraceptives are embryo destructive,[43] and some

[39] PPACA, Section 1303(b)(1)(A) as amended by Section 10104(c).

[40] 107 Stat. 1488, as amended, 42 U.S.C. § 2000bb *et seq.*

[41] 42 U.S.C. § 2000bb-1(a).

[42] 42 U.S.C. § 2000bb-1(b).

[43] Whatever one's position on contraceptives, in general, there is no denying that Ella, a drug covered by the contraceptive mandate has the capability to destroy embryonic life implanted in the uterus. As such, Ella is properly classified as an abortifacient.

also believe that even if no embryo destruction occurs contraceptives interfere with the moral integrity of sexual relations between men and women.

PPACA's contraceptive mandate will force those employers and employees with either set of beliefs or both to face a moral dilemma. Either they can purchase or participate in insurance plans that cover drugs and devices that may destroy embryonic human life or facilitate unacceptable sexual behavior, or they can decline to purchase or participate in such insurance policies. The overall point is that the contraceptive mandate will compel such employers either to violate their consciences by keeping such plans or drop coverage for their employees. In turn, that will cause employees to lose their coverage and be forced to find coverage elsewhere. Given the universality of the contraceptive mandate, individuals could be forced to refuse to obtain insurance coverage and face various penalties. Many employers who drop coverage for their employees will be forced to pay penalties under certain circumstances.

As established in RFRA and *Sherbert v. Verner*, the case that set forth the legal standard later adopted by Congress in RFRA, the contraceptive mandate places a substantial burden on the practice of religion by employers and employees.[44] In *Sherbert* the Supreme Court observed that the state's denial of benefits to the appellant in that case "derive[d] solely from the practice of her religion," and that "the pressure upon her to forego that practice [was] unmistakable."[45] The government's action "force[d] her to choose between following the precepts of her religion and forfeiting benefits, on the one hand, and abandoning one of the precepts of her religion…, on the other hand."[46] This, the court believed was tantamount to placing "the same kind of burden upon the free exercise of religion as would a fine imposed against the appellant for her Saturday worship."[47]

The HHS contraceptive mandate places a similar burden upon the free exercise rights of religious organizations and individual believers. Individuals are placed in the position either of participating in health insurance plans that cover the provision of drugs and devices that violate their consciences or dropping health insurance coverage. Religious organizations have the dilemma of either providing insurance coverage to which they object morally or not doing so and being penalized under PPACA.

Under RFRA a law or regulation that imposes a "substantial burden" on a person's free exercise of religion is only allowed when the government can demonstrate "that application of the burden" furthers "a compelling governmental interest."[48] The contraceptive mandate does not further a compelling governmental interest. It does not relate to the treatment of a serious or life-threatening disease – or, indeed, to any disease - and certainly does not involve a medical threat that is easily transmissible and could pose a widespread public health concern.

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[44] In *Sherbert*, the Court actually used the term "substantial infringement," but "substantial burden" is the commonly used term in such analysis. *Sherbert v. Verner*, 374 U.S. 398, 406 (1963)

[45] *Sherbert*, 374 U.S. at 404.

[46] *Sherbert*, 374 U.S. at 404.

[47] *Sherbert*, 374 U.S. at 404 (the appellant was a Seventh Day Adventist and attended church on Saturday not Sunday).

[48] 42 U.S.C. § 2000bb-1(b).

For example, one could imagine that a compelling governmental interest would exist for policies needed to contain the outbreak of a virulent airborne disease like the 1918 flu pandemic. However, as stated in Section I, pregnancy is not a transmissible disease. Rather, it is a normal medical condition from which serious medical complications can arise but typically do not. The Institute of Medicine's recommendations did not present a compelling governmental interest related to pregnancy prevention that can justify the burdens on religious freedom produced by this contraceptive mandate.

Next, the contraceptive mandate does not provide the "least restrictive means of furthering" the government's putative compelling interest.[49] As noted above in Section II, scientific studies have questioned the efficacy of contraceptives in improving certain medical outcomes like rates for STDs and abortion, and even for reducing the rate of unintended pregnancies. Even if the reduction of these conditions warranted urgent governmental action, the provision of contraceptives does not seem to be effective in producing desirable outcomes, and the mandatory provision of contraceptives has even less justification. It seems logical to conclude that a "narrowly tailored" policy would only employ effective means to achieve its ends.

For decades, employers and employees have been able to address the ethical concerns raised by contraceptives with minimal disruption to the provision of health care in America. The contraceptive mandate under consideration will be divisive for American society and damaging to the effective provision of health care for many religious people. Accordingly, the contraceptive mandate should be rescinded as a poorly conceived, coercive policy that violates the protections for religious freedom established in federal law by RFRA.

VII. Conclusion.

The interim final rule as published by the Administration on August 1, 2011 is an unprecedented mandate which deeply conflicts with religious and conscience freedom protections the American people currently receive. We reiterate that in a democratic society it is not the role of the Administration to dictate what does or does not violate another person's conscience on matters as critical as life and death. Family Research Council strongly opposes the contraceptive mandate for the many reasons outlined above and asks that HHS fully rescind this rule.

In the event that HHS does not rescind the contraceptive mandate, FRC asks that an adequate "religious employer" definition for exemption to this mandate be developed. As drafted, so few religious groups will be eligible for the protection from the mandate that as previously stated, most religious employers will be faced with either violating their consciences or dropping health coverage, which undermines the primary goal of the PPACA. Regarding the extreme narrowness of the exemption offered by HHS, we agree with Daniel Cardinal DiNardo who recently stated, "Jesus himself, or the Good Samaritan of his famous parable, would not qualify as 'religious enough' for the exemption, since they insisted on helping people who did not share their view of God."[50]

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[49] 42 U.S.C. § 2000bb-1(b).

Sincerely,

/s/ Jeanne Monahan
Director, Center for Human Dignity

/s/ Chris Gacek, J.D., Ph.D.

Senior Fellow for Regulatory Policy

Family Research Council
801 G Street, N.W.
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[50] "Statement for Respect Life Month," Cardinal Daniel N. DiNardo, Chairman, Committee on Pro-Life Activities United States Conference of Catholic Bishops (Sept. 26, 2011).

Ms. SCHAKOWSKY. Mr. Chairman?

Mr. PITTS. Yes?

Ms. SCHAKOWSKY. I don't know if this is an appropriate time, but I have some things I would like to submit for the record.

Mr. PITTS. All right. If you would——

Ms. SCHAKOWSKY. Thank you. This is testimony from NARAL Pro-Choice America, Center for Reproductive Rights, National Women's Law Center, ACLU, National Partnership for Women and Families, National Health Law Program, Physicians for Reproductive Choice and Health, and then a letter organized by Advocates for Youth. These have all been submitted previously and I would appreciate if they could be part of the record.

Mr. PITTS. All right. We have received these. Without objection, so ordered.

[The information follows:]

Refusal Laws: Another Front in the War on Women

Testimony Presented by

Nancy Keenan
President

On Behalf of
Illinois Choice Action Team
NARAL Pro-Choice Arizona
NARAL Pro-Choice California
NARAL Pro-Choice Colorado
NARAL Pro-Choice Connecticut
NARAL Pro-Choice Maryland
NARAL Pro-Choice Massachusetts
NARAL Pro-Choice Minnesota
NARAL Pro-Choice Missouri
NARAL Pro-Choice Montana
NARAL Pro-Choice New Hampshire
NARAL Pro-Choice New Mexico
NARAL Pro-Choice New York
NARAL Pro-Choice North Carolina
NARAL Pro-Choice Ohio
NARAL Pro-Choice Oregon
NARAL Pro-Choice South Dakota
NARAL Pro-Choice Texas
NARAL Pro-Choice Virginia
NARAL Pro-Choice Washington
NARAL Pro-Choice Wisconsin
NARAL Pro-Choice Wyoming

U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

November 2, 2011

Members of the Energy and Commerce Subcommittee on Health: I am honored to submit this testimony.

The question before the panel today is whether corporations or employers that oppose birth control should be allowed to impose those beliefs on their employees. NARAL Pro-Choice America strongly believes that all women should have access to reproductive-health care, regardless of their employer.

Family Planning is Basic Health Care for Women

Access to family planning is essential to women's health. The average woman wants only two children and will spend five years of her life pregnant or trying to get pregnant and nearly three decades trying to avoid pregnancy.[1] If a woman does not have access to contraception, she could have between 12 and 15 pregnancies, endangering her health and the health of her children.[2]

And family-planning services reduce the negative health outcomes strongly associated with unplanned pregnancy. These outcomes include delayed or inadequate prenatal care, increased fetal exposure to tobacco and alcohol, increased likelihood of low birth weight and death in the first year of life, and higher risk of abuse and failure to receive sufficient resources for healthy development.[3] When women have access to affordable family-planning services, rates of low-birth-weight births, infant deaths, and neonatal deaths considerably decrease.[4]

Yet despite contraception's many health benefits, the current U.S. family-planning "system," such as it is, is expensive, uncoordinated, and, frankly, patchwork at best. In particular, for many women, contraception is simply too expensive.[5] One in three women has struggled with the cost of prescription birth control at some point, and research shows that even small cost-sharing requirements can put contraception out of reach.[6] Consequently, the United States has a far higher unintended-pregnancy rate than other industrialized countries.[7]

Paying out of pocket for contraception can result in annual fees of more than $700.[8] Over the span of a woman's reproductive years (15-44),[9] the cost of contraception can amount to more than $20,000. Given that studies have shown a link between lack of insurance and decreased use of prescription birth control,[10] coverage is critical for promoting women's health.

Additionally, cost has an overwhelming effect on whether women are able to use contraception consistently. Financial barriers to birth control have a significant, documented effect: women who are concerned with cost are twice as likely to use less effective birth-control methods as women who do not worry about the cost.[11] Moreover, research shows that when women cannot afford highly effective contraceptive methods, such as intrauterine contraceptives (IUCs), they use methods with higher failure rates.[12]

And in our current economic climate, the situation has become more acute. A 2009 Guttmacher Institute survey found that because of the economic recession, 23 percent of women reported having trouble paying for birth control and 24 percent put off a gynecological or birth-control exam due to cost.[13] This study underscores the difficulty women face affording contraception and meeting basic health-care needs. Providing universal no-cost birth-control coverage is essential to increasing access to critical preventive-health care.

The Affordable Care Act Offers an Historic Opportunity to Expand Women's Access to Contraception

The federal health-reform law presents an unprecedented opportunity to improve women's access to comprehensive, preventive health care by ensuring the affordability of family-planning services for almost all U.S. women. In particular, Section 2713(a)(4), known as the Women's Health Amendment, removes significant financial obstacles for women seeking preventive reproductive-health care.[14]

As part of its work to implement this section of the law, in August the Obama administration accepted an Institute of Medicine panel's recommendation that family planning be considered preventive-health care. With this groundbreaking decision, newly issued insurance plans must cover the full range of Food and Drug Administration-approved contraception at no additional cost. If allowed to go into effect fully, this historic policy will represent a tremendous step forward for women's reproductive health.

Do Employers and Corporations Have Consciences?

Birth control is entirely noncontroversial. Ninety-nine percent of sexually active women have used contraception.[15] Despite this, some still attempt to block women's access to family-planning services. Their latest tactic is to try to undermine the Affordable Care Act's new family-planning benefit by claiming corporations and employers have "consciences" that override women's rights.

Make no mistake: in most cases, the debate around employer "conscience" is a proxy for opposition to birth control, one of the many fronts in the War on Women. Rep. Steve King (R-IA) took to the House floor in August in protest against the contraception benefit, claiming that preventive medicine like birth control could lead to a dying civilization.[16] In discussing whether birth control should be considered preventive care, American Life League President Judie Brown railed, "Providing free birth control may, sadly, prevent a life of a child; yet it also causes more promiscuous activity which leads to more cases of sexually transmitted disease and more opportunities for the users to experience stroke, heart attack and even death — not to mention the pill's potential effect as the silent killer of preborn children."[17] Sandy Rios, president of Family-Pac Federal, mocked the benefit: "We're $14 trillion in debt and now we're

going to cover birth control, breast pumps, counseling for abuse," she challenged. "Are we going to do pedicures and manicures as well?"[18]

These elected officials, organizations, and their allies' comments appear in the context of employer "conscience" – but their baseline position is opposition to contraception altogether. In this view, they are far out of the mainstream. And precisely because Americans correctly see birth control as noncontroversial, the public strongly opposes refusal laws. Nearly nine out of 10 Americans oppose refusal laws that allow certain institutions to refuse to provide health-care payment or services.[19] Eighty-nine percent oppose allowing insurance companies to deny coverage for medical services.[20] Eighty-six percent oppose allowing employers to exclude coverage for medical services from their employees' health plans.[21] Simply put, the public does not agree that a corporation or an employer has a "conscience" that overrules an individual's.

NARAL Pro-Choice America believes that persons have consciences, which they may exercise in an individual capacity. We do not believe that it is appropriate for institutions at large to claim a "conscience," thereby denying others medical care that is safe, legal, and medically indicated. Carefully crafted refusal laws may be appropriate in some circumstances to protect individuals. But an individual who is also an employer is in that capacity effectively acting as a corporate entity; she retains an individual right of conscience that governs her own behavior, but does not have the right to impose her views on employees.

Moreover, institutions that operate in the public sphere and serve the public should not be allowed to impose one particular religious view on the general public, including their employees. Some of the most vocal opposition to the regulation requiring contraceptive coverage comes from the Catholic Health Association. Currently, Catholic hospitals employ more than 750,000 individuals,[22] many of whom may not share the same religious beliefs as their employer. The mission of Catholic hospitals is to serve the general public; they do not limit their services strictly to adherents.[23] These institutions accept federal funds and participate in federal health-care programs. Given these facts, it would be unwarranted to allow these entities to choose which public standards with which to comply.

Finally, some claim that employers and corporations should not be forced to pay for a service they oppose on religious grounds. We live in a pluralistic society; such a claim is at least impractical, if not entirely untenable. The Church of Jesus Christ of Latter-Day Saints opposes tobacco use; may a Mormon employer deny his employees smoking-cessation benefits? Is every corporation and employer to be allowed to force its view on its employees – even if the employees do not share the same beliefs? That in essence is what those requesting a broad refusal right from contraception are demanding.

All Women Should Have Access to Family-Planning Care

A key promise of the health-care law is that women will no longer be subject to extra charges for necessary preventive care. This benefit has the potential to help millions of women and will

be one of the most impactful provisions of the Affordable Care Act. Denying benefits to large populations of women undermines one of the most important public-health goals of the Women's Health Amendment. Those who wish to block their employees' access to a full range of contraceptive services are not required to prescribe or take birth control against their beliefs, nor are they being asked to endorse it. They are free to continue opposing the use of contraception in their personal capacity. But they may not deny others their right of conscience to use birth control, should they so choose.

On behalf of NARAL Pro-Choice America and its more than one million member activists around the country, we urge the subcommittee to ensure that all women, regardless of where they work, are able to realize the full benefits of comprehensive reproductive-health care.

[1] Guttmacher Institute, *In Brief: Facts on Contraceptive Use in the United States*, June 2010, *at* http://www.guttmacher.org/pubs/fb_contr_use.html (last visited Oct. 31, 2011); Rachel Benson Gold, *The Need for and Cost of Mandating Private Insurance Coverage of Contraception*, ALAN GUTTMACHER REP. ON PUB. POL'Y, Aug. 1998, at 5; Abigail Trafford, *Viagra and the Other Sex Pill*, WASH. POST, May 19, 1998, at Z6.

[2] Abigail Trafford, *Viagra and the Other Sex Pill*, WASH. POST, May 19, 1998, at Z6.

[3] Committee on Unintended Pregnancy, Institute of Medicine, THE BEST INTENTIONS: UNINTENDED PREGNANCY AND THE WELL-BEING OF CHILDREN AND FAMILIES (Sarah S. Brown & Leon Eisenberg, eds. 1995).

[4] Guttmacher Institute, *Issues in Brief: The U.S. Family Planning Program Faces Challenges and Change, at* http://www.guttmacher.org/pubs/ib3.html (last visited Oct. 31, 2011).

[5] Guttmacher Institute, *Contraceptive Needs and Services: National and State Data, 2008 Update* (May 2010), *at* http://www.guttmacher.org/pubs/win/contraceptive-needs-2008.pdf (last visited Oct. 31, 2011).

[6] Adam Sonfield, *Contraception: An Integral Component of Preventive Care for Women*, 13 GUTTMACHER POLICY REVIEW (2010) *at* http://www.guttmacher.org/pubs/gpr/13/2/gpr130202.html (last visited Sept. 27, 2011).

[7] Lawrence B. Finer, and Mia R. Zolna, *Unintended Pregnancy in the United States: Incidence and Disparities, 2006*, CONTRACEPTION, Jul. 28 2011.

[8] Adam Sonfield, *The Case for Insurance Coverage of Contraceptive Services And Supplies Without Cost-Sharing*, 14 GUTTMACHER POLICY REVIEW (2011), *at* http://www.guttmacher.org/pubs/gpr/14/1/gpr140107.html (last visited Oct. 26, 2011).

[9] Guttmacher Institute, *In Brief: Facts on Contraceptive Use in the United States*, June 2010, *at* http://www.guttmacher.org/pubs/fb_contr_use.html (last visited Oct. 31, 2011).

[10] Adam Sonfield, *The Case for Insurance Coverage of Contraceptive Services And Supplies Without Cost-Sharing*, 14 GUTTMACHER POLICY REVIEW (2011), *at* http://www.guttmacher.org/pubs/gpr/14/1/gpr140107.html (last visited Oct. 26, 2011).

[11] Adam Sonfield, *The Case for Insurance Coverage of Contraceptive Services And Supplies Without Cost-Sharing*, 14 GUTTMACHER POLICY REVIEW (2011), *at* http://www.guttmacher.org/pubs/gpr/14/1/gpr140107.html (last visited Oct. 26, 2011).

[12] Kelly Cleland, et al., *Family Planning as a Cost-Saving Preventive Health Service*, THE NEW ENGLAND JOURNAL OF MEDICINE (2011), *at* http://healthpolicyandreform.nejm.org/?p=14266&query=TOC (last visited Sept. 27, 2011).

[13] Guttmacher Institute, *A Real Time Look at the Impact of the Recession on Women's Family Planning and Pregnancy Decisions*, (Sept. 2009), *at* http://www.guttmacher.org/pubs/RecessionFP.pdf (last visited Oct. 28, 2011).

[14] P.L. 111-148, 111th Cong. (2010) § 2713(a)(4).

[15] Rachel K. Jones and Joerg Dreweke, *Countering Conventional Wisdom: New Evidence on Religion and Contraceptive Use*, Guttmacher Institute 4 (Apr. 2011), *at* http://www.guttmacher.org/pubs/Religion-and-Contraceptive-Use.pdf (last visited Oct. 31, 2011).

[16] 157 CONG. REC. H5879 (daily ed. Aug. 2, 2011) (statement of Rep. King).

[17] Judie Brown, *Villains, Vultures, and 'Preventive Services,'"* RenewAmerica.com, *at* http://www.renewamerica.com/columns/brown/101109 (last visited Oct. 28, 2011).

[18] Tanya Somanader, *Fox 'Expert' Blasts Expanding Access To Birth Control: 'Are We Going To Do Pedicures And Manicures As Well?'*, ThinkProgress.com, Aug. 2, 2011 *at* http://thinkprogress.org/health/2011/08/02/285620/fox-expert-blasts-expanding-access-to-birth-control-are-we-going-to-do-pedicures-and-manicures-as-well/ (last visited Oct. 31, 2011).

[19] ACLU Reproductive Freedom Project, *American Civil Liberties Union (ACLU), Religious Refusals and Reproductive Rights*, at 20 (2002).

[20] ACLU Reproductive Freedom Project, *American Civil Liberties Union (ACLU), Religious Refusals and Reproductive Rights*, at 20 (2002).

[21] ACLU Reproductive Freedom Project, *American Civil Liberties Union (ACLU), Religious Refusals and Reproductive Rights*, at 20 (2002).

[22] The Catholic Health Association of the United States, *Catholic Health Care in the United States*, January 2011, *at* http://www.chausa.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=2147489259 (last visited Oct. 28, 2011).

[23] The Catholic Health Association of the United States, *Catholic Health Care in the United States*, January 2011, *at* http://www.chausa.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=2147489259 (last visited Oct. 28, 2011).

Testimony of the Center for Reproductive Rights

Hearing: Do New Health Law Mandates Threaten Conscience Rights and Access to Care?

Energy and Commerce Committee
Subcommittee on Health

November 2, 2011

The Center for Reproductive Rights respectfully submits the following testimony to the Energy and Commerce Committee's Subcommittee on Health. Since 1992, the Center for Reproductive Rights has worked toward the time when the promise of reproductive freedom is enshrined in law in the United States and throughout the world. We envision a world where every woman is free to decide whether and when to have children; where every woman has access to the best reproductive healthcare available; where every woman can exercise her choices without coercion or discrimination. More simply put, we envision a world where every woman participates with full dignity as an equal member of society.

Summary

The Majority staff's framing of this hearing, as set forth in the Internal Memorandum dated October 28, 2011, and circulated to Members of the Subcommittee on Health, is fundamentally flawed, because it only conceives of conscience rights as belonging to healthcare providers and employers. By stating that the Affordable Care Act lacks "adequate conscience rights protections," the Majority staff narrowly defines "conscience rights" to mean ***only*** the rights of the 1% who object to birth control – ignoring the fact that 99% of American women[1] – and 98% of Catholic women[2] – have used contraception.

The Memorandum presents two related, but distinct, issues: the exemption for "religious employers" from the contraceptive coverage requirements, and a bill, H.R. 1179, that would go much further and allow insurers to opt out of any of the coverage requirements contained in the Affordable Care Act. We will first briefly address the threat posed by H.R. 1179, and then develop the case against any exemption from the contraceptive coverage requirement. In sum, the religious exemption proposed by the Department of Health and Human Services is not

[1] CDC, NATIONAL SURVEY OF FAMILY GROWTH ,VITAL AND HEALTH STATISTICS, USE OF CONTRACEPTION IN THE UNITED STATES 1982-2008 (Aug. 2010) *available at* http://www.cdc.gov/nchs/data/series/sr_23/sr23_029.pdf (More than 99% of women 15-44 years of age who have ever had sexual intercourse with a male, referred to as "sexually experienced women," have used at least one contraceptive method).
[2] CDC, NATIONAL SURVEY OF FAMILY GROWTH, NATIONAL HEALTH STATISTICS REPORT, SEXUAL BEHAVIOR, SEXUAL ATTRACTION, AND SEXUAL IDENTITY IN THE UNITED STATES: DATA FROM THE 2006–2008 NATIONAL SURVEY OF FAMILY GROWTH (Mar. 3, 2011) *available at* http://www.cdc.gov/nchs/data/nhsr/nhsr036.pdf.

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required by either the Constitution or the Religious Freedom Restoration Act, and would be terrible public policy. But the proposed bill – the so-called "Respect for Rights of Conscience Act" (H.R. 1179) – is far, far worse.

I. The "Respect for Rights of Conscience Act of 2011" (H.R. 1179) is an Insurance-Refusal and Healthcare-Denial Bill that Provides No Protections for Employees or Patients

By embracing a cramped and insupportably narrowly conception of "conscience rights," the Majority staff endorses H.R. 1179 – an insurance refusal bill that would allow insurance companies, hospital administrators, and employers to impose their religious beliefs on patients and employees – without any regard for patients' and employees' consciences or beliefs. The bill would permit, for example, a Catholic-affiliated insurer to deny prenatal coverage for an out-of-wedlock pregnancy. It would permit a Latter Day Saints-affiliated employer to limit insurance benefits for gay or lesbian employees. It would permit a Baptist-affiliated hospital to refuse to treat a Jew. And it would permit a Muslim doctor to refuse to treat injuries resulting from an accident caused by alcoholic intoxication. It would, in short, give every employer the right to veto essential insurance coverage to employees; and give every hospital administrator or individual doctor the right to deny even life-saving treatments to patients in need.

The misleadingly titled "Respect for Rights of Conscience Act of 2011" (H.R. 1179) would allow healthcare administrators and corporations to cut medical benefits and services to employees and patients in the name of religion. The bill aims to strip patients of the protections of the Affordable Care Act by giving companies and hospital bureaucrats a veto over employees' healthcare benefits. The bill cynically protects the so-called "right" of insurance companies and employers to deny coverage, while doing nothing to protect the rights of patients and employees. The bill undermines every requirement within the Affordable Care Act and is an attack on the nature of insurance, which is intended to spread risk and provide enrollees with access to a basic standard of care.

The bill also fails to protect the consciences of doctors and nurses who have a conscientious duty to provide the highest quality of medical care to patients – even if doing so may contravene official Catholic dogma. The proposed bill would allow hospitals to prevent doctors from treating patients – even when necessary to save a patient's life – if doing so would contravene the hospital's official professed belief. For example, Catholic hospitals could block doctors from saving the lives of women with ectopic pregnancies if a therapeutic abortion were required. A 2008 peer-reviewed article in the *American Journal of Public Health*[3] reveals that Catholic hospitals are already preventing doctors from treating women suffering from life-threatening miscarriages and late ectopic pregnancies; this bill would give these hospitals legal cover and allow them to force doctors to stand idly by while patients die from treatable conditions.

The bill is particularly dangerous because it provides absolutely no safeguards for patient quality of care. Any policy to protect the right of conscience must be even-handed and protect the conscience rights of both those would deny and those who would provide services, and any

[3] Lori Freedman, Uta Landy, and Jody Steinauer, *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. PUBLIC HEALTH 1774 (2008).

institution that would like to make arrangements to accommodate conscience objections must ensure that patient care is not compromised in so doing. Any policy to protect the right of conscience must be even-handed and protect the conscience rights of both those would deny and those who would provide services. Conscience protections must:

- Limit religious objections to individuals – not institutions or corporations – and limit religious objections to participation in a procedure – not for pre- or post-operative care, health-insurance coverage, or prescription-drug coverage.

- Assure that providers that do want to provide care are insulated from retaliation or other harm.

- Require fully informed consent to medical procedures (or a lack thereof) on the part of patients without any delay in care.

- Require that the employee or patient be referred to another healthcare provider to ensure continuity of care, and protect the rights of doctors and other providers who want to provide care.

- Religious objections may not be invoked in emergencies in which doing so would jeopardize a patient's health or life.

These basic and minimum safeguards are essential to insure that patient care is not compromised, and that conscience provisions, in practice, preserve the right for those doctors and other providers who do want to provide care to practice medicine consistent with their own views.

Indeed, H.R. 1179 is an attack on the very nature of insurance, as it would allow insurers to deny coverage on allegedly "moral" grounds, however pre-textual these may be. This breathtakingly broad abdication of authority runs counter to the central goal of the Affordable Care Act and numerous other consumer and patient protection laws, which seek to expand coverage (and thereby increase care and diminish costs), and to set out a fundamental and basic level of access to medical care for all Americans.

For example, as with H.R. 358, the "Let Women Die" bill, H.R. 1179 could be invoked to permit the refusal of care to women facing emergency situations by allowing a claim of conscience to supersede the treatment requirements in the Emergency Medical Treatment and Active Labor Act. EMTALA today does provide basic and fundamental levels of protections. As first-hand accounts by doctors from the American Journal of Public Health survey mentioned above show, a religiously-affiliated hospital that refused to complete a miscarriage, essentially risking a woman's health, was reported for an EMTALA violation:

> Dr B, an obstetrician-gynecologist working in an academic medical center, described how a Catholic-owned hospital in her western urban area asked her to accept a patient who was already septic [suffering from infection]. When she received the request, she recommended that the physician from the Catholic-owned hospital perform a uterine aspiration there and not further risk the health of the woman by delaying her care with the

> transport. [From the doctor:] "Because the fetus was still alive, they wouldn't intervene. And she was hemorrhaging, and they called me and wanted to transport her, and I said, "It sounds like she's unstable, and it sounds like you need to take care of her there." And I was on a recorded line, I reported them as an EMTALA violation. And the physician [said], "This isn't something that we can take care of." And I [said], "Well, if I don't accept her, what are you going to do with her?" [He answered], "We'll put her on a floor [i.e., admit her to a bed in the hospital instead of keeping her in the emergency room]; we'll transfuse her as much as we can, and we'll just wait till the fetus dies."[4]

This shocking delay in care is caused by hospitals' adherence to Religious Directives from the U.S. Conference of Catholic Bishops – including those cases that clearly conflict with medical standards. The Directives require doctors to wait until the fetal heartbeat stops before completing a miscarriage, even if the pregnancy is no longer viable. In the meantime, women risk a life-threatening form of infection.

H.R. 1179 bill would allow institutions to insist on policies that deny patients care, trumping doctors' professional judgment and training. Freedman's report tells one such story: a doctor appalled at the denial of care to a woman having a miscarriage – a woman so ill that her eyes filled with blood from the infection caused by the delay – subsequently quit his job in disgust.

Nationally, one-sixth of hospital visits are to religiously affiliated hospitals. The notion that care would differ so drastically from one emergency room to another is out-of-step with public health needs and the beliefs of religious adherents, who, polls indicate, agree that medical care should not be restricted by religion.[5]

Only physicians, not institutions, have a conscience. Granting institutions a right of refusal merely guarantees that doctors who choose to provide care consistent with their own beliefs and training won't be able to do so, and thereby hurts patients. Chillingly, H.R. 1179 would ensure that hospitals' and insurers' institutional dictates, including those at odds with medical science, could override the consciences of doctors, even when those dictates risk women's lives.

For the first time, H.R. 1179, the "Insurance Refusal" bill, would extend refusal rights to insurers. For those concerned about the rights of individual doctors to refuse to provide a particular medical service, existing law already amply protects doctors, nurses, and other providers who have an objection to performing abortions, sterilizations, and related procedures. H.R. 1179 would go much further than current law, and would harm the rights and care of doctors and patients.

II. A Religious Exemption Broader than that Proposed by the Department of Health and Human Services Would Gut the No-Copay-Contraception Requirement

A. Broader Exemption Would Undermine the Preventive-Services Requirement

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[4] Id.

[5] *See, e.g.*, Belden, Russonnello, and Stewart, *Surveys of Voters in Four Congressional Districts for Catholics for Choice* (2009), *available at http://www.catholicsforchoice.org/documents/DistrictPollingExecutiveSummary.pdf.*

We next address the problematic exemption proposed by HHS to the contraceptive coverage requirements. As set forth below, no religious exemption to the no-copay-contraception requirement is required by the Constitution or the Religious Freedom Restoration Act. To the extent that there is such an exemption, it should be as narrowly drawn as possible, and apply solely to ministerial employees, rather than denying coverage to, for example, a church secretary, a parish groundskeeper, or a gentile hired by a synagogue to perform tasks on the Sabbath.[6]

Broadening the religious-exemption grounds beyond those proposed by the Department of Health and Human Services ("HHS") risks gutting the entire no-copay-contraception requirement. For example, giving religious hospitals an exemption would create a system in which exemptions swallow the rule and thus become unworkable. According to the Catholic Health Association of the United States, Catholic Hospitals account for 15.8 percent of all hospital admissions – about one out of every six patients – nationwide, and more than one-fifth of all admissions in 22 states.[7] And Catholic hospitals employ nearly 800,000 people nationwide – 532,011 full-time employees and 237,657 part-time employees.[8] Many of these employees are not themselves Catholic – regardless, 98 percent of Catholic women use contraception.[9] Extending the exemption to Catholic hospitals would make Swiss cheese out of the coverage requirement.

Extending a religious exemption to religious schools would strip more than 300,000 workers and their families of critical preventive services, including no-copay contraception.[10] Of these more than 300,000 employees, more than 150,000 work at Catholic schools.[11] But the National Catholic Education Association admits that only a tiny fraction of these Catholic school employees – 3.7 percent – are actually members of the clergy. The remaining 96.3 percent of Catholic school employees are laity – and a substantial number of them are not even Catholic.[12]

Allowing religious universities to receive an exemption would further frustrate the purpose of the preventive-services requirement. There are about 900 religiously affiliated colleges and

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[6] Observant Jews are prohibited from doing work on the Sabbath, which some interpret to include tasks such as opening doors and turning on or off lights. Orthodox synagogues often hire a non-Jew to perform these duties on the Sabbath.

[7] Catholic Health Association of the United States, *Catholic Health Care in the United States*, Jan. 2011, *available at* http://www.chausa.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=2147489259.

[8] *Id.*

[9] CENTERS FOR DISEASE CONTROL, NATIONAL SURVEY OF FAMILY GROWTH, NATIONAL HEALTH STATISTICS REPORT, SEXUAL BEHAVIOR, SEXUAL ATTRACTION, AND SEXUAL IDENTITY IN THE UNITED STATES: DATA FROM THE 2006–2008 (Mar. 3, 2011) *available at* http://www.cdc.gov/nchs/data/nhsr/nhsr036.pdf.

[10] U.S. Dep't of Education, National Center for Education Statistics, *Characteristics of Private Schools in the United States: Results from the 2009-2010 Prviate School Universe Survey*, at 7, Table 2, May 26, 2011, *available at* http://nces.ed.gov/pubsearch/pubsinfo.asp?pubid=2011339. Indeed, because the statistics indicate 314,489 full-time equivalent employees, the real number of religious-school employees, in light of the fact that some employees are part-time, is actually larger.

[11] According to the National Catholic Education Association, Catholic schools in the United States employee 151,473 "full-time equivalent professional staff." Given the number of part-time workers, and non-professional staff (such as groundskeepers and maintenance workers), the number is even greater.

[12] While schools may give a preference to Catholics, it is not a requirement for employment in most positions. *See, e.g.*, Archdiocese Chicago Catholic Schools, *Careers*, *available at* http://schools.archchicago.org/careers/elementaryschool/ ("[p]reference in hiring ***may*** be given to teachers who are Catholic...").

universities, with 1.7 million students in the United States,[13] including 244 Catholic degree-granting institutions.[14] These institutions employ tens, if not hundreds, of thousands of people – the vast majority of whom are not members of the clergy, and a substantial percentage of whom are not even Catholic. These thousands of people – plus their families – would be stripped of no-copay access to contraception if the exemption were broadened.

And, of course, there are numerous other kinds of businesses beyond charities, hospitals, schools, and universities that are affiliated with religious organizations – everything from radio[15] and television stations[16] to condominiums[17] to paintball courses.[18] These businesses, many of which operate as secular businesses, employ untold thousands of people across the nation – all of whom could be stripped of their access to no-copay contraception if the exemption were widened. Given the life-altering impact of an unintended pregnancy, even one woman's health interest should be sufficiently compelling to provide a basis for the rule.

B. The ERISA Church-Plan Exemption Policy is Not a Workable Religious Exemption

The Alliance of Catholic Health Care proposes using the church-plan exemption in the Employee Retirement Income Security Act (ERISA). Under ERISA, an organization is eligible for church-plan status if it "shares common religious bonds and convictions with that church or convention or association of churches."[19]

The ERISA church-plans exemption is vague and overly broad. It is not a workable definition. The contours of precisely which employers are eligible for church plans continues even 37 years after the exemption was created. The constitutionality of the church-plan exemption has never been decided by the Supreme Court. Despite claims to the contrary, the reason for the exemption, as a matter of legislative history, was not related to "church governance," but rather was the outcome of routine legislative horse-trading needed to enact ERISA. There are no "church governance" reasons why pension plans for religious employers should lack the kind of basic consumer and transparency protections that ERISA provides.

Moreover, notwithstanding the uncertainty about which employers are eligible, the broad church-plan language could exclude millions of women from contraceptive coverage, including many employers with virtually no connection to houses of worship, such as religiously affiliated businesses, schools, universities, broadcasters, and entertainment venues.

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[13] United States Conference of Catholic Bishops, *The Catholic Church in the United States at a Glance*, (figures through 2009) http://www.usccb.org/comm/catholic-church-statistics.shtml; Council for Christian Colleges and Universities, *About CCCU*, http://www.cccu.org/about; Lutheran Colleges, *Our Colleges* http://www.lutherancolleges.org/.

[14] Association of Catholic Colleges and Universities, *Colleges and Universities, available at* http://www.accunet.org/i4a/pages/index.cfm?pageid=3489.

[15] For example, Bonneville International, which owns more than a dozen radio stations, is owned by the Church of Latter Day Saints. http://bonneville.com.

[16] *See, e.g.*, KSL-TV Utah (NBC affiliate owned by the Church of Latter Day Saints), http://www.ksl.com/.

[17] *See* Lesley Mitchell, *Mormon Church Has Built Downtown Housing; Will People Come?*, SALT LAKE TRIBUNE, Sept. 27, 2011, *available at* http://www.sltrib.com/sltrib/news/52583204-78/creek-units-church-lake.html.csp.

[18] *See, e.g.*, Joshua's Paintball Jungle, a ministry of First Bible Baptist Church in Rochester, NY. http://jpj.fbbc.info/about.shtml.

[19] Title 26, section 414 of the Internal Revenue Code, at (e).

In light of its dubious constitutionality and unworkability, Congress has wisely been moving away from exempting church plans from federal healthcare requirements over the past fifteen years: HIPAA (1996); Newborns and Mothers Health Protection Act of 1996; Michelle's Law (coverage for certain dependent children); CHIPRA (requiring notice of certain state children's health insurance programs); the Mental Health Parity and Addition Equity Act; and, of course, the Affordable Care Act.

There is no reason for Congress to now change course and resuscitate the broken church-plan model. And for the reasons explained below, expanding the scope of the religious exemption would be terrible policy.

C. Expanding the Religious Exemption to Include Hospitals and other Religiously Affiliated Institutions is Unwarranted Under the Law and Would Be Terrible Policy

There is simply no reason for Congress to expand the already overbroad proposed exemption. First, many hospitals, even those with "religious affiliations," do not receive funding from any religious sources, or receive only very *de minimus* funding from religious sources. When St. Joseph's, the Phoenix hospital in which an abortion was performed last year, lost its Catholic designation, hospital officials indicated to news reporters that the only change in hospital practice would be related to the performance of religious services at the hospital. As ABC News reported, "[h]ospital officials insist the severing of ties with the Catholic Church will have no practical implications for health care delivery although the bishop will no longer allow mass to be said at the hospital."[20]

Such hospitals are also subject to hundreds, if not thousands, of state and federal laws regulating hospital practices, as well as to generally applicable accreditation standards. To name a few, the Medicare Conditions of Participation regulate hospital practice at the federal level, while states license facilities and grant their Certificates of Need. In addition, the Emergency Medical Treatment and Active Labor Act ("EMTALA") imposes conditions requiring emergency treatment when a patient is presented, without consideration of economic or other factors related to the characteristics of the patient. Even more importantly, a majority of employees at most institutions are likely to have no connection to the religious affiliation of the institution. The actions of hospitals and affiliated providers are also subject to generally applicable standards of medical negligence as determined by state law. In sum, hospitals, including those with religious affiliations, serve the health needs of the general public. In both function and form, these institutions perform a secular purpose for the broad and general public.

Separately incorporated social services centers, even if faith-based, are also subject to generally applicable tort standards and a host of federal and state laws and regulations, including those related to hiring practices, discrimination, hygiene and other standards. Those that serve a majority of religious adherents and employ a majority of religious adherents may qualify for the exemption; others, who do not qualify on these two grounds, are clearly serving the general public and employ members of general public who deserve to be able to avail themselves, as

[20] Dan Harris, *Bishop Strips Hospital of Catholic Status After Abortion*, ABC NEWS, Dec. 22, 2010. See http://abcnews.go.com/Health/abortion-debate-hospital-stripped-catholic-status/story?id=12455295.

they choose, of the benefits of contraceptive coverage. The lines drawn by HHS, while unnecessarily overbroad, do some service by clearly excluding institutions that are performing a secular function.

In both situations, an expansion of the exemption would also raise the specter that some institutions that lack an obvious religious function will claim the exemption for reasons unrelated to religious sentiment. To the extent that no-copay contraception is an expense for insurers, it is indisputable that employers who seek to price and obtain coverage could prefer insurance coverage within the exemption for cost reasons alone. Without a narrowly tailored exemption, it will be exceedingly difficult to patrol the boundaries of the exemption, and to ascertain whether its invocation is purely a pretext for an economic rationale.

The Bishops also claim that a failure to expand the refusal provision will result in hospital and social-services closures. Yet in California and New York, where a similar exemption is in operation, there is no evidence to suggest that religiously-affiliated institutions have closed or are offering diminished care. Indeed, some Catholic Universities, such as Loyola Marymount, apparently offer contraception despite being permitted not to by virtue of a self-insurance loophole.[21] In light of the Bishops' implied threat that a key source of charity care for low-income individuals might be at risk, it is important to note that, in fact, Catholic hospitals appear to provide less care to Medicaid patients and less charity care than hospitals under other forms of sponsorship.[22]

The implied threat of religious hospital and social-services closures also rings hollow given the broad nature of responsibilities for compliance with the requirement under the proposed rule. The religious exemption proposed by HHS does not place the burden of compliance on any particular individual within the institutions regulated. Instead, the requirement rests with the institution as a whole. It begs credulity that the hostility to insurance coverage for contraception is so uniform across healthcare institutions the size and scope of hospital systems; and this notion appears particularly dubious in light of the data regarding religious adherents' widespread use of, and support for, contraception.

D. Evidence Demonstrates Harm to Employees of Catholic Institutions from Denial of Coverage

Research interviews conducted over the past year by the Center for Reproductive Rights underscore the hardships faced by employees at Catholic hospitals from denial of insurance coverage for contraception. At one hospital in Muskegon, Michigan, Hackley Hospital, that was acquired by a Catholic health system, Trinity Health, in 2008, employees told us of their dismay and distress when, without notice, contraceptive coverage was dropped for staff members and employees of affiliated medical practices.

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[21] See Catholics for Choice, "Student Bodies: Reproductive Health Care at Catholic Universities" (2002), at 18; http://www.catholicsforchoice.org/topics/healthcare/documents/2002studentbodies.pdf; Brochure, Aetna's health care coverage for Loyola Students, at 22; http://www.aetnastudenthealth.com/schools/lmu/brochure1112.pdf.

[22] Lois Uttley & Ronnie Pawelko, *No Strings Attached: Public Funding of Religiously-Sponsored Hospitals in the United States*, (2002), at 5.

All of the former Hackley employees the Center interviewed reported that the ban had a harmful impact on themselves and their colleagues. One nurse indicated that the out-of-pocket costs of permanent contraception were prohibitive. (While costs vary by location, costs for tubal ligation generally range from $1500 to $6000.[23]) Another spoke of her difficult situation and the stress on her relationship:

> We are just praying I don't get pregnant until we can figure out how to get something. My doctor is Mercy-employed and he doesn't have samples. ... I got pregnant twice on birth control. One was the Nuva Ring, the second was the minipill when my baby was 4 and a half months old. I'm an OB nurse, so I know how to use birth control. Some patients like me need some form of permanent birth control. ... My third pregnancy I lost twins. ... I can't go through more. It's taken a toll on my marriage.

Intra-uterine devices (IUDs) were also unaffordable for the employees we interviewed. In response, some nurses paid up to $40 per month for birth control pills or made a special trip to obtain them more cheaply elsewhere. Some hospital employees initially sought sliding scale services at the local Title X clinic, which closed in 2009.

Even employees who had a history of pregnancy complications, high-risk pregnancies or a history of contraceptive failure could not obtain insurance coverage for contraception following the merger at Hackley Hospital. Moreover, medical conditions for which the use of oral contraceptives are recommended went untreated: One nurse had endometriosis, a medical indication for birth control pills, but still had to pay out-of-pocket for her pills.

Every hospital employee we interviewed in this setting condemned the lack of coverage as an unwelcome intrusion by their new employer into a private healthcare decision. One employee noted, "All these other insurances [sic] paid for it. ... If I have health insurance, I should get birth control. ... Why should I have to follow what they believe?"

III. The No-Copay-Contraception Requirement Does Not Violate the Constitution, Nor Is a Religious Exemption Required

The Constitution does not require a religious exemption.[24] Statements suggesting otherwise – such as those of Bishop William E. Lori on behalf of the United States Conference of Catholic Bishops (the "Bishops"), as well as the Bishops' comments to HHS[25] – are based upon a flawed understanding of both First Amendment and RFRA jurisprudence.

A. The Constitution Permits Neutral, Generally Applicable Laws that May Burden Religious Exercise

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[23] YourContraception.com, *Tubal Ligation*, *available at* http://www.yourcontraception.com/birth-control-methods/tubal-ligation/tubal-ligation.html.

[24] We note that the HHS's justification for its proposed religious exemption is ***not*** grounded in either the Constitution or RFRA. Instead, HHS proposed the religious exemption as an attempted "accommodation" of the "religious beliefs of certain religious employers." 76 Fed. Reg. at 46623. We agree with HHS's determination that nothing in the Constitution or federal law compels an exemption from the no-copay-contraception requirement.

[25] Comments of the U.S. Conference of Catholic Bishops, Interim Final Rules on Preventive Services (CMS-9992-IFC2) (submitted Aug. 31, 2011) ("Bishops' Comments").

The Supreme Court has made it clear that neutral, generally applicable laws do not violate the Free Exercise Clause of the First Amendment, even if they burden the exercise of religion. In *Employment Division, Department of Human Resources of Oregon v. Smith*, the Supreme Court rejected a challenge to a statute that denied unemployment benefits to drug users, including Native Americans who consumed sacramental peyote.[26] Writing for the Court, Justice Scalia explained that under the Constitution,[27] a neutral law of general applicability that happens to burden one's religious practice does not violate the Free Exercise Clause of the First Amendment: "[t]he government's ability...to carry out...aspects of public policy, 'cannot depend on measuring the effects of a governmental action on a religious objector's spiritual development.'"[28] The alternative, according to the Court, was to permit every religious objector to "become a law unto himself"[29] – a result which "contradicts both constitutional tradition and common sense."[30]

The *Employment Division* decision demonstrates that the Constitution permits the enactment of neutral laws that burden religion; it also makes it clear that no exemption or opt-out provision is required. As Justice Scalia wrote, the fact that a religious exemption "is permitted, or even that it is desirable, is not to say that it is constitutionally required..."[31] In other words, with respect to the Constitution, the question is not whether a religious exemption is required; it is whether a religious exemption is sensible.[32] For the reasons set forth in this testimony, a religious exemption to the no-copay-contraception requirement is not "desirable."

B. The No-Copay-Contraception Requirement is Neutral and Therefore Constitutional

After *Employment Division*, the only laws that remain constitutionally suspect are those based on anti-religious animus. According to the Court, laws targeting "acts or abstentions ***only*** when they are engaged in for religious reasons, or ***only*** because of the religious belief that they display" would be presumptively unconstitutional.[33] Short of such animus, however, "neutral law[s] of general applicability"[34] are consonant with the First Amendment, regardless of the fact that they might burden individuals' religious exercise.

The no-copay-contraception Requirement is a neutral rule that is part of a comprehensive effort to ensure that important preventive services for women are available and affordable. The critical role that contraception plays in preventing unintended pregnancy and promoting healthy birth spacing was articulated in the Institute of Medicine's comprehensive report, *Clinical Preventive Services for Women: Closing the Gaps*. And as the IOM report noted, "[n]umerous

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[26] 494 U.S. 872 (1990) (abrogated by statute).
[27] As examined below, Congress subsequently created a ***statutory*** – not constitutional – obligation for government to justify any substantial burden on religious exercise by demonstrating a compelling state interest. *See* Religious Freedom Restoration Act, 42 U.S.C. § 2000bb *et seq.*
[28] 494 U.S. at 885 (citation omitted).
[29] *Id.* at 885 (citation omitted).
[30] *Id.* at 885.
[31] *Id.* at 890.
[32] *Id.* at 890.
[33] *Employment Division*, 494 U.S. 872, at 877 (emphasis added).
[34] *Id.* at 879.

health care professional associations...recommend the use of family planning services as part of preventive care for women," as described above.

Nonetheless, comments submitted to HHS by the United States Conference of Catholic Bishops allege that the IOM's recommendation is nothing more than a "'religious gerrymander' that targets Catholicism for special disfavor *sub silentio*." This wholly unsupported allegation is absurd on its face, and it should be dismissed out-of-hand. There is not a shred of evidence to suggest that the Institute of Medicine's recommendations were based on anti-Catholic or anti-religious animus. This unsupported and unsupportable claim is an insult to the countless doctors, researchers, and public-health experts who contributed to the IOM's conclusions and the rigorous scholarship upon which they rest.

To bolster its outlandish claim, the Bishops' comment compares the no-copay-contraception requirement to a statute outlawing animal sacrifice, the subject of the Supreme Court's decision in *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*.[35] In that case, the City of Hialeah promulgated a thinly veiled ordinance designed to prohibit members of the Santeria religion from practicing the ritual slaughter of animals. The ordinance was preceded by various animus-driven resolutions, such as one condemning "any and all religious groups which are inconsistent with public morals, peace or safety;" another resolution noted "great concern regarding the possibility of public ritualistic animal sacrifices."[36] In light of these resolutions targeting Santeria religious rituals, and a number of other facts, the Court had no trouble determining that "suppression of the central element of the Santeria worship service was the object of the ordinances," and on that basis held that the ordinance was unconstitutional under the Free Exercise Clause.

In contrast, the Bishops provide no proof whatsoever that the IOM panel was motivated by an anti-Catholic or anti-religious bias. Instead, the Bishops claim that the no-copay-contraception requirement "implicitly" targets Catholicism "by imposing burdens on conscience that are well known to fall almost entirely on observant Catholics."[37] But *Employment Division* and *Church of the Lukumi* stand for the proposition that a party seeking to challenge a government action that burdens religious exercise must demonstrate that the law is not neutral. Merely saying that it is not neutral is not sufficient. And unlike in the case of the ordinance in *Church of the Lukumi* that plainly targeted Santeria practitioners, there is no evidence that the IOM intended to discriminate against Catholics, nor is there a history of actions by the IOM or HHS that demonstrate anti-religious or anti-Catholic animus.

Indeed, IOM took testimony from all members of the public wishing to present it, including representatives of religious organizations, who testified both in support of, and in opposition to, a requirement for contraception. HHS, in adopting the IOM's recommendations, has provided an unprompted (and, we believe, unnecessary) exemption from the requirement for religious employers, and solicited further comment on the rulemaking, thus inviting submissions regarding the views of religious institutions. Moreover, the legislative history on the Women's Health

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[35] 508 U.S. 520 (1993).
[36] *Id.* at 526, 527.
[37] *Comments of the United States Conference of Catholic Bishops*, Interim Final Rules on Preventive Services, CMS-9992-IFC2, Aug. 31, 2011, at 8.

Amendment is replete with information regarding the financial challenges women face in accessing preventive health services. Nothing in the record suggests even the slightest animus towards religious institutions. In sum, every decision maker, at every stage of the process, has acted with nothing less than civility and solicitude to produce an open and accountable process for decisions. Instead of targeting religious institutions, the IOM and HHS have consistently engaged religious institutions and sought out their views.

In addition, we note that this rule also would fail to affect Catholics in a manner that is any different than the manner in which it affects the general population, underscoring the lack of animus towards religious practice or believers. Like everyone else, those religious adherents who decline to benefit from no-copay contraceptive coverage need not use it. Yet for the 98 percent of Catholic women who use contraception at essentially the same rate as the general population, the benefit will serve their interests as it does those of everyone.[38] Because it will actually provide a benefit to, rather than harm, an overwhelming majority of Catholics, the Bishops' argument that the law demonstrates an anti-Catholic animus must fail.

IV. The No-Copay-Contraception Requirement Does Not Violate the Religious Freedom Restoration Act, Nor is a Religious Exemption Required

The Supreme Court has not vacillated on its understanding of the Free Exercise Clause, and it is clear that under the Constitution, the no-copay-contraception requirement is a permissible exercise of governmental authority. For its part, Congress responded to the *Employment Division* decision by enacting the Religious Freedom Restoration Act (42 U.S.C. § 2000bb-1 *et seq.*) ("RFRA"). RFRA explicitly reinstated the compelling-interest test for laws that burden religious exercise – the same test rejected in *Employment Division*.[39] Under RFRA, where the federal government[40] seeks to "substantially burden" a person's exercise of religion, it must demonstrate that the application of the burden to the person—

(1) is in furtherance of a compelling governmental interest; and

(2) is the least restrictive means of furthering that compelling governmental interest.[41]

RFRA applies to all federal law and the implementation of that law, unless the law "explicitly excludes such application."[42]

The no-copay-contraception requirement – even without a religious exemption – does not violate RFRA. First, the burden upon religious exercise is not "substantial," as required by the statute. And second, even if the burden were substantial, the government has sufficiently demonstrated a compelling interest in ensuring access to no-copay contraception, and has shown

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[38] CENTERS FOR DISEASE CONTROL, NATIONAL SURVEY OF FAMILY GROWTH, NATIONAL HEALTH STATISTICS REPORT, SEXUAL BEHAVIOR, SEXUAL ATTRACTION, AND SEXUAL IDENTITY IN THE UNITED STATES: DATA FROM THE 2006–2008 (Mar. 3, 2011) *available at* http://www.cdc.gov/nchs/data/nhsr/nhsr036.pdf.

[39] 42 U.S.C. § 2000bb(b)(1).

[40] RFRA was originally applicable to the States as well as the federal government. However, in *City of Boerne v. Flores*, 521 U.S. 507 (1997), the Supreme Court held that Congress lacked the statutory authority to apply RFRA to the States. It remains applicable to the federal government.

[41] 42 U.S.C. § 2000bb-1(b).

[42] 42 U.S.C. § 2000bb-3(b).

that a no-copay-contraception requirement is the least restrictive means of accomplishing that compelling goal.

A. The Religious Freedom Restoration Act's Compelling-Interest Test is Inapplicable Because the No-Copay-Contraception Requirement Does Not "Substantially Burden" the "Exercise" of Religion

1. Providing Preventive Health Services Without Cost Sharing Has Nothing to Do With the "Exercise" of Religion

RFRA's compelling-state-interest test only applies where the underlying government action places a substantial burden upon a person's "exercise" of religion. RFRA's "definition" of the term, "exercise of religion," is entirely unhelpful; it defines the "exercise of religion" as "any exercise of religion, whether or not compelled by, or central to, a system of religious belief."[43] The Supreme Court, however, has held that the "exercise of religion" "often involves not only belief and profession ***but the performance of...physical acts*** [such as] assembling with others for a worship service [or] participating in sacramental use of bread and wine..."[44]

The Bishops make no claim that unprotected sexual activity is central to, or even a part of, their worship or religious practice. In fact, health needs addressed by the requirement have no relation to any recognized religious practice, and therefore the Bishops' statements of their disapproval of contraception constitutes part of their religious beliefs, rather than an exercise of religion.

The Bishops are also unable to point to any case in which the refusal to provide insurance coverage – even on religious grounds – was considered to be a religious exercise, and, as described below, several State supreme courts have upheld similar contraceptive-coverage requirements over objections by religious organizations on similar grounds.[45]

The belief/exercise distinction is of paramount importance to the courts. And, indeed, virtually all cases upholding RFRA-based challenges have focused on the practice of religious worship, rather than abstract beliefs. The Supreme Court, for example, in *Gonzales v. O Centro Espirita Beneficiente Uniao do Vegetal*,[46] upheld a RFRA-based challenge to the Controlled Substances Act, which prohibited members of a religious sect from imbibing *hoasca*, an hallucinogenic tea – a "central" part of the sect's communion ritual. The lower courts have similarly focused on religious rituals when determining whether a practice constitutes a "religious exercise."[47]

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[43] 42 U.S.C. § 2000cc-5(7). RFRA's definition of "exercise of religion" is the same as "religious exercise" in the Protection of Religious Exercise in Land Use and by Institutionalized Persons Act (RLUIPA), 42 U.S.C. § 2000cc *et seq.*

[44] *Cutter v. Wilkinson*, 544 U.S. 709 (2005) (quoting *Employment Division*, 494 U.S. at 877) (emphasis added).

[45] *Catholic Charities of the Diocese of Albany v. Serio*, 859 N.E.2d 459 (N.Y. 2006); *Catholic Charities of Sacramento, Inc. v. Superior Court*, 85 P.3d 67 (Cal. 2004).

[46] 546 U.S. 418 (2006).

[47] *See, e.g., Van Wyhe v. Reisch*, 581 F.3d 639 (8th Cir. 2009) (inmate deprived of the use of sukkah, a mandatory part of the Jewish "Sukkot" festival made a threshold showing of a burden upon "religious exercise"); *Rouser v. White*, 630 F. Supp. 2d 1165 (E.D. Cal. 2009) (prison's failure to hire a chaplain to attend to Wiccans' religious

What the Bishops seek is to deny access to needed health services in an effort to coerce employees into kowtowing to church dogma. While religious employers may urge and cajole others to obey religious proscriptions on sexual activity, they may not withhold needed health services from their employees to enforce their will. The very notion that the Bishops would hold their employees' health hostage flies in the face of the very definition of sexual health used by the Centers for Disease Control and the World Health Organization:

> *Sexual health* is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, ***free of coercion***, discrimination and violence.[48]

Moreover, it is clear that the mere availability of a benefit does no violence to their beliefs. Should the Bishops' arguments related to the undesirability of using contraception be accepted, those who accept them will not use the benefit. But those 98 percent of Catholics who use contraception should be entitled to make that choice for themselves, as a matter of their own beliefs and health.

For this reason, it is critical that HHS not permit an exemption that would allow the Bishops or others to deny coverage for needed health services in an attempt to coerce behavior utterly unrelated to religious practice.

2. Even if the No-Copay-Contraception Requirement Imposes a Burden on Religious Exercise, that Burden is Not "Substantial"

RFRA imposes no restrictions whatsoever on government actions that burden religious exercise. Rather, it subjects government action to a "compelling interest" test ***only*** if the burden upon religious exercise is "substantial."[49] Even assuming, *arguendo*, that the no-copay-contraception requirement did burden "religious exercise," the burden would be *de minimus*, or at most insubstantial.

Religious employers (as well as non-religious ones) already cover health services to which they may, in principle, object. For example, existing Catholic employers' health insurance plans may cover maternity care for unwed mothers or HIV tests without regard to sexual orientation; existing Latter Day Saints employers' insurance may cover emergency services for injuries that happen to have been caused by reckless, alcohol-fueled behavior.

In their comments to HHS, the Bishops attempt to bolster their claim that the religious-exercise burden is "substantial" by claiming that the no-copay-contraception requirement

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needs constituted a burden upon the exercise of religion); *Henderson v. Ayers*, 476 F. Supp. 2d 1168 (C.D. Cal. 2007) (inmate prohibited from attending Friday Islamic prayer services stated a claim that his exercise of religion had been burdened).

[48] Centers for Disease Control, *Sexual Health*, *available at* http://www.cdc.gov/sexualhealth (emphasis added).

[49] RFRA, 42 U.S.C. § 2000bb-1.

interferes with church governance; that it compels speech; and that it compels unwanted association. Each of these three claims rings hollow.

a. The No-Copay-Contraception Requirement Does Not Interfere With Church Governance

The no-copay-contraception requirement does not interfere with church governance. The Bishops, in their comments, quote the Supreme Court's decision in *Kedroff v. St. Nicholas Cathedral* for the proposition that churches can "decide for themselves, free from state interference, matters of church government as well as those of faith and doctrine."[50] As a preliminary matter, *Kedroff* concerned an intra-church dispute within the Russian Orthodox Church between those deferring to the head of the American branch and the Moscow-based church hierarchy. The dictum cited by the Bishops stands for the proposition that government should not weigh in on intra-church disputes, and is wholly irrelevant to the instant matter: promulgation of a neutral, generally applicable policy that affects all employers – whether secular or religious – equally.

Moreover, the Bishops only selectively quote the *Kedroff* decision. The very next sentence following the quotation above makes it even more obvious that the Court's admonition that government not interfere with church governance was strictly limited to ***internal*** church policies: "Freedom to select the clergy, where no improper methods of choice are proven, we think, must now be said to have federal constitutional protection as a part of the free exercise of religion against state interference." Indeed, the notion that government should not interfere in the inner workings of religious institutions is obvious and non-controversial. Thus, for example, courts presumptively avoid wading into religiously motivated hiring decisions: "it would surely be unconstitutional under the First Amendment to order the Catholic Church to reinstate, for example, a priest whose employment the Church had terminated on account of his excommunication based on a violation of core Catholic doctrine."[51]

Here, however, the proposed HHS rule is a neutral and generally applicable policy that requires all employers, including all religiously affiliated employers, to offer insurance coverage for certain preventive services, including contraception. There is no governmental intrusion upon the internal doctrinal workings of the church. The government is not mandating that women be ordained as priests. It is not determining the proper relationship between cardinals and bishops. In short, the no-copay-contraception requirement has nothing to do with church governance.

[50] 344 U.S. 94, 116 (1952).
[51] *Rweyemamu v. Cote*, 520 F.3d 198, 205 (2d Cir. 2008).

b. The No-Copay-Contraception Requirement Does Not Compel Speech

The Bishops also contend that the no-copay-contraception requirement compels speech. The gist of this claim is that by requiring religious employers to cover contraception without cost sharing, the religious employers are being forced to communicate a pro-contraception message in violation of their beliefs. This argument is not credible, because nothing in the no-copay-contraception requirement requires the Catholic Church – or any religious institution – to articulate its support for the government policy. It must simply obey the law and provide the coverage. At the same time, religious institutions are free to speak out against contraception; priests may inveigh against birth control in sermons; churches may publish anti-contraception broadsides. They may even indicate to one and all that the extension of coverage for contraception is not the organization's choice, but the result of a government requirement.

The limited instances where the courts have found unconstitutional compelled speech are cases in which the speaker was forced to make a particular statement of belief. For example, the Supreme Court struck down as unconstitutional a law requiring motorists to display the motto, "Live Free or Die," on license plates.[52] Similarly, the state may not compel students to salute the flag or recite the Pledge of Allegiance.[53] But as the California Supreme Court held, "Catholic [organizations'] compliance with a law regulating health care benefits is not speech."[54] Indeed, the very idea that mere compliance with a law is compelled speech is absurd on its face. Thus, for example, a court dismissed as "ludicrous" a motorcyclist's claim that a compulsory-helmet law compelled speech in support of the law.[55]

c. The No-Copay-Contraception Requirement Does Not Force Believers to Associate

The no-copay-contraception requirement does not violate religious organizations' freedom of association. The Bishops claim that including no-cost-sharing contraceptive coverage violates their "freedom of expressive association." For support, they cite two cases in which groups were permitted to exclude ***individuals*** from their midst: a gay scoutmaster in the case of the Boy Scouts,[56] and a gay and lesbian group in the case of the St. Patrick's Day parade.[57] The Bishops try to analogize paying for an insurance benefit they disapprove of to being forced to include an unwanted individual in a group.

Here, there is no unwanted association whatsoever. The law is not forcing the Bishops to allow atheists to become members, or to allow women to become ordained priests. Instead, the no-copay-contraception requirement merely requires religious employers to offer coverage to all employees already part of the organization or hired in the normal course of business. Because there is no forced association, the Bishops' claim must be rejected.[58]

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[52] *Wooley v. Maynard*, 430 U.S. 705 (1977).
[53] *Board of Educ. v. Barnette*, 319 U.S. 624 (1943).
[54] *Catholic Charities of Sacramento, Inc. v. Superior Court*, 85 P.3d 67 (Cal. 2004).
[55] *Buhl v. Hannigan*, 16 Cal. App. 4th 1612, 1226 n. 11 (1993).
[56] *Boy Scouts of Am. v. Dale*, 530 U.S. 640 (2000).
[57] *Hurley v. Irish-American Gay, Lesbian & Bisexual Group*, 515 U.S. 557 (1995).
[58] In addition, the Bishops' comments conveniently ignore the Supreme Court's most recent case about religion and expressive association – *Christian Legal Society Chapter of the University of California, Hastings College of the*

B. The No-Copay-Contraception Requirement Furthers a Compelling Governmental Interest and Is the Least Restrictive Means of Furthering that Compelling Interest

Under RFRA, the government is permitted to substantially burden a person's exercise of religion if: (1) it is in furtherance of a compelling governmental interest; and (2) if the burden being challenged is the least restrictive means of furthering that compelling governmental interest.[59] Even if the no-copay-contraception requirement substantially burdened religious exercise – which it does not – it would still be a permissible governmental exercise of power under RFRA.

1. The No-Copay-Contraception Requirement Furthers a Compelling Governmental Interest

The no-copay-contraception requirement is permissible under RFRA because it furthers a compelling governmental interest in women's health; in children's health; in women's equality; in women's autonomy; and in the health and wellbeing of third parties. In other words, religious employers seek a religious exemption that would adversely affect a host of other actors – women, children, and the families of those employed by religious organizations. The Bishops thus seek a religious exemption from a neutral law at the expense of third parties. But as the court observed in the California decision upholding a similar contraceptive-coverage requirement, "[w]e are unaware of any decision in which...the United States Supreme Court...has exempted a religious objector from the operation of a neutral, generally applicable law despite the recognition that the requested exemption would detrimentally affect the rights of third parties."[60]

a. The No-Copay-Contraception Requirement Furthers the Government's Compelling Interest in Women's Health

It ought to be axiomatic to state that the government has a compelling interest in the health of its people, including women. For example, in *Planned Parenthood v. Casey*, the Supreme Court held that while the state has an interest in protecting post-viability fetal life, even that interest must give way to the more compelling interest in protecting a woman's health.[61] Similarly, the Court struck down a law prohibiting so-called "partial birth abortions" as unconstitutional precisely because of the lack of "any exception 'for the preservation of the...health of the mother."[62]

Law v. Martinez, 130 S.Ct. 2971 (2010). In that case, the Court held that a religious law-school club can be required to admit all-comers pursuant to a neutral, non-discrimination policy. There is no expressive association at stake with regard to the no-copay-contraception requirement; if there were, it would be pursuant to a neutral, generally applicable policy (all employers must offer no-copay contraception), and thus be governed by *Martinez* rather than *Dale* or *Hurley*, neither of which involved the application of a neutral, non-discriminatory policy.

[59] RFRA, 42 U.S.C. § 2000bb-1(b)(1)-(2).

[60] *Catholic Charities of Sacramento v. Superior Court*, 85 P.3d 67, 93 (2004).

[61] 505 U.S. 833, 846 (1992) (plurality opinion).

[62] *Stenberg v. Carhart*, 530 U.S. 914, 930 (citation omitted). While the Supreme Court subsequently upheld a federal prohibition on so-called "partial birth abortions," it do so on the basis of congressional findings – to which the Court

These cases, and others, "unequivocally express the Supreme Court's view as to the state's compelling interest in preserving women's health."[63] And the fact that the Bishops and other religious objectors seek special treatment at the expense of women only strengthens the government's interest. The California Supreme Court, for example, in reviewing claims regarding a similar law held, "[s]trongly enhancing the state's interest is the circumstance that any exemption from the [contraceptive-coverage requirement] sacrifices the affected women's interest in receiving equitable treatment with respect to health benefits."[64]

The IOM panel fully explained why access to a full range of FDA-approved contraceptives is essential for women's health. In particular, women without access to safe and affordable contraceptives are more likely to experience unintended pregnancies, leading to a host of health-related complications. Reducing the numbers of pregnant women who suffer from health complications is a critically important state interest: the "United States Supreme Court has recognized that the state has a compelling interest in preserving the health of expectant mothers."[65]

b. The No-Copay-Contraception Requirement Furthers the Government's Compelling Interest in Improving Children's Health

In addition, the IOM panel catalogued the numerous health problems that affect the development of children that result from unintended or improperly spaced pregnancies when those pregnancies are taken to term. Such children can experience low birth weight and developmental difficulties. It is obvious that the state has a compelling interest in ensuring the health of the nation's children, as the Supreme Court has stated directly: "[s]afeguarding the physical and psychological well-being of a minor...is a compelling [interest]."[66]

c. The No-Copay-Contraception Requirement Furthers the Government's Compelling Interest in Combating Sex-Based Inequality

While promoting women's health was a primary motivation behind the no-copay-contraception requirement, it was also designed to help eliminate sex-based inequalities in the healthcare system – namely, the fact that women significantly outspend men on healthcare-related services, in significant part due to costs associated with contraception and unintended pregnancies. And Congress has recognized that discrimination against women based on "pregnancy, child-birth, or related medical conditions" constitutes discrimination on the basis of sex.[67]

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deferred – that the procedure was "never medically necessary" to protect a woman's health. *Gonzales v. Carhart*, 550 U.S. 124, 141 (2007).

[63] *Simat Corp. v. Arizona Health Care Cost Containment Sys.*, 56 P.3d 28, 35 (Ariz. 2002).

[64] *Catholic Charities of Sacramento*, 85 P.3d at 93.

[65] *Simat*, 56 P.3d at 33-34.

[66] *Globe Newspaper Co. v. Superior Court for Norfolk Cty.*, 457 U.S. 596, 607 (1982), *quoted in PJ ex rel. Jensen v. Wagner*, 603 F.3d 1182, 1198 (10th Cir. 2010) (holding that "states have a compelling interest in and a solemn duty to protect the lives and health of the children within their borders.").

[67] Pregnancy Discrimination Act, 42 U.S.C. § 2000e(k).

Not surprisingly, the Women's Health Amendment, which added no-copay coverage of preventive services for women, was motivated by a desire to eliminate sex-based inequalities in healthcare spending. Senator Barbara Mikulski, the driving force behind the Women's Health Amendment, emphasized that "[w]omen of childbearing age incur 68 percent more out of pocket health care costs than men," and stated that "We [women] face gender discrimination."[68]

Consequently, the elimination of sex-based discrepancies is a compelling state interest. For example, in *Catholic Charities of Sacramento v. Superior Court*, the California Supreme Court held that a contraceptive-coverage statute "serves the compelling state interest of eliminating gender discrimination."[69] The discrimination the court referred to was the same fact pointed to by Senator Mikulski: "women during their reproductive years spent as much as 68 percent more than men in out-of-pocket health care costs, due in part to the cost of prescription contraceptives and the various costs of unintended pregnancies, including health risks, premature deliveries and increased neonatal care."[70] The no-copay-contraception requirement was thus designed to address the state's compelling interest in eliminating the discriminatory impact of sex-based healthcare-spending inequalities.

d. The Government Has a Compelling Interest in Promoting Women's Autonomy

Access to affordable contraception is essential – unlike almost any other health service – in ensuring individuals' independence and autonomy. The Supreme Court has long held, for example, that laws prohibiting the use of contraceptives are an unconstitutional violation of the right to privacy.[71] In so doing, the Court held that, "[i]f the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."[72]

Because, by virtue of biology, only women can become pregnant, the importance of contraceptive access to women is particularly compelling. As Justice O'Connor explained, "[t]he ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives."[73] Other courts have similarly noted the important role contraception plays in assuring women's equal participation as citizens: "the adverse economic and social consequences of unintended pregnancies fall most harshly on women and interfere with their choice to participate fully and equally in the 'marketplace and the world of ideas.'"[74] Consequently, the law recognizes women's special need for access to contraception: "the law is no longer blind to the fact that only women can get pregnant, bear

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[68] Senator Barbara Mikulski, Press Release: *Mikulski Puts Women First in Health Care Debate* (Nov. 30, 2009), *available at* http://mikulski.senate.gov/media/pressrelease/11-30-2009-2.cfm.
[69] *See Catholic Charities of Sacramento v. Superior Court*, 85 P.3d 67, 92 (Cal. 2004).
[70] *Id.* at 92.
[71] *See, e.g., Griswold v. Connecticut*, 381 U.S. 479 (1965) (law prohibiting the use of contraceptives violates married couple's right to privacy); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (law prohibiting the distribution of contraceptives to unmarried people violates the right to privacy).
[72] *Eisenstadt*, 405 U.S. at 453.
[73] *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 856 (1992).
[74] *Erickson v. Bartell Drug Co.*, 141 F.Supp.2d 1266, 1273 (W.D. Wash. 2001).

children, or use prescription contraception. The special or increased healthcare needs associated with a woman's unique sex-based characteristics must be met to the same extent, and on the same terms, as other healthcare needs."[75]

Under RFRA, the government must demonstrate a compelling interest to justify a substantial burden of religious exercise. But with respect to contraception, that burden is effectively neutralized, because the government would be required to simultaneously demonstrate a compelling interest ***in limiting access to contraception***. The Supreme Court has held that "[r]egulations imposing a burden on a decision as fundamental as whether to bear or beget a child may be justified only by compelling state interests, and must be narrowly drawn to express only those interests."[76]

As part of any consideration of broadening the exemption, the government must also weigh the resulting incursion on women's fundamental reproductive rights. Because "the Constitution places limits on a State's right to interfere with a person's most basic decisions about family and parenthood," and preserves the autonomy of decision making concerning the "private realm of family life which the state cannot enter,"[77] these interests are also acute. Only a rule preserving freedom of a choice of contraceptive and the accompanying insurance coverage fully respects the rights to privacy and decisional autonomy at the heart of this constitutional sphere.

Indeed, we have amply demonstrated that the choice of health-plan coverage is ancillary to any reasonable definition of religious exercise, whereas access to contraception is a constitutionally protected right. The government cannot and should not allow third parties to interpose themselves and thereby interfere with employees' access to affordable contraception.

e. The No-Copay-Contraception Requirement Furthers the Government's Compelling Interest in Protecting the Interests of Third Parties

The no-copay-contraception requirement, in addition to promoting women's and children's health and women's equality, also protects others. Pregnancy is a unique condition because it impacts other people – spouses and domestic partners, other children, and extended families. An unintended pregnancy affects the woman, her partner, and often her family in a qualitatively different way than other kinds of medical conditions. Consequently, any determination of the relevant state interest in the no-copay-contraception requirement must take into account not only the interests of women and children, but also of the women's partners and families.

2. The No-Copay-Contraception Requirement is the Least Restrictive Means of Furthering the Government's Compelling Interest

Not only does the no-copay-contraception requirement serve a compelling government interest; it is also the least restrictive means of furthering that interest. The system of ensuring

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[75] *Id.* at 1271.

[76] *Carey v. Population Services Int'l*, 431 U.S. 678, 686 (1977). *See also Casey*, 505 U.S. at 851 ("Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education"), *quoting Carey*, 431 U.S. at 685.

[77] *Casey*, 505 U.S. at 852 (*quoting Prince v. Massachusetts*, 321 U.S. 158 (1944)).

coverage for preventive services for women is an essential part of the Affordable Care Act. As Senator Mikulski noted, "[a]ccess to preventive health care is essential for improving the health of our nation and bringing our health care costs back under control."[78] This "essential" element of the Affordable Care Act cannot function if every religious objector is permitted to opt out of parts of the system: "[i]nsurance would basically become unworkable if everyone got a veto over what services any other member of the insurance pool could use."[79]

In *United States v. Lee*, the Supreme Court denied a religious exemption to the social-security system, reasoning that "it would be difficult to accommodate the comprehensive social security system with myriad exceptions flying from a wide variety of religious beliefs."[80] Its holding recognized that any complex and all-encompassing system cannot function if every individual is permitted to opt out based on a religious qualm: "The tax system could not function if denominations were allowed to challenge the tax system because tax payments were spent in a matter that violates their religious belief."[81] The "broad public interest" in maintaining a cohesive system "is of such a high order," the Court stated, that "religious belief in conflict...affords no basis for resist[ance]."[82] The Supreme Court has similarly held that religious foundations are not entitled to an exemption from the system of labor standards and must comply with minimum wage, overtime, and employment-related recordkeeping requirements.[83]

More recently, and in the context of RFRA, the Supreme Court in *Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal* held that "the Government can demonstrate a compelling interest in ***uniform application*** of a particular program by offering evidence that granting the requested religious accommodations would seriously compromise its ability to administer the program."[84] While in *O Centro Espirita* the Court permitted a religious exception to the Controlled Substances Act to allow a religious sect to use a hallucinogenic tea, the facts there were utterly different from those present here. For example, in *O Centro Espirita*, the government conceded that it did not have a compelling interest in enforcing the law, and the health impact at stake from permitting the very limited use of the tea was "in equipoise."[85] In contrast, with respect to the no-copay-contraception requirement, the government has a compelling interest and the health impact of permitting employers to opt out of providing contraceptive coverage without a copay for women is great.

Other courts have similarly recognized in the context of RFRA that comprehensive systems admitting no exemptions are the least restrictive means of furthering compelling governmental

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[78] Sen. Barbara Mikulski, Press Release: *Mikulski, Senate Colleagues Urge Secretary Sebelius to Swiftly Adopt IOM's New Recommendations on Women's Preventive Health* (July 22, 2011), *available at* http://mikulski.senate.gov/media/pressrelease/7-22-2011-6.cfm.

[79] Adam Sonfield, Senior Public Policy Associate, Guttmacher Institute, *quoted in* Lucia Rafanelli, *Inaccurate Conceptions*, AMERICAN SPECTATOR: THE SPECTACLE BLOG (Sept. 26, 2011), *available at* http://spectator.org/blog/2011/09/26/inaccurate-conceptions.

[80] 455 U.S. 252, 259-60 (1982).

[81] *Id.* at 260.

[82] *Id.* at 260.

[83] *Tony and Susan Alamo Foundation v. Secretary of Labor*, 471 U.S. 290 (1985).

[84] 546 U.S. 418, 435 (2006)

[85] *Id.* at 426.

objectives. For example, in *Jenkins v. Commissioner of Internal Revenue*,[86] the Second Circuit Court of Appeals noted that "It is...well settled that RFRA does not afford a right to avoid payment of taxes for religious reasons" and consequently rejected the claim of a taxpayer challenging on religious grounds the collection of a portion of his taxes to be used for military spending.[87] Other courts have denied RFRA-based claims seeking exemptions to the Bald and Golden Eagle Protection Act,[88] the Endangered Species Act,[89] and the Controlled Substances Act.[90] Certainly the government's ability to enforce a comprehensive system to protect women's health is at least as important as one to prevent the trade in eagle feathers.[91]

V. International Human Rights Law Requires Governments to Ensure Access to Affordable Contraception and to Prevent Third Parties – Such as Employers – from Interfering With that Access

A. International Human Rights Law Requires States to Ensure Access to Affordable Contraception

Binding international human rights law recognizes women's fundamental right to access to contraception. For example, Article 3 of the International Covenant on Civil and Political Rights – to which the United States is a state party – requires states to "ensure the equal right of men and women to the enjoyment of all civil and political rights set forth in the...Covenant." The Human Rights Committee, the treaty-monitoring body charged with authoritatively interpreting the Convention, has specifically cited the "high cost of contraception" as a potential treaty violation.[92] And only last year, the Human Rights Committee instructed a state party to "strengthen measures aimed at the prevention of unwanted pregnancies, by *inter alia* making a comprehensive range of contraceptives widely available at an affordable price and including them on the list of subsidized medicines."[93]

Other human rights instruments, all of which the United States has signed, similarly require affordable access to contraception. For example, the Convention on the Elimination of All Forms of Discrimination Against Women includes article 12, which requires states to "eliminate discrimination against women in the field of health care in order to ensure...access to health care services, ***including those related to family planning.***"[94] The Committee on the Elimination of

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[86] 483 F.3d 90 (2d Cir. 2007).
[87] *Id.* at 92. *See also Browne v. United States*, 176 F.3d 25 (2d Cir. 1999) (RFRA does not prohibit the collection of revenue that will be used for purposes religious adherents find objectionable).
[88] *United States v. Vasquez-Ramos*, 531 F.3d 987 (9th Cir. 2008) (denying RFRA claim where defendant sought a religious exemption to law prohibiting the possession of eagle feathers and talons).
[89] *United States v. Adeyemo*, 624 F. Supp. 2d 1081 (N.D. Cal. 2008) (denying RFRA claim where defendant sought a religious exemption to a prohibition on the importation and transportation of leopard skins into the United States).
[90] *United States v. Lepp*, No. CR 04-0317 MHP, 2007 WL 2669997 (N.D. Cal. 2007) (denying RFRA claim where defendant sought a religious exemption to the Controlled Substances Act).
[91] *See Vasquez-Ramos, supra.*
[92] *Concluding Observations of the Human Rights Committee: Poland*, U.N. Doc. CCPR/CO/82/POL (2004), at para. 9.
[93] *Concluding Observations of the Human Rights Committee: Poland*, U.N. Doc. CCPR/C/POL/CO/6 (2010), at para. 12.
[94] G.A. res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46, *entered into force* Sept. 3, 1981, at art. 12(1).

All Forms of Discrimination Against Women, the treaty-monitoring body tasked with interpreting the Convention, has held that article 12 obligates states to "take measures to increase the access of women and adolescent girls to affordable health-care services, including reproductive health care, and ***to increase access to information and affordable means of family planning***..."[95]

The Committee on Economic, Social and Cultural Rights, charged with monitoring the International Covenant on Economic, Social and Cultural Rights (another treaty the United States has signed) emphasized the importance of access to affordable contraception in its General Comment on the Right to the Highest Attainable Standard of Health. In order to fulfill their treaty obligations, states must endeavor to "provide access to a full range of high quality and ***affordable health care, including sexual and reproductive services***..."[96]

B. International Human Rights Law Requires Governments to Protect Access to Contraceptive Service from Interference by Third Parties, Such as Employers

Under international human rights law, the right to health – including the aforementioned right to access affordable contraception – must be respected, protected, and fulfilled by governments.[97] A government meets its obligation to ***respect*** the right to health by not interfering with individuals' enjoyment of the right. And it ***fulfills*** the right by affirmatively facilitating access to health-related services, including "sexual and reproductive health services."[98] The no-copay-contraception requirement is a positive step towards respecting and protecting women's right to health, including reproductive health.

However, under international human rights law, a government must also ***protect*** the right to health from interference: "States should also ensure that third parties do not limit people's access to health-related information and services."[99] This means that in order to abide by the United States' international commitments, it is not enough for the government to facilitate no-cost-sharing access to contraceptives. Instead, the government must also ensure that third parties – such as religious employers – are not permitted to do what government may not, and interfere with individuals' right to access affordable contraception. Consequently, the proposed religious exemption, which allows private employers to impede individuals' right to access affordable contraception, violates international norms and our commitments under the international human rights treaties that the United States has signed.

VI. Any Religious Exemption to the No-Copay Contraception Requirement Must be Limited to Individuals Employed Specifically for Ministerial Duties

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[95] *See, e.g., Concluding Observations of the CEDAW Committee: Slovakia*, U.N. Doc. CEDAW/C/SVK/CO/4 (2008), at para. 22.

[96] *Committee on Economic, Social and Cultural Rights, General Comment 14, The right to the highest attainable standard of health* (Twenty-second session, 2000), U.N. Doc. E/C.12/2000/4 (2000), reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 at 85 (2003), at para. 21.

[97] *Id.* at para. 33.

[98] *Id.* at para. 36.

[99] *Id.* at para. 35.

For the reasons set forth above, the no-copay-contraception requirement – without any exemption – is both constitutional and permissible under RFRA. Any exemption Congress may contemplate should be strictly limited to employees in ministerial positions.[100] Thus, the proposed language in section 147.130 should be changed as follows:

> (a)(1)(iv)(A)) In developing the binding health plan coverage guidelines specified in this paragraph (a)(1)(iv), the Health Resources and Services Administration shall be informed by evidence and may establish exemptions from such guidelines with respect to group health plans established or maintained by religious employers and health insurance coverage provided in connection with group health plans established or maintained by religious employers with respect to any requirement to cover contraceptive services under such guidelines **for those individuals employed *specifically* for ministerial duties.**

This is a more narrow and targeted means of achieving the goal of balancing the conscience-rights interests of insurers/employers/hospitals and employees/patients.

A. Religious-Conscience Rights Belong to Individuals, Not Institutions

As currently phrased, however, the proposed religious exemption protects the rights of religious employers at the expense of individual employees, giving houses of worship a *de facto* veto over the health coverage of their employees. But the Supreme Court has repeatedly emphasized that conscience rights inure to individuals, not institutions. For example, in *McCreary County, Kentucky v. ACLU of Kentucky*, the Court noted that "[t]he Framers and the citizens of their time intended…to protect the integrity of ***individual*** conscience in religious matters…"[101] *Wallace v. Jaffree* similarly held that "the Court has unambiguously concluded that the ***individual*** freedom of conscience protected by the First Amendment embraces the right to select any religious faith or none at all."[102] And in *Glickman v. Wileman Brothers & Elliott, Inc.*, the Court proclaimed that "at the 'heart of the First Amendment [is] the notion that an ***individual*** should be free to believe as he will, and that in a free society one's beliefs should be shaped by his mind and his conscience.'"[103]

As written, the exemption proposed by HHS cedes to employers the religious conscience rights that rightfully belong to the employees. But individual employees – and not their employer – should have the religious conscience right to decide whether they wish to receive co-copay coverage for contraception. The draft exemption, however, permits a religious institution to trample upon the religious beliefs of their employees – whether or not they agree with those views, and whether or not they are even members of the same religious group. For example, a Methodist groundskeeper employed by a Catholic parish will be unable to access no-copay contraception – regardless of her own conscience or religious beliefs – by virtue of happening to

[100] We use the term "ministerial position" here to refer to those hired to perform exclusively or almost exclusively religious functions as part of the house-of-worship's religious hierarchy, such as priests, rabbis, nuns, or imams. We do not endorse the broader meaning of the term that has been used by some of the lower courts, which have incorrectly broadened the term to include music directors, teachers at religiously affiliated colleges, and the like.
[101] 545 U.S. 844, 876 (2005) (emphasis added).
[102] 472 U.S. 38, 53 (1985) (emphasis added).
[103] 521 U.S. 457, 472 (1997) (emphasis added).

work for a church. The fact that the groundskeeper does not share the religious beliefs of the church[104] and engages in no religious duties whatsoever – and indeed, that she performs an essentially secular function – is of no moment. Under the interim rule, the church, as her employer, can dictate to her which health benefits she can access. Indeed, the logic underlying the interim rule would also allow a church to deny neonatal benefits to a mother whose child was born out of wedlock;[105] or to all male employees;[106] or to gay or lesbian employees.[107] And Christian Scientist churches would be entitled to deny all medical coverage except spiritual care.[108]

B. Religious Exemptions Should Be Limited to Employees Employed Specifically for Ministerial Duties

Any religious exemption to the no-copay-contraception requirement should be limited to religious-institution employees hired to perform ministerial duties, such as rabbis, priests, or imams. These employees are hired specifically because of their religious beliefs and leadership of the religious institution and have specifically volunteered for such designation. The Fifth Circuit Court of Appeals noted, for example, that "[t]he relationship between an organized church and its ministers is its lifeblood. The minister is the chief instrument by which the church seeks to fulfill its purpose."[109] Similarly, the Fourth Circuit Court of Appeals recognized that "[t]he right to choose ministers…underlies the wellbeing of a religious community…for perpetuation of a church's existence may depend upon those whom it selects to preach its values, teach its message, and interpret its doctrine both to its own membership and to the world at large."[110]

Because ministers are selected precisely because of their religious beliefs and leadership, offering them an exemption is a permissible – though unrequired – accommodation of religion. But other employees of religious institutions – be they secretaries, groundskeepers, or receptionists – are not the "lifeblood" of a house of worship; nor does a house of worship depend upon such non-ministerial employees to "preach its values, teach its message, and interpret its doctrine." Because non-ministerial employees are not hired because of their religious beliefs and leadership, they ought not to be held hostage to the religious employers' religious dogma and denied a health benefit generally available to everyone else.

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[104] Although the interim rule limits its applicability to organizations that "***primarily*** employ[] persons who share [their] religious tenets," (emphasis added) it is clear that religious institutions would be exempt from providing no-copay contraception to any non-believers who work there.

[105] Numerous religions, including Roman Catholicism, disapprove of sexual relations outside of marriage.

[106] *See, e.g.*, Re-Formed Congregation of the Goddess, International, *RCG-1 Membership, available at* http://www.rcgi.org/members/members.asp (congregation only permits women to become full members).

[107] Numerous religions disapprove of homosexuality.

[108] Lest this sound like hyperbole, *see* Fox13now.com, *Should State Health Exchanges Pay for Spiritual Care*, Sept. 25, 2011, *available at* http://www.fox13now.com/news/kstu-spiritual-care-should-state-health-exchanges-pay-for-spiritual-care-20110925,0,5284457.story (Utah's Legislative Health Care Reform Task Force discussed proposals to permit insurance coverage for 'spiritual care'…"[t]he legislature heard personal stories [from the] Christian Science…a church[, which] believes spiritual care should replace medical care.").

[109] *McClure v. Salvation Army*, 460 F.2d 553, 558-59 (5th Cir. 1972).

[110] *Rayburn v. General Conference of Seventh-Day Adventists*, 772 F.2d 1164, 1167-68 (4th Cir. 1985).

VII. Other Key Protections Would Be Required If the Exemption is Maintained or Expanded, Including a Mechanism to Allow Affected Employees to Obtain No-Copay Contraceptive Coverage

As the above history indicates, if Congress decides to maintain or expand the proposed exemption, it must establish a robust and clear set of protections for women's health. For example: 1) Congress should exclude from any exemption contraception prescribed for a medical purpose unrelated to birth control; 2) employees subjected to an employer exemption should be allowed to otherwise obtain contraceptive coverage free of cost through a state or federal program for an extension of coverage; 3) employees should be given appropriate advance notice of the employer's exemption and the resulting absence of coverage and provided at the same time with information required to obtain coverage elsewhere; and 4) employers should be required to certify that they comply with each of the exemption's requirements and this documentation should be submitted to the Department of Health and Human Services.

The distinct autonomy and privacy interests that individuals have in accessing family planning services and in reproductive health require a system in which individuals denied contraceptive coverage due to the religious exemption are provided with an alternative means to obtain contraceptive coverage. Such coverage could be offered through a federally mandated insurance supplement or through a special program in the Exchanges. Without such a mechanism, the religious beliefs or consciences of the many individuals who are employed at houses of worship will be trampled upon by their employers' decision to seek an exemption.

Consistent with privacy safeguards, Congress should require HHS to publish annually data on the extent to which exemptions have been allowed from the rule, the number of policyholders impacted by the exemption by state, the mechanisms by which these policyholders have been offered contraceptive coverage from another source, and any monitoring and enforcement activity related to the exemption or certification of exemption.

VIII. Conclusion

Any policy proposal concerning individuals' right of conscience must proceed from the understanding that ***all individuals'*** consciences must be protected. That includes individual employers and doctors who object to contraception – but also employees, patients, and doctors who do not object to it. The religious exemption proposed by HHS protects the conscience rights of the church hierarchy at the expense of employees, including non-ministerial employees who may not share the church's dogmatic view of contraception.

The proposed insurance- and care-refusal bill – H.R. 1179 – goes light-years beyond the HHS proposal and permits insurers, employers, and hospital administrators to impose their beliefs on policyholders, employees, and patients. It privileges the conscience rights of the 1% who disavow contraception at the expense of the 99% of American women – including 98% of Catholics – who do use contraception.

Finally, a religious exemption is required by neither the Constitution nor the Religious Freedom Restoration Act. Promulgating a broad religious exemption that trammels upon the

rights of the 99% of women who use contraception is bad policy – undermining the goals of the no-copay-contraception to improve the health of women and children, and reducing America's astronomical unintended pregnancy rate. Congress should implement policies motivated by public health and science – not dictated by theology or religious dogma.

With questions, please contact Laura MacCleery, Director of Government Relations, at (202) 629-2658 or Aram Schvey, Policy Counsel, at (202) 629-2657.

Testimony of Judy Waxman, Vice President for Health and Reproductive Rights
National Women's Law Center

House Committee on Energy and Commerce, Subcommittee on Health
Hearing on the Affordable Care Act's Contraceptive Coverage Guarantee
November 2, 2011

Mr. Chairman and Members of the Committee:

I am Judy Waxman, Vice President of Health and Reproductive Rights at the National Women's Law Center. Since 1972, the National Women's Law Center has worked to protect and advance the progress of women and their families in core aspects of their lives, with an emphasis on the needs of low-income women. The Center utilizes a wide range of tools—including public policy research, monitoring, and analysis; litigation, advocacy, and coalition-building; and public education—to achieve gains for women and their families, including to protect and advance women's reproductive health and rights. Thank you for the opportunity to submit testimony today.

One of the Affordable Care Act's key protections is the guarantee that all new insurance plans will cover preventive services, including counseling, screenings, and interventions that have received either "A" or "B" recommendations from the United States Preventive Services Task Force.[1] The Women's Health Amendment, enacted because Congress recognized that these recommendations left some important gaps in preventive care for women,[2] required the Department of Health and Human Services (HHS) to identify additional preventive health services for women that should be covered and provided to patients at no cost. The Institute of Medicine (IOM) reviewed the available evidence and recommended additional women's preventive health services that should be included in the required coverage of preventive health services without cost- sharing.

The IOM released its findings on July 19, 2011, recommending coverage and no cost-sharing for a range of important women's preventive health services including screening for cervical cancer; critical health services for pregnant women, including breastfeeding support; screening for intimate partner violence; and all FDA-approved forms of contraception.[3] HHS adopted the IOM's recommendations on August 1, 2011. Unfortunately, HHS has included in its Interim Final Rules (IFR) a provision that would allow certain religious employers to exclude contraceptive services from their employees' health plans. Rather than giving all women true contraceptive access, the exemption arbitrarily precludes certain women from receiving needed preventive care. Women who work for employers who invoke an exemption will not receive the intended benefits, and will be required to pay for what the IOM and HHS itself have determined should be available at no cost.

No cost-sharing contraceptive coverage provides tremendous benefits for women. Contraception is critical preventive health care for women. Contraceptive use is nearly universal among women of reproductive age in the United States.[4] Planned pregnancies—which for most women require contraception—improve women's health and their ability to have healthy pregnancies. The ability to determine the timing of a pregnancy can prevent a range of pregnancy complications that can endanger a woman's health, including gestational diabetes, high blood pressure, and placental problems, among others.[5] Contraception is critical to helping women achieve healthy pregnancies. Women who wait for some time after delivery before conceiving their next child lower their risk of adverse perinatal outcomes, including low birth weight, preterm birth, and small-for-size gestational age.[6] Guaranteeing access to contraception therefore benefits the health of women and their families.

Cost plays a major role in women's ability to use contraceptives. Contraception costs burden women's access to birth control. Evidence suggests that even moderate co-payments can cause individuals to forgo needed preventive care, particularly those with low and moderate incomes. For example, a survey by Planned Parenthood found that one in three women reported struggling with the cost of prescription birth control at some point.[7] Another survey, conducted by the Guttmacher Institute in 2009, found that because of the economic recession, 23% of women reported having difficulty paying for birth control and 24% put off a gynecology or birth control visit because of cost.[8] Costs can also lead women to use contraception inconsistently or incorrectly; for example, 18% of women report inconsistent use as a means of saving money. Removing these barriers to access is critical for improving women's health.

HHS's decision to guarantee no cost-sharing coverage of contraception is a milestone for women. Removing these cost-related barriers is a tremendous benefit for women and their families and underscores the real and tangible impact the new health care law will have on women's lives.

Nothing in the Women's Health Amendment requires any person to use contraception. The requirement is merely that contraceptive services be covered in insurance plans at no cost-sharing, such that individuals may choose whether or not to access those services. Senator Barbara Mikulski, the author of the Women's Health Amendment, put it well when explaining the purpose of the provision on the Senate floor: "[W]e do not mandate that you have the service; we mandate that you have access to the service. The decision as to whether you should get it will be a private one, unique to you."

Requiring employers—including religious employers—to cover contraceptives does not break any new legal ground. In fact, states have long guaranteed contraceptive coverage. Twenty eight states have laws and policies that guarantee health insurance coverage of prescription contraceptives in insurance policies that cover other prescription drugs and devices.[9] The first of these laws was enacted in 1998; the most recent in 2010. Eight states have no religious exemption.

In addition to these state laws and policies, Title VII of the Civil Rights Act of 1964 requires employers with fifteen or more employees to provide coverage of contraception if the employee health insurance plan covers other preventive drugs and services. In December 2000, the EEOC

issued a Commission Ruling stating that it is sex discrimination for employer-sponsored health insurance plans to provide coverage of other prescription drugs and preventive services but fail to provide coverage of contraceptives. This guidance has remained in place throughout the Bush Administration to this day. Title VII contains no provision allowing employers, religious or otherwise, to discriminate against their employees in pay or benefits. Moreover, many religiously-affiliated employers already provide contraceptive coverage. The National Women's Law Center has identified a number of religiously-affiliated employers that cover contraception in the health insurance policies they offer to their employees.

An exemption that allows religious employers to refuse to comply with the contraceptive coverage guarantee has no basis under the law. The Affordable Care Act does not allow for any exemptions that discriminate against women. Section 1557(a) of the Affordable Care Act prohibits sex discrimination in any health program or activity, any part of which is receiving Federal financial assistance. As described above, it has been determined that it is sex discrimination to exclude coverage of contraception for women when the employee health insurance plan covers other preventive drugs and services.[10] It is unacceptable—as a matter of law and policy—for an agency to create an exception to longstanding civil rights principles that allow religious employers not to comply with the law.

Contrary to the assertion of some who oppose the contraceptive coverage provision, the Constitution does not require a religious exemption. The Supreme Court has held that neutral, generally applicable laws do not violate the Free Exercise Clause of the First Amendment, even if they were to burden the exercise of religion.[11] The coverage of contraception is a neutral regulation that applies to all employers; it does not single out any religious entity or practice. Accordingly, guaranteeing contraception coverage does not violate the First Amendment.

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[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010), amended by Health Care and Education Affordability and Reconciliation Act, Pub. L. No. 111-152 (2010) (to be codified at 42 U.S.C. § 18023).
[2] Public Health Service Act, Pub. L. No. 78-410 (1944), amended by Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1001 (2010) (to be codified at 42 U.S.C. § 18023).
[3] Institute of Medicine, Clinical Preventive Services for Women: Closing the Gaps (July 19, 2011), available at http://www.iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx.
[4] Rachel Jones & Joerg Dreweke, Countering Conventional Wisdom: New Evidence on Religion and Contraceptive Use 4 (Apr. 2011), available at, http://www.guttmacher.org/pubs/Religion-and-Contraceptive-Use.pdf.
[5] March of Dimes, Pregnancy After 35 (May 2009), http://www.marchofdimes.com/Pregnancy/trying_after35.html.
[6] U.S. Dep't of Health and Human Servs., Healthy People 2010 9-32 (2nd ed. 2000), available at http://www.healthypeople.gov/Document/pdf/Volume1/09Family.pdf.
[7] Planned Parenthood, Survey: Nearly Three in Four Voters in America Support Fully Covering Prescription Birth Control, (Oct. 2010), available at http://www.plannedparenthood.org/about-us/newsroom/press-releases/survey-nearly-three-four-voters-america-support-fully-covering-prescription-birth-control-33863.htm.
[8] Guttmacher Institute, A Real Time Look at the Impact of the Recession on Women's Family Planning and Pregnancy Decisions, (Sept. 2009), available at http://www.guttmacher.org/pubs/RecessionFP.pdf.
[9] In addition to the states that have enacted laws, Michigan and Montana also require contraceptive coverage. Michigan's requirement is based on an Administrative ruling, while Montana's requirement is based on an Attorney General opinion.
[10] *See* EEOC Guidance, adopted December 14, 2000.
[11] *See, e.g., Employment Division, Department of Human Resources of Oregon v. Smith*, 494 U.S. 872 (1990) (abrogated by statute).

Written Statement of the American Civil Liberties Union

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Submitted to the House of Representatives
Subcommittee on Health
Committee on Energy and Commerce

November 2, 2011

"Do New Health Law Mandates Threaten Conscience Rights and Access to Care?"

The American Civil Liberties Union ("ACLU") thanks the Committee on Energy and Commerce, Subcommittee on Health for the opportunity to submit this statement for the hearing record – "Do New Health Law Mandates Threaten Conscience Rights and Access to Care?" – addressing the Department of Health and Human Services ("HHS") requirement that new health plans cover contraception without extra out of pocket costs.

The ACLU is a nonpartisan public interest organization with more than a half million members, countless additional activists and supporters, and 53 affiliates nationwide, dedicated to protecting the principles of freedom and equality set forth in the Constitution and in our nation's civil rights laws. The ACLU has a long history of defending both religious liberty and reproductive freedom. In Congress and in the courts, we have supported legislation providing stronger protection for religious exercise. At the same time, we have participated in nearly every critical case concerning reproductive rights to reach the Supreme Court, and we routinely advocate in Congress and state legislatures for policies that promote access to reproductive health care. Because of our profound respect for both religious liberty and for reproductive rights, the ACLU is particularly well-positioned to comment on the issues before this Subcommittee.

Sexually active individuals should have affordable access to the full range of contraceptive options. Women need access to contraception to prevent unintended pregnancies, plan the size of their families, plan their lives, and protect their health. Meaningful access to contraception is integral to a world in which people are free to express their sexuality, to form intimate relationships, to lead healthy sexual lives, to flourish, and to decide when and whether to have children.

Although some have expressed concern about the impact on institutions that oppose the use of birth control,[1] religious liberty is not infringed by requiring insurance plans to cover contraception. The religious beliefs of those who employ and serve diverse populations no more justify denying employees contraceptive coverage than they did denying African-Americans service at restaurants owned by those whose religious beliefs opposed desegregation.

Religious liberty does not come with the right to impose one's faith on others. Indeed, the contraceptive coverage provision serves the nation's interest in gender equality, reproductive autonomy, and religious freedom by making contraception accessible and affordable, and therefore allowing women – using their own consciences – to choose for themselves whether, when, and how to use birth control.

[1] *See, e.g.*, Internal Memorandum from Majority Staff of Comm. on Energy and Commerce to Members of the Subcomm. On Health (Oct. 28, 2011), *available at* http://Republicans.EnergyCommerce.house.gov/Media/file/Hearings/Health/110211/Memo.pdf.

Calls to expand the religious employer exception in the HHS rule or pass radical bills like H.R. 1179, the Respect for Rights of Conscience Act of 2011, must be rejected. Each time more entities are allowed to deny women contraceptive coverage, the religious beliefs of some are imposed on the lives of others, and gender equality is undermined.

I. Background

The Patient Protection and Affordable Care Act ("ACA") provides that certain preventive services must be provided in health insurance plans without cost-sharing.[2] The preventive services provision is designed to ensure that health insurance provides real access to vital health care. Because existing preventive care guidelines otherwise incorporated into the ACA have significant gaps when it comes to women's health, Congress included the Women's Health Amendment ("WHA"), which requires health insurance plans to cover additional preventive services for women,[3] as described in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).[4]

To implement the WHA, the Institute of Medicine ("IOM") "review[ed] what preventive services are necessary for women's health and well-being"[5] and developed recommendations for comprehensive guidelines. After an extensive science-based process, the IOM published *Clinical Preventive Services for Women: Closing the Gaps*, a report of its analysis and recommendations, on July 19, 2011. Among other things, the report recommended that the HRSA guidelines include "the full range of Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity."[6] On August 1, 2011, HRSA adopted the IOM's recommendations, including the recommendation on contraceptive services.[7]

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[2] Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, sec. 1001, § 2713(a), 124 Stat. 131 (2010).

[3] *See, e.g.*, 155 CONG. REC. S12019, 12025 (daily ed. Dec. 1, 2009) (statement of Sen. Boxer) ("The underlying bill introduced by Senator Reid already requires that preventive services recommended by the U.S. Preventive Services Task Force be covered at little to no cost. . . . But [those recommendations] do not include certain recommendations that many women's health advocates and medical professionals believe are critically important . . . ."); *see also* 155 CONG. REC. S12261, S12271 (daily ed. Dec. 3, 2009) (statement of Sen. Franken) ("The current bill relies solely on the U.S. Preventive Services Task Force to determine which services will be covered at no cost. The problem is, several crucial women's health services are omitted. [The Women's Health] amendment closes the gap.").

[4] ACA, Pub. L. No. 111-148, sec. 1001, § 2713(a)(4), 124 Stat. 131.

[5] INSTITUTE OF MEDICINE ("IOM"), CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS 1 (prepublication ed.) (2011) [hereinafter CLOSING THE GAPS].

[6] *Id.* at 94.

[7] Health Resources and Services Administration, U.S. Dep't of Health & Human Services, *Women's Preventive Services: Required Health Plan Coverage Guidelines* http://www.hrsa.gov/womensguidelines/.

Also on August 1, HHS promulgated amendments to the interim final regulation implementing the preventive services provision, creating an exception to the HRSA Guidelines' contraceptive coverage requirement. The rule allows HRSA to "establish exemptions from such guidelines with respect to group health plans established or maintained by religious employers and health insurance coverage provided in connection with group health plans established or maintained by religious employers with respect to any requirement to cover contraceptive services under such guidelines."[8] HHS explained that its purpose in creating this exception was to "provide for a religious accommodation that respects the unique relationship between a house of worship and its employees in ministerial positions," while extending contraceptive coverage to "as many women as possible."[9] The definition of religious employer in the rule tracks the definition of the exempted entities in contraceptive equity laws in California and New York, each of which has been upheld against challenges arguing for expansion.[10]

II. Contraceptive Coverage is Essential for Women's Health and Equality

Access to safe and effective contraception is a critical component of basic health care for women. Virtually all sexually active women use contraception over the course of their lives.[11] Since 1965, when the U.S. Supreme Court first protected a woman's access to contraception,[12] maternal and infant mortality rates have declined.[13] Without contraception, women have more unplanned pregnancies and are less likely to obtain adequate prenatal care in a timely manner.[14] Controlling pregnancy spacing affects birth outcomes such as low birth-weight and premature birth. Pregnancy planning can also help women control a number of conditions that negatively impact their health, such as gestational diabetes and high blood pressure.[15]

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[8] 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, 46,626 (Aug. 3, 2011) (to be codified at 45 C.F.R. pt. 147).

[9] *Id.* at 46,623.

[10] *See Catholic Charities of Sacramento, Inc. v. Super. Ct.*, 85 P.3d 67 (Cal. 2004); *Catholic Charities of Diocese of Albany v. Serio*, 859 N.E.2d 459 (NY 2006).

[11] Guttmacher Institute, Testimony before the Committee on Preventive Services for Women, Institute of Medicine 7 (Jan. 12, 2011) [hereinafter Guttmacher Institute Testimony].

[12] *Griswold v. Conn.*, 381 U.S. 479 (1965).

[13] *See* Centers for Disease Control and Prevention ("CDC"), *Ten Greatest Public Health Achievements – United States, 1990-1999, Family Planning*, MORBIDITY AND MORTALITY WEEKLY REPORT 242 (April 2, 1999), *available at* http://www.cdc.gov/mmwr/PDF/wk/mm4812.pdf (access to family planning has led to "fewer infant, child, and maternal deaths"); *see also* U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTH, UNITED STATES, at 222 (2006); U.S. DEP'T OF HEALTH & HUMAN SERVS., VITAL AND HEALTH STATISTICS: TRENDS IN INFANT MORTALITY BY CAUSE OF DEATH AND OTHER CHARACTERISTICS, 1960-88, at 3 (1993).

[14] Adam Sonfield, *The Case for Insurance Coverage of Contraceptive Services and Supplies Without Cost-Sharing*, 14 GUTTMACHER POL'Y REV. 7-8 (Winter 2011), *available at* http://www.guttmacher.org/pubs/gpr/14/1/gpr140107.pdf.

[15] *See, e.g.*, March of Dimes, *Pregnancy After 35* (May 2009), http://www.marchofdimes.com/trying_after35.html.

Access to contraception gives women control of their fertility, enabling them to decide whether and when to become a parent. Contraception not only furthers the health of women and their children but equality as well, allowing women to make educational and employment choices that benefit themselves and their families. It is imperative that the benefits of access to birth control reach all women.

Contraception has an important role in women's preventive care beyond preventing unintended pregnancies. As the IOM noted in its report, "[l]ong-term use of oral contraceptives has been shown to reduce a woman's risk of endometrial cancer, as well as protect against pelvic inflammatory disease and some benign breast diseases."[16] Contraception can also decrease the risk of ovarian cancer and eliminate menopause symptoms.[17]

The HRSA Guidelines' contraceptive coverage requirement is based on decades of experience with the benefits of family planning, recognized by the Centers for Disease Control and Prevention as one of the ten most significant public health achievements of the 20th century.[18] In addition to the IOM, "[n]umerous health care professional associations and other organizations recommend the use of family planning services as part of preventive care for women."[19] Multiple federal programs promote contraception access.[20]

The Women's Health Amendment, through the HRSA Guidelines, also builds on a network of state contraceptive coverage laws. Twenty-eight states require health plans that include prescription drug coverage to cover contraception. These laws were passed in response to decades of gender discrimination in the provision of health insurance; without contraceptive coverage mandates, women routinely pay more than men for their health care. Similarly, the Equal Employment Opportunity Commission has made clear that Title VII of the Civil Rights Act of 1964, which prohibits discrimination in employment on the basis of sex, requires employers to provide contraceptive coverage when they offer coverage for comparable drugs and devices.[21]

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[16] CLOSING THE GAPS, *supra* note 5, at 92.

[17] Guttmacher Institute Testimony, *supra* note 11, at 6; Dep't of Health & Human Servs., *Menopause Symptom Relief and Treatments*, Sept 29. 2010, http://www.womenshealth.gov/menopause/symptom-relief-treatment/.

[18] CDC, *supra* note 13, at 241.

[19] CLOSING THE GAPS, *supra* note 5, at 93 (including "the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the American Academy of Pediatrics, the Society of Adolescent Medicine, the American Medical Association, the American Public Health Association, the Association of Women's Health, Obstetric and Neonatal Nurses, and the March of Dimes").

[20] *See, e.g.*, Susan. A. Cohen, *The Numbers Tell the Story: The Reach and Impact of Title X*, 14 GUTTMACHER POL'Y REV. 1 (2011), *available at* http://www.guttmacher.org/pubs/gpr/14/2/gpr140220.pdf; Rachel Benson Gold & Adam Sonfield, *Block Grants Are Key Sources of Support for Family Planning*, 2 GUTTMACHER REPORT ON PUB. POL'Y (1999), *available at* http://www.guttmacher.org/pubs/tgr/02/4/gr020406.pdf.

[21] Equal Employment Opportunity Commission, Decision of Coverage of Contraception (Dec. 14, 2000), *available at* http://www.eeoc.gov/policy/docs/decision-contraception.html ("Contraception is a means by which a woman

The IOM found, however, that "[d]espite increases in private health insurance coverage of contraception since the 1990s, many women do not have insurance coverage or are in health plans in which copayments for visits and for prescriptions have increased in recent years."[22] Contraceptive copays can be so expensive that women can pay almost as much out-of-pocket as they would without coverage at all.[23] These high costs have posed a substantial barrier to access and effective use. The cost of contraceptive methods can cause women to have gaps in their use of birth control, or to employ less effective methods with lower upfront costs like condoms, as opposed to long-acting reversible methods like the IUD. Eliminating cost-sharing increases use of these more effective methods.[24]

The WHA, and the HRSA Guidelines developed pursuant to it, close the gap, facilitating affordable coverage for this essential health care service.[25] Contrary to the suggestion in the title of this hearing, the contraceptive coverage requirement *increases* access to care; that is its purpose.

III. Requiring Insurance Coverage of Contraception Does Not Infringe on Religious Liberty

Opponents of family planning are urging HHS to eliminate contraceptive services from the HRSA Guidelines altogether, in furtherance of their agenda to prevent all women from having this benefit.[26] Indeed, some go as far as to say that contraception "is not properly seen as basic health care."[27] Such arguments contravene basic medical science.[28]

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controls her ability to become pregnant. . . . [Employers] may not discriminate in their health insurance plan by denying benefits for prescription contraceptives when they provide benefits for comparable drugs and devices."); *see also Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266 (W.D. Wash. 2001). *But see In re Union Pacific Railroad Employment Practices Litigation*, 479 F.3d 936, 943 (8th Cir. 2007) (concluding that the Pregnancy Discrimination Act did not encompass contraceptives).

[22] CLOSING THE GAPS, *supra* note 5, at 94.

[23] *See* Guttmacher Institute Testimony, *supra* note 11, at 7-8; Su-Ying Liang et al., *Women's Out-of-Pocket Expenditures and Dispensing Patterns for Oral Contraceptive Pills between 1996 and 2006*, 83 CONTRACEPTION 491, 531 (June 2010).

[24] Sonfield, *The Case for Insurance Coverage of Contraceptive Services*, *supra* note 14.

[25] *See, e.g.*, 155 CONG. REC. at S12026-7 (daily ed. Dec 1, 2009) (statement of Sen. Mikulski) ("We want to either eliminate or shrink those deductibles and eliminate that high barrier, that overwhelming hurdle that prevents women from having access to" preventive care.).

[26] *See, e.g.*, Christian Medical Association, Comments on Interim Final Rule on Preventive Services (Sept. 29, 2011).

[27] United States Conference of Catholic Bishops (USCCB), Comments on Interim Final Rules on Preventive Services, 3 (Aug. 31, 2011).

[28] Contraception is preventive care. *See* CLOSING THE GAPS, *supra* note 5, at 91. Despite baseless claims to the contrary, the HRSA Guidelines, which require coverage of all FDA-approved *contraceptives*, do *not* require

Short of removing the requirement, family planning opponents want an expansion of the exception to give *any* individual or entity a veto over the coverage available in *any* health plan.[29] They seek a regime under which individuals, insurers, secular employers, and organizations that self-identify as religious but employ a religiously diverse workforce – such as hospitals, social service agencies, and universities – would be able to deny others contraceptive coverage, despite the IOM's conclusion that contraception is indicated preventive care for *all* women, without regard to whom they happen to work for, be insured by, or share enrollment in a health plan with.

Requiring coverage of contraception in insurance plans does not infringe on religious liberty. The HRSA Guidelines – like the contraceptive coverage laws that have come before them[30] and a host of generally applicable anti-discrimination and labor laws across the country – are constitutionally unremarkable. Opposition to neutral laws from religious organizations is not unique to contraception. For example, individuals and institutions have claimed religious objections to desegregation and to equal pay laws:

> In 1964, three African-American residents of South Carolina brought a suit against Piggie Park restaurants, and their owner, Maurice Bessinger, for refusal to serve them. Bessinger argued that enforcement of the Civil Rights Act of 1964's public accommodations provision violated his religious freedom "since his religious beliefs compel[ed] him to oppose any integration of the races whatever."[31]
>
> In 1976, Roanoke Valley Christian Schools added a "head of household" supplement to their teachers' salaries – but only to heads of household as determined by scripture. For Roanoke Valley, that meant married men. According to the church pastor affiliated with the school, "[w]hen we turned to the Scriptures to determine head of household, by scriptural basis, we found that the Bible clearly teaches that the husband is the head of the house, head of the wife, head of the family."[32] When sued under the Equal Pay Act,

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coverage of medical abortion. Any arguments, therefore, that by including all FDA-approved contraceptives the HRSA Guidelines violate restrictions on abortion in the ACA or other federal laws is pure misdirection.

[29] *See* USCCB, *supra* note 27, at 18-19; *see also* The Respect for Rights of Conscience Act, H.R. 1179/S. 1467, 112th Cong. (2011). The USCCB endorsed this legislation as their response to the HRSA Guidelines. *See* Press Release, USCCB, HHS Mandate for Contraceptive and Abortifacient Drugs Violates Conscience Rights (Aug. 1, 2011), http://www.usccb.org/news/2011/11-154.cfm.

[30] First Amendment claims brought against the California and New York contraceptive equity laws were rejected by the high court of each state. *See Catholic Charities of Sacramento, Inc.*, 85 P.3d at 74; *Catholic Charities of Diocese of Albany*, 859 N.E.2d at 461. Those courts did not address the Religious Freedom Restoration Act ("RFRA") because it is inapplicable to state laws.

[31] *Newman v. Piggie Park Enters., Inc.*, 256 F. Supp. 941, 944 (D. S.C. 1966), *aff'd in part and rev'd in part on other grounds*, 377 F.2d 433 (4th Cir. 1967), *aff'd and modified on other grounds*, 390 U.S. 400 (1968).

[32] *Dole v. Shenandoah Baptist Church*, 899 F.2d 1389, 1392 (4th Cir. 1990).

> Roanoke Valley claimed a right to an exemption from equal pay laws because its "head-of-household practice was based on a sincerely-held belief derived from the Bible."[33]

But just as it was not a violation of religious freedom to require segregated restaurants to integrate,[34] or schools to pay their teachers equally,[35] in the face of longstanding and sincerely held religious objections, it is not a violation of religious freedom to require that women have access to contraceptive coverage.

A. The First Amendment

The United States Supreme Court has rejected the notion that the Free Exercise Clause of the First Amendment requires exemptions from generally applicable and neutral laws like the Women's Health Amendment.[36] As the Court noted in *Employment Division v. Smith*, to do otherwise would be to create a system "in which each conscience is a law unto itself."[37] The WHA requires all new insurance plans to include coverage of the preventive services listed in the HRSA Guidelines. It applies to plans held by secular and religiously affiliated employers alike. Such a neutral law does not violate the First Amendment, despite the existence of theological doctrines opposing contraception.

In their advocacy on this issue, the United States Conference of Catholic Bishops ("USCCB") and others have attempted to skirt the *Smith* standard in two ways. First, they argued that the contraceptive coverage requirement was somehow targeted at the Catholic Church. Although contraception and support for contraceptive coverage are overwhelmingly popular, objection to it is in no way limited to Catholic institutions.[38] Regardless, the HRSA Guidelines are not aimed at any religious objector. Rather, the Guidelines "target" *all* insurance plans toward the goal of bettering women's health and well-being by requiring coverage of preventive services at no cost-sharing.

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[33] *Id.* at 1397.

[34] *Piggie Park Enters., Inc.*, 256 F. Supp. at 945.

[35] *Shenandoah Baptist Church*, 899 F.2d 1389 (4th Cir. 1990) (holding that a religious school that gave extra payments to married male teachers, but not married women, based on the religious belief that men should be "heads of households" could be held liable under equal pay laws); *see also E.E.O.C. v. Fremont Christian Sch.*, 781 F.2d 1362 (9th Cir. 1986) (holding that a religious school that gave male employees family health benefits but denied such benefits to similarly situated women because of the sincerely held belief that men are the "heads of households" violated Title VII).

[36] *See Employment Div. v. Smith*, 494 U.S. 872 (1990).

[37] *Id.* at 890.

[38] *See, e.g.*, Christian Medical Association, *supra* note 26; Press Release, Family Research Council, FRC Opposes HHS Mandated Coverage of Abortifacients Under Obamacare (Aug 1, 2011); *Catholic Charities of Diocese of Albany*, 859 N.E.2d at 463 (plaintiffs challenging New York's contraceptive equity law included several Baptist groups).

Second, the USCCB invokes the "hybrid rights" exception to *Smith*, claiming that the contraceptive coverage requirement violates freedom of speech and association. In *Smith*, the Supreme Court explained its prior precedents, which did require exemptions from neutral laws, as implicating both religious liberty and a separate constitutional right. The lower federal courts have disagreed about whether the Court created a new "hybrid rights" exception to the *Smith* doctrine, and if so, what showing it demands of a religious adherent.[39] But even the most expansive view of the hybrid rights exception could not call into question the WHA. It is well established that one does not make out a hybrid rights claim "merely by combining a free exercise claim with an utterly meritless claim of the violation of another alleged fundamental right or a claim of an alleged violation of a non-fundamental or non-existent right."[40] The WHA implicates neither speech nor association.

Like other contraceptive coverage laws, the WHA does not "compel [anyone] to associate, or prohibit [anyone] from associating, with anyone."[41] Compliance with a health insurance law does not implicate expressive association. Similarly, compliance with the WHA is not an endorsement of birth control; adherence to a law does not violate the speech rights of someone who disagrees with it. As the California Supreme Court held in this context, "for purposes of the free speech clause, simple obedience to a law that does not require one to convey a verbal or symbolic message cannot reasonably be seen as a statement of support for the law or its purpose. Such a rule would, in effect, permit each individual to choose which laws he would obey merely by declaring his agreement or opposition."[42] Employers and insurance issuers remain free to oppose birth control, to attempt to persuade others not to use contraception, and to convey their moral messages. What they may not do is impose their religious beliefs on third parties by choosing which essential health services third parties are able to access.

B. Religious Freedom Restoration Act

Congress enacted the Religious Freedom Restoration Act ("RFRA") to restore the strict scrutiny standard that protected religious exercise from substantial burdens imposed by neutral laws prior to *Smith*. The ACLU advocated for its passage. Despite claims to the contrary, RFRA

[39] *See McTernan v. City of York*, 564 F.3d 636, 647 n.5 (3d Cir. 2009) (listing the circuits that have rejected the notion of a special hybrid rights rule); *Jacobs v. Clark County Sch. Dist.*, 526 F.3d 419, 440 n. 45 (9th Cir. 2008) (declining to adopt doctrine after noting widespread scholarly criticism); *Knight v. Conn. Dep't of Pub. Health*, 275 F.3d 156, 167 (2d Cir. 2001) (describing hybrid rights theory as non-binding dicta); *Kissinger v. Bd. of Trs.*, 5 F.3d 177, 180 (6th Cir. 1993) (describing doctrine as "completely illogical").

[40] *Miller v. Reed*, 176 F.3d 1202, 1208 (9th Cir. 1999).

[41] *Catholic Charities of Diocese of Albany*, 859 N.E.2d at 465.

[42] *Catholic Charities of Sacramento, Inc.*, 85 P.3d at 89; *see also Gay Rights Coalition of Georgetown Univ. Law Ctr. v. Georgetown Univ.*, 536 A.2d 1, 20-21 (D.C. 1987) (holding that provision of benefits to a student group would amount to neither "an abstract expression of the University's moral philosophy" nor an expression of support for the group or its views).

is not implicated here for the simple reason that the contraceptive coverage requirement does not impose a substantial burden on religion. And even if the statute did impose such a burden, it furthers a compelling state interest in promoting gender equality, reproductive autonomy, and religious liberty.

1. Substantial Burden

Under RFRA, a "substantial burden exists when government action puts 'substantial pressure on an adherent to modify his behavior and to violate his beliefs[.]'"[43] But the fact that government action "is offensive to [an individual's] religious sensibilities" does not render the action a substantial burden.[44] The link between the contraceptive coverage requirement and the religiously prohibited behavior is too attenuated to amount to a substantial burden.

The contraceptive coverage requirement simply requires employers to pay money, which purchases insurance, which covers a range of health care, which an employee may ultimately use to access birth control in her private life. The same, or greater, attenuation applies to insurers and individual purchasers. The long journey between a devout person's paying money, and *someone else's* use of that money to engage in behavior that the devout person considers sinful does not compel the government to excuse a religious adherent from a general law.[45]

Courts have routinely rejected similar claims for exemption from paying taxes or providing benefits which conflict with its religious doctrine. In *United States v. Lee*, an Amish taxpayer objected to participating in the Social Security system on religious grounds. The Supreme Court unanimously rejected that free exercise claim, explaining:

> [I]t would be difficult to accommodate the comprehensive social security system with myriad exceptions flowing from a wide variety of religious beliefs . . . . If, for example, a religious adherent believes war is a sin, and if a certain percentage of the federal budget can be identified as devoted to war-related activities, such individuals would have a similarly valid claim to be exempt from paying that percentage of the income tax. The

[43] *Kaemmerling v. Lappin*, 553 F.3d 669, 678 (D.C. Cir. 2008) (quoting *Thomas v. Review Bd.*, 450 U.S. 707, 718 (1981)); *accord Goodall by Goodall v. Stafford County Sch. Bd.*, 60 F.3d 168, 171 (4th Cir. 1995) (explaining that since RFRA does not create a new test to determine what constitutes a "substantial burden," courts look to pre-*Smith* free exercise cases for that analysis).

[44] *Navajo Nation v. U.S. Forest Serv.*, 535 F.3d 1058, 1070 (9th Cir. 2008) (en banc).

[45] *See, e.g., Tarsney v. O'Keefe*, 225 F.3d 929 (8th Cir. 2000) (paying taxes that subsidize Medicaid abortion coverage cannot even support standing to assert a free exercise claim because the injury it inflicts on a taxpayer religiously opposed to abortion is too attenuated).

tax system could not function if denominations were allowed to challenge the tax system because tax payments were spent in a manner that violates their religious belief.[46]

Importantly, nothing in the HRSA Guidelines requires any person to *use* contraception. The requirement is merely that contraceptive services be covered in insurance plans at no cost-sharing, such that individuals may choose whether or not to access those services. Senator Barbara Mikulski, the author of the Women's Health Amendment, put it well when explaining the purpose of the provision on the Senate floor: "[W]e do not mandate that you have the service; we mandate that you have *access* to the service. The decision as to whether you should get it will be a private one, unique to you."[47]

Any entity covered by this provision remains free to relate its teachings about contraception to its adherents, its employees, and the general public, and attempt to persuade them not to use birth control. Indeed, when Wisconsin enacted a contraceptive equity provision with no religious refusal, a spokesman for the Diocese of Madison explained "Our employees know what church teaching is. And we trust them to use their conscience and do the right thing."[48]

Insurance typically provides a broad range of benefits, some of which individual insureds will never use. Because Jehovah's Witnesses believe that accepting blood transfusions is a sin, devout Jehovah's Witnesses presumably do not use transfusion coverage. But this is a long way from asserting that a Jehovah's Witness employer should be entitled to purchase customized health plans that exclude coverage for blood transfusions for all its employees. As New York's highest court explained in a similar context, there is no "absolute right for a religiously-affiliated employer to structure all aspects of its relationship with its employees in conformity with church teachings."[49]

Offering or contributing to insurance coverage that provides numerous health services, including one to which you object, simply is not a substantial burden cognizable under RFRA.[50]

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[46] *United States v. Lee*, 455 U.S. 252, 259-60 (1982) (citations omitted); *see also United States v. Indianapolis Baptist Temple*, 224 F.3d 627 (7th Cir. 2000); *Adams v. Comm'r*, 170 F.3d 173 (3d Cir. 1999).

[47] 155 CONG. REC. at S12277 (daily ed. Dec 3, 2009) (statement of Sen. Mikulski) (emphasis added).

[48] Annysa Johnson, *Catholic Church, Contraception Coverage Collide*, MILWAUKEE JOURNAL-SENTINEL, Aug. 12, 2010, *available at* http://www.jsonline.com/features/religion/100504294.html.

[49] *Catholic Charities of Diocese of Albany*, 859 N.E.2d at 465 (rejecting a challenge to New York's contraceptive equity law). *See also U.S. Dep't. of Labor v. Shenandoah Baptist Church*, 707 F. Supp. 1450 (W.D. Va. 1989), *aff'd sub nom. Dole v. Shenandoah Baptist Church*, 899 F.2d 1389 (4th Cir. 1990); *E.E.O.C. v. Freemont Christian School*, 781 F.2d 1362 (9th Cir. 1986).

[50] *See Goehring v. Brophy*, 94 F.3d 1294, 1297, 1300 (9th Cir. 1996), *overruled on other grounds by City of Boerne v. P.F. Flores*, 521 U.S. 507 (1997) (rejecting students' objections to a university registration fee that was used to subsidize the schools' health program which covered abortion care, reasoning that the payments did not impose a

Any claim to the contrary would turn RFRA into a blanket religious exemption that would threaten numerous health, welfare, and civil rights protections. Thus, any RFRA claim fails at the threshold. Even if it did not, the contraceptive coverage requirement survives RFRA review intact.

2. Compelling Interest

Allowing organizations to ignore the contraceptive coverage requirement would directly harm their employees' rights. The Supreme Court has recognized that granting an exemption to a religious employer "operates to impose the employer's religious faith on the employees."[51] Exempting employers from the contraceptive coverage requirement injures three fundamental rights of the women affected: gender equality, reproductive autonomy, and religious liberty. Those interests should not be sacrificed here.

a. Gender Equality

Omitting contraceptive coverage from a comprehensive benefit package is gender discrimination.[52] Prescription contraceptives are, for the most part, a form of health care available *only* to women. The consequences of the failure to be able to access and use contraception fall primarily on women. Denying contraceptive coverage undermines women's control over childbearing, which directly affects women's ability to participate equally in society. The Supreme Court has recognized as much: "The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives."[53]

Equality is unquestionably a compelling government interest.[54] Ending sex discrimination in employment benefits is "equally if not more compelling than other interests

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substantial burden on the plaintiffs' religious exercise because "the plaintiffs [were] not required to accept, participate in, or advocate in any manner for the provision of abortion services.").

[51] *Lee*, 455 U.S. at 261. This is all the more true for an insurer that would impose its beliefs on the employees of a range of different organizations.

[52] *See* Equal Employment Opportunity Commission, Decision of Coverage of Contraception (Dec. 14, 2000), *available at* http://www.eeoc.gov/policy/docs/decision-contraception.html ("Contraception is a means by which a woman controls her ability to become pregnant. . . . [Employers] may not discriminate in their health insurance plan by denying benefits for prescription contraceptives when they provide benefits for comparable drugs and devices."); *Erickson v. Bartell Drug Company*, 141 F. Supp. 2d 1266 (W.D. Wash. 2001).

[53] *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 856 (1992).

[54] *Roberts v. United States Jaycees*, 468 U.S. 609, 623 (1984).

that have been held to justify legislation that burdened the exercise of religious convictions."[55] Ensuring equal benefits to men and women promotes "interests of the highest order."[56]

The WHA was designed to improve women's health and redress sex discrimination in health benefits. "[T]his legislation . . . offers free preventive services to millions of women who are being discriminated against . . . ."[57] As Senator Mikulski noted: "Often those things *unique to women* have not been included in health care reform. Today we guarantee it and we assure it and we make it affordable by dealing with copayments and deductibles . . . ."[58] In particular, Congress intended to address gender disparities in out-of-pocket health care costs, much of which stems from reproductive health care:

> Not only do [women] pay more for the coverage we seek for the same age and the same coverage as men do, but in general women of childbearing age spend 68 percent more in out-of-pocket health care costs than men. . . . This fundamental inequity in the current system is dangerous and discriminatory and we must act. The prevention section of the bill before us must be amended so coverage of preventive services takes into account the unique health care needs of women throughout their lifespan.[59]

Creating gaping holes in the contraceptive coverage requirement would perpetuate the fundamental inequity that the WHA was designed to erase.

b. Reproductive Autonomy

At the core of the right to privacy is every person's right to make the profound, life-altering decision of whether to become a parent. The "realm of personal liberty" includes a woman's right "to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."[60]

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[55] *Fremont Christian Sch.*, 781 F.2d at 1369 (quoting *E.E.O.C. v. Pac. Press Publ'g Assoc.*, 676 F.2d 1272, 1280 (9th Cir. 1982)).

[56] *Shenandoah Baptist Church*, 899 F.2d at 1398 (quoting *Wisconsin v. Yoder*, 406 U.S. 205, 215 (1972)). The high courts of California and New York each reached this conclusion when considering their respective contraceptive coverage laws. *See Catholic Charities of Sacramento, Inc.*, 85 P.3d at 92 ("The [contraceptive requirement] serves the compelling state interest of eliminating gender discrimination."); *Catholic Charities of Diocese of Albany*, 859 N.E.2d at 468 (describing the "State's substantial interest in fostering equality between the sexes, and in providing women with better health care").

[57] 155 CONG. REC. at S12020 (daily ed. Dec 1, 2009) (statement of Sen. Reid); *see also* 155 CONG. REC. S11979, S11987 (daily ed. Nov. 30, 2009) (Statement of Sen. Mikulski).

[58] 155 CONG. REC. at S11988 (daily ed. Nov. 30, 2009) (statement of Sen. Mikulski) (emphasis added).

[59] *See* 155 CONG. REC. at S 12027 (daily ed. Dec. 1, 2009) (statement of Sen. Gillibrand); *see also* 155 CONG. REC. at S12272 (daily ed. Dec. 3, 2009) (statement of Sen. Stabenow) ("Women of childbearing age pay on average 68 percent more for their health care than men do.").

[60] *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972).

Reproductive health care, including contraception, is constitutionally protected as necessary to implementing fundamental childbearing decisions.[61] Protecting access to reproductive health services is a compelling public interest.[62]

Virtually all women of reproductive age have used birth control at some point.[63] Denial of contraceptive coverage causes some women to forgo birth control or use less expensive and less effective methods, resulting in unintended pregnancies.[64] Further, cost-sharing requirements pose substantial barriers to accessing this preventive care.[65] The contraceptive coverage requirement promotes women's interest in planning their families.[66]

c. Religious Liberty

Just as those religious tenets opposing the use of contraception are entitled to respect, so too are contrary religious traditions, which hold that sexual intimacy need not be linked to procreation and that planning childbearing is a morally responsible act. In our constitutional system, the government is supposed to be a neutral actor, allowing individuals to follow their own religious or moral consciences. Requiring contraceptive coverage in health plans does just that – it allows every woman to decide for *herself* what is right for her and her family.[67] That is not an employer's decision to make.

IV. Creating Sweeping Exceptions to the Contraceptive Coverage Requirement Is the Top of a Slippery Slope

The argument that the Affordable Care Act cannot require contraception coverage because some oppose birth control on religious grounds knows no limit. In a "cosmopolitan nation made up of people of almost every conceivable religious preference,"[68] innumerable

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[61] *Griswold*, 381 U.S. 479.

[62] *Am. Life League, Inc. v. Reno*, 47 F.3d 642, 655-56 (4th Cir. 1995); *Council for Life Coal. v. Reno*, 856 F. Supp. 1422, 1430 (S.D. Cal. 1994).

[63] CLOSING THE GAPS, *supra* note 5, at 92.

[64] Guttmacher Institute Testimony, *supra* note 11, at 8.

[65] CLOSING THE GAPS, *supra* note 5, at 94.

[66] *See, e.g.*, 155 CONG. REC. at S12025 (daily ed. Dec. 1, 2009) (statement of Sen. Boxer) ("These health care services include . . . family planning services."); *id.* at S12027 (statement of Sen. Gillibrand) ("With [the WHA], even more preventive screening will be covered, including . . . family planning."); 155 CONG. REC. at S12271 (daily ed. Dec. 3, 2009) (statement of Sen. Franken) ("Under [the WHA], the Health Resources and Services Administration will be able to include other important services at no cost, such as . . . family planning"); *id.* at 12274 (statement of Sen. Murray) ("We have to make sure we cover preventive services, and [the WHA] takes into account the unique needs of women. . . . Women will have improved access to . . . family planning services.").

[67] As the California Supreme Court has recognized, "[o]nly those who join a church impliedly consent to its religious governance on matters of faith and discipline." *Catholic Charities of Sacramento, Inc.*, 85 P.3d at 77.

[68] *Braunfeld v. Brown*, 366 U.S. 599, 606 (1961).

medical procedures will be disfavored by adherents of one religion or another. Indeed, the legislative "fix" some have proposed goes far beyond creating loopholes to the contraceptive coverage requirement. H.R. 1179, the Respect for Rights of Conscience Act of 2011, would allow *any* insurer, employer, or individual, to refuse coverage of *any* health service. Prenatal care, testing for HIV, mental health services, screening for cervical cancer, health care for smokers – coverage for all of these services and countless others could be denied to any person under this radically broad bill. Applying this approach to the ACA would undermine one of its most fundamental purposes: ensuring that all health insurance plans cover basic health services. In fact, it would undermine the very notion of health insurance.

* * *

Meaningful access to effective contraception is essential for women. The contraceptive coverage requirement is a huge step forward for women's health and equality. Every exception to the contraceptive coverage requirement "increases the number of women affected by discrimination in the provision of health care benefits."[69] The HHS Guidelines should be celebrated, not dismantled.

[69] *Catholic Charities of Sacramento, Inc.*, 85 P.3d at 94 (concluding that California's contraceptive coverage law was narrowly tailored).

national partnership
for women & families
Because actions speak louder than words

"Do New Health Law Mandates Threaten Conscience Rights and Access to Care?"

Testimony submitted by

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Committee on Energy & Commerce
Subcommittee on Health

November 2, 2011

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Members of the House Energy & Commerce Subcommittee on Health: we are honored to submit this testimony on behalf of the National Partnership for Women & Families and the women and families we represent.

That National Partnership for Women & Families is a nonprofit, nonpartisan 501(c)3 organization located in Washington, D.C. We have worked tirelessly for the last forty years to expand access to quality, affordable health care that includes comprehensive reproductive health services for all Americans; to eliminate discrimination in the workplace; and to enable women to meet the dual demands of work and family. The National Partnership for Women & Families strongly supports contraceptive coverage for all women and opposes efforts that would undermine this vital health care for many women. Efforts to restrict contraceptive access for some women by allowing employers to impose their own religious views on their employees undermine the important purposes of the Patient Protection and Affordable Care Act (ACA) and violate federal anti-discrimination law.

All Women Deserve Equal Access to the Important Health Benefits of Contraceptive Coverage

Virtually all women (99%) will use contraception during their reproductive lives.[i] Those numbers remain constant for Catholics (98%) and only 2% of Catholics use natural family planning as their method of contraception.[ii] These women deserve access to the same preventive health services as all other women. As the IOM Committee convened by HHS to assist it in making a determination about coverage under the women's health amendment to the ACA noted in its report, access to contraceptive coverage is vital to women's health. Unintended pregnancy has serious implications for women and babies and for public health. As the IOM Committee explained:

> The risk factors for unintended pregnancy are female gender and reproductive capacity. ...
> [A]ll sexually active women with reproductive capacity are at risk for unintended pregnancy. ... Pregnancy spacing is important because of the increased risk of adverse pregnancy outcomes for pregnancies that are too closely spaced (within 18 months of a prior pregnancy). Short interpregnancy intervals in particular have been associated with low birth weight, prematurity and small for gestational age births. In addition, women with certain chronic medical conditions (e.g., diabetes and obesity) may need to postpone pregnancy until appropriate weight loss or glycemic control has been achieved. Finally, pregnancy may be contraindicated for women with serious medical conditions such as pulmonary hypertension (etiologies can include idiopathic pulmonary arterial hypertension and others) and cyanotic heart disease, and for high-risk women with the Marfan Syndrome. ...
>
> The IOM Committee on Women's Health Research recently identified unintended pregnancy to be a health condition of women for which little progress in prevention has been made, despite the availability of safe and effective preventive methods. This report also found that progress in reducing the rate of unintended pregnancy would be possible by "making contraceptives more available, accessible, and acceptable through

> improved services. Another IOM report on unintended pregnancy recommended that "all pregnancies should be intended" at the time of conception and set a goal to increase access to contraception in the United States. ...
>
> Family planning services are preventive services that enable women and couples to avoid an unwanted pregnancy and to space their pregnancies to promote optimal birth outcomes.[iii]

The IOM Committee was made up of a wide variety of medical experts, including specialists in disease prevention, women's health issues, adolescent health issues, and evidence-based guidelines. The IOM Committee thoroughly examined the scientific evidence over a period of six months. As noted above, their scientific findings made clear that contraceptive coverage is a critical aspect of women's health care and thus to the public health of the United States. Currently, 28 states require that insurance plans include coverage of contraceptives if other similar services are covered. Eight of those states do not provide any sort of exemption.[iv]

Allowing Certain Employers to Opt Out of Comprehensive Coverage Requirements Undermines the Promise of the ACA

The ACA requires that women's preventive health services be covered without cost-sharing. As you are well aware, the Women's Health Amendment to the ACA, section 2713(a)(4), was approved by Congress to remedy past discrimination against women in the provision of health care and to ensure that all women's health care needs were met under the act.[v] The Congressional record makes clear that contraceptive coverage was contemplated as part of this important provision.[vi]

Neither the Women's Health Amendment, nor any other portion of the ACA, contemplates allowing certain employers to discriminate against women in the provision of contraceptive services. Rather section 2713 of the ACA applies to *all* group health plans and plan issuers and states: "A group health plan and a health insurance issuer offering group or individual health insurance coverage *shall*, at a minimum provide coverage for and shall not impose any cost sharing requirements for ... with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph."[vii] Nothing in this provision allows certain religious employers to be treated differently than all other employers.

This is even more notable because Congress has included refusal provisions in many laws. In fact, another section of the ACA includes a refusal clause. Section 1303 of the ACA establishes "Special Rules" for coverage of abortion in health plans. Among other provisions, this section specifically allows individuals and entities to refuse to provide abortion care.[viii] It also incorporates other federal laws that allow individuals and entities to refuse to provide some care to which they object.[ix] None of the refusal provisions in these federal laws extend to provision or coverage of contraception.[x] Moreover, the statute explicitly states that "Nothing in section 1303(c) of the Affordable Care Act shall alter the rights and obligations of employees

and employers under Title VII of the Civil Rights Act of 1964."[xi] As explained in greater detail below, allowing certain employers to fail to provide contraceptive coverage to their employees violates Title VII.

One of the important goals of the ACA was to eliminate the discrimination against women that had so long interfered with their ability to get all of their health care needs met. Several important provisions were included in the law to ensure that these goals would be achieved. Section 1557 prohibits discrimination in health care on the basis of – among other things – sex.[xii] Since the burdens of pregnancy fall entirely on women and most contraceptive methods are available only to women, failure to provide equal access to contraception constitutes discrimination on the basis of sex. Furthermore, access to contraception is essential to gender equality, as it is only when women can control their fertility that they are able to participate equally in society.

Allowing some employers to opt out of contraceptive coverage requirements would also violate Section 1554 of the ACA, which states that the "Secretary of Health and Human Services shall not promulgate any regulation that ... (1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care; (2) impedes timely access to health care services ... or (6) limits the availability of health care treatment for the full duration of a patient's medical needs."[xiii] Providing a religious exemption means that some women seeking legal reproductive healthcare services will be subjected to unnecessary and sometimes prohibitive financial obstacles in accessing the services. The exemption would create an unreasonable barrier for women seeking appropriate medical care by requiring those who work for certain religious employers to bear the substantial costs of contraceptive counseling and services.

Allowing Some Employers to Opt Out of Comprehensive Coverage Requirements Violates Federal Non-Discrimination Law

Section 1557, detailed above, makes clear that it does nothing to modify employers' obligation to comply with other civil rights laws.[xiv] One of those laws is Title VII of the Civil Rights Act of 1964, as amended by the Pregnancy Discrimination Act (PDA), which prohibits sex discrimination in employment.[xv] The PDA specifically prohibits discrimination against women "affected by pregnancy, childbirth, or related medical conditions" in all aspects of employment, including the receipt of fringe benefits.[xvi] The Supreme Court has long held that it is discrimination under this section to treat women differently, not just because they are pregnant, but because of their potential to become pregnant.[xvii] Just as it is discrimination prohibited under section 1557, it is a violation of Title VII to allow some employers to refuse to provide contraceptive coverage for their female employees.

The specific issue of failing to provide contraceptive coverage along with other related health services was addressed by the Equal Employment Opportunity Commission in 2000. Two registered nurses filed complaints with the EEOC against their employers for their employers' refusal to cover prescription contraception while covering a wide array of other prescription drugs and preventative health care services. The EEOC panel noted that pregnancy discrimination included discrimination based on the potential to become pregnant and found

that the PDA clearly prohibited discrimination in benefits, including prescription contraception. They based their decision on the language of the PDA, Supreme Court cases interpreting it, and Congress' legislative intent. The EEOC rejected the employers' arguments that they could exclude contraception for strictly financial reasons or because it was not used to treat "something abnormal about [the employee's] mental or physical health." They found that the employers had treated contraception differently than other preventative services and had, thereby, "discriminated on the basis of pregnancy." Because prescription birth control is only available for women, the EEOC also rejected the employers' argument that they did not explicitly distinguish between men and women. The EEOC ordered the employers to cover the expenses of prescription contraceptives, including "the full range of prescription contraceptive choices."[xviii] The few courts that have addressed this issue have reached varied results, with a number of federal courts agreeing that failing to provide contraceptive coverage violates Title VII.[xix]

Conclusion

The National Partnership for Women & Families urges Congress to ensure that all women have access to comprehensive health services, including contraceptive methods. Attempts to dismantle these requirements discriminate against certain women because of where they are employed and endanger their health. Congress should reject all attempts to undermine the promise of the Women's Health Amendment to the ACA.

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[i] Rachel K. Jones and Joerg Dreweke, *Countering Conventional Wisdom: New Evidence on Religion and Contraceptive Use*, Guttmacher Institute (April 2011), *available at* http://www.guttmacher.org/pubs/Religion-and-Contraceptive-Use.pdf.

[ii] Id.

[iii] Committee on Preventive Services for Women Board on Population Health and Public Health Practice; *Clinical Preventive Services for Women: Closing the Gaps*; Institute of Medicine 90-91 (July 2011) (internal citations omitted).

[iv] *See*, State Policies In Brief: Insurance Coverage of Contraceptives, Guttmacher Institute (Sept. 1, 2011), *at* http://www.guttmacher.org/statecenter/spibs/spib_ICC.pdf

[v] *See*, David Herszenhorn and Robert Pear, *Senate Passes Women's Health Amendment*, Prescriptions: The Business of Health Care, New York Times blogs, *at* http://prescriptions.blogs.nytimes.com/2009/12/03/senate-passes-womens-health-amendment/

[vi] Sen. A. Franken, *Congressional Record*, Dec. 3, 2009, p. S.12271; Sen. B. Boxer, *Congressional Record*, Dec. 1, 2009, p. S.12025; Sen. D. Feinstein, *Congressional Record*, Dec. 2, 2009, p. S. 12114; Sen. B. Nelson, *Congressional Record*, Dec. 3, 2009, p. S.12277.

[vii] Patient Protection and Affordable Care Act, Pub L. No. 111-148, § 2713, codified at 42 U.S.C. 300gg–13 (2010) (emphasis added).

[viii] Patient Protection and Affordable Care Act, Pub L. No. 111-148, § 1303(a)(3), codified at 42 U.S.C. § 18023 (2010).

[ix] §1303(b)(2).

[x] *See*, Church Amendment, an amendment to the Health Programs Extension Act of 1973 §401, 42 U.S.C. §300a-7; Coats Amendment, an amendment to the Public Health Services Act of 1996 §245, 42 U.S.C. §238n; Weldon Amendment, Consolidated Appropriations Act of 2010 §508.

[xi] §1303(b)(3).

[xii] "Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et

seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments)." Patient Protection and Affordable Care Act, Pub L. No. 111-148, § 1557(a), codified at 42 U.S.C. § 18116 (2010).

[xiii] Patient Protection and Affordable Care Act, Pub L. No. 111-148, § 1554, codified at 42 U.S.C. § 18114 (2010).

[xiv] "Nothing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or the Age Discrimination Act of 1975 (42 U.S.C. 611 et seq.), or to supersede State laws that provide additional protections against discrimination on any basis described in subsection (a)." Patient Protection and Affordable Care Act, Pub L. No. 111-148, § 1557(b), codified at 42 U.S.C. § 18116 (2010).

[xv] 42 U.S.C. § 2000e et seq.

[xvi] 42 U.S.C. § 2000e(k).

[xvii] *See* Int'l Union, UAW v. Johnson Controls, 499 U.S. 187 (1991).

[xviii] Equal Employment Opportunity Commission (EEOC), Decision on Coverage of Contraception (Dec. 14, 2000), *at* http://www.eeoc.gov/policy/docs/decision-contraception.html (last visited Sept. 21, 2011).

[xix] *Compare*, Erickson v. Bartell Drug Co., 141 F. Supp. 2d 1266 (W.D. Wash. 2001) (holding that failure to provide contraceptive coverage resulted in less comprehensive coverage for women than for men and violated Title VII); Cooley v. DaimlerChrysler Corp., 281 F.Supp.2d 979 (E.D. Mo. 2003); Mauldin v. Wal-Mart, 89 Fair Empl. Prac. Cas. (BNA) 1600 (N.D. Ga. 2002) (certifying plaintiff class of contraceptive-using women and citing *Erickson*. Wal-Mart ultimately settled the case by agreeing to provide contraceptive coverage); *with*, In re Union Pacific Railroad Employment Practices Litigation, 479 F.3d 936, 943 (8th Cir. 2007) (holding that the potential to become pregnant is not "related to pregnancy" under the PDA and that contraceptives did not have to be compared with other preventive health services, an argument in direct contrast to the WHA and IOM Committee findings); Stocking v. AT&T, No. 03-0421, 2007 U.S. Dist. LEXIS 78188 (W.D. Mo. 2007) (controlled by *Union Pacific*); Cummins v. Illinois, No. 02-4201, 2005 U.S. Dist. LEXIS 42634 (S.D. Ill 2005).

TESTIMONY BEFORE THE COMMITTEE ON ENERGY AND COMMERCE

SUBCOMMITTEE ON HEALTH

FOR THE HEARING ENTITLED "DO NEW HEALTH LAW MANDATES THREATEN CONSCIENCE RIGHTS AND ACCESS TO CARE?"

NOVEMBER 2, 2011

BY THE

NATIONAL HEALTH LAW PROGRAM

The National Health Law Program ("NHeLP") submits this testimony to the Energy and Commerce Committee's Subcommittee on Health. NHeLP is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. NHeLP provides technical support to direct legal services programs, community-based organizations, the private bar, providers, and individuals who work to preserve a health care safety net for the millions of uninsured or underinsured low-income people. In a just society, every woman must be able to make her own decisions about whether or when to have children based on her own beliefs and needs. The Patient Protection and Affordable Care Act ("the ACA") recognizes that preventive health services are critical to individual and community health, and that cost is often a barrier to accessing the preventive services we need. Moreover, it acknowledges the critical role that a woman's health plays in her family and her community by explicitly requiring that women's preventive health services be covered without cost-sharing.

NHeLP's testimony addresses issues raised by the Majority staff's Internal Hearing Memorandum dated October 28, 2011, and circulated to Members of the Subcommittee on Health. NHeLP strongly supports the decision by the U.S. Department of Health and Human Services Secretary, Kathleen Sebelius, to adopt the recommendations from the Institute of Medicine ("IOM") to require insurance coverage of women's preventive health services, including contraception, without cost-sharing. NHeLP strongly opposes efforts to undermine the health and autonomy of women, and the Majority staff's Memorandum presents two such threats: (1) HRSA's proposed exemption from the contraceptive requirement for certain religious employers; and (2) H.R. 1179, an expansive bill that undermines health reform by permitting insurers to opt-out of providing insurance coverage.

These efforts disregard accepted "standards of care," practices that are medically necessary and services that any practitioner under the circumstances should be expected to render. Every person who enters a doctor's office or hospital expects that the care he or she gets will be based on the best medical evidence and will meet accepted medical guidelines – in other words, that care will comport with medical standards of care. Refusal clauses and denials of care

violate these standards. They undermine standards of care by allowing or requiring health care professionals and institutions to abrogate their responsibility to deliver services and information that would otherwise be required by generally accepted practice guidelines. Ultimately, refusal clauses and institutional denials of care conflict with professionally developed and accepted medical standards of care and have adverse health consequences for patients.

A. THE REQUIREMENT TO COVER CONTRACEPTIVES AS A COMPONENT OF PREVENTIVE CARE IS EVIDENCE-BASED.

The ACA requires group health plans and health insurance issuers to cover certain preventive services without cost-sharing.[1] Among other things, the ACA requires new group health plans and health insurance issuers to cover such additional women's health preventive care and screenings as provided for in guidelines supported by the Health Resources and Services Administration ("HRSA").[2] By doing so, the ACA recognizes that women have unique reproductive and gender specific health needs, disproportionately lower incomes, and disproportionately higher out-of-pocket health care expenses. HRSA commissioned the independent IOM to conduct a scientific review and provide recommendations on specific preventive measures that meet women's unique health needs and help keep women healthy. The IOM developed eight recommendations based on scientific evidence, including the input of independent physicians, nurses, scientists, and other experts. HRSA recently adopted eight recommendations submitted by the Institute of Medicine ("IOM"), which include the recommendation that women receive coverage for all FDA-approved methods of contraception free of cost-sharing.[3] Requiring coverage of all eight preventive services recommended by the IOM, including coverage of all-FDA approved methods of contraception, is good medical and economic policy.

HRSA charged the IOM with convening a committee to determine the preventive services necessary to ensure women's health and well-being.[4] To this end, the IOM convened a committee of 16 eminent researchers and practitioners to serve on the Committee on Preventive Services for Women.[5] The Committee met five times in six months.[6] The Committee reviewed existing guidelines, gathered and reviewed evidence and literature, and considered public comments.[7] With respect to women, the IOM identified gaps in the coverage for preventive services not already addressed by the ACA, including services recommended by the United States Preventive Services Task Force, the Bright Futures recommendations for adolescents from the American Academy of Pediatrics, and vaccinations specified by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. The IOM

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[1] Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010), § 2713(a), 42 U.S.C. § 300gg-13.
[2] ACA § 2713(a)(4), 42 U.S.C. § 300gg-13.
[3] U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Women's Preventive Services: Required Health Plan Coverage Guidelines, http://www.hrsa.gov/womensguidelines.
[4] Institute of Medicine of the National Academies, *supra* note 3, at 1.
[5] *Id.* at 2.
[6] *Id.*
[7] *Id.*

recommended that, among other things, women receive coverage for all United States Food and Drug Administration ("FDA")-approved methods of contraception free of cost-sharing because: (1) pregnancy affects a broad population; (2) pregnancy prevention has a large potential impact on health and well-being; and (3) the quality and strength of the evidence is supportive of the recommendation to provide contraceptive coverage free of cost-sharing.[8]

B. CONTRACEPTION EFFECTIVELY PREVENTS UNINTENDED PREGNANCIES, AND WOMEN NEED TO BE ABLE TO SELECT THE METHOD THAT IS MOST APPROPRIATE.

Family planning is an essential preventative service for the health of women and families. In 2008, there were 66 million United States women of reproductive age (ages 13-44).[9] Over half of these women—36 million—were in need of contraceptive services and supplies because they were sexually active with a male, capable of becoming pregnant, and neither pregnant nor seeking to become pregnant.[10] Each year, nearly half of the pregnancies in the United States are unintended—meaning they were either unwanted or mistimed.[11] Forty-two percent of unintended pregnancies end in abortion.[12] By age 45, more than half of all women in the United States will have experienced an unintended pregnancy, and four in ten will have had an abortion.[13] Increased access to, and use of, contraceptive information and services could reduce the rate of these unwanted pregnancies.

The IOM report recognized that not all contraceptive methods are right for every woman, and access to the full range of pregnancy prevention options allows a woman to choose the most effective method for her lifestyle and health status. Current methods for preventing pregnancy include hormonal contraceptives (such as pills, patches, rings, injectables, implants, and emergency contraception), barrier methods (such as male and female condoms, cervical caps, contraceptive sponges, and diaphragms), intrauterine contraception, and male and female sterilization. As the IOM reported, female sterilization, intrauterine contraception, and contraceptive implants have failure rates of less than one percent.[14] Injectable and oral contraceptives have failure rates of seven and nine percent, largely due to misuse.[15] Failure rates for barrier methods are higher.[16] A woman has an 85 percent chance of an unintended pregnancy

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[8] *Id.* at 6, 151.
[9] Jennifer J. Frost, Stanley K. Henshaw & Adam Sonfield, Guttmacher Institute, *Contraceptive Needs and Services: National and State Data, 2008 Update* 3 (2010), http://www.guttmacher.org/pubs/win/contraceptive-needs-2008.pdf.
[10] *Id.*
[11] Lawrence B. Finer & Stanley K. Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, Perspectives on Sexual & Reprod. Health 90, 92 (2006), http://www.guttmacher.org/pubs/psrh/full/3809006.pdf; Guttmacher Institute, *Facts on Induced Abortion in the United States* (Aug. 2011), www.agi-usa.org/pubs/fb_induced_abortion.html.
[12] Institute of Medicine of the National Academies, *supra* note 3, at 102.
[13] Guttmacher Institute, *Fact Sheet: Facts on Induced Abortion in the United States* (Aug. 2011), http://www.guttmacher.org/pubs/fb_induced_abortion.html.
[14] Institute of Medicine of the National Academies, *supra* note 3, at 104-05.
[15] *Id.*
[16] *Id.*

if she uses no method of contraception.[17] Approximately 50 percent of unintended pregnancies in the United States occur among the eleven percent of women using no contraceptive method.[18] According to the Guttmacher Institute, in the United States, publicly funded family planning services and supplies alone help women avoid approximately 1.5 million unintended pregnancies each year.[19] If these services were not provided in 2008, unintended pregnancy rates would have been 47 percent higher, and the abortion rate would have been 50 percent higher.[20]

C. CONTRACEPTIVES ARE WIDELY USED IN THE UNITED STATES.

Most sexually active women in the United States use contraception to prevent pregnancy. Contraceptive use is nearly universal in women who are sexually active with a male partner: more than 99 percent of women 15–44 years of age who have ever had sexual intercourse with a male have used at least one contraceptive method.[21] This is true for nearly all women, of all religious denominations.[22] Indeed, the overwhelming majority of sexually active women of all denominations who do not want to become pregnant are using a contraceptive method.[23] Approximately 98 percent of sexually active Catholic women have used contraceptive methods banned by the Catholic Church.[24] Even among those Catholic women who attend church once a month or more, only two percent rely on the natural family planning method to prevent unintended pregnancy.[25]

D. COST PREVENTS WOMEN FROM ACCESSING CONTRACEPTIVE INFORMATION AND SERVICES.

Financial barriers impede women's access to contraceptive information and services. Cost-sharing can pose barriers to accessing health care services, particularly for low-income women. Indeed, one of the major barriers to universal contraceptive access is the high out-of-pocket cost for women—who are also disproportionately low-income—whose health plans do not cover contraception. Low-income women have higher rates of unintended pregnancy, as compared to higher-income women.[26] Low-income women are the least likely to have the resources to obtain reliable methods of family planning, and yet, they are most likely to be impacted negatively by unintended pregnancy.[27]

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[17] *Id.* at 105.
[18] Guttmacher Institute, *supra* note 14.
[19] Jennifer J. Frost, Stanley K. Henshaw & Adam Sonfield, Guttmacher Institute, *Contraceptive Needs and Services: National and State Data, 2008 Update* 5 (2010), http://www.guttmacher.org/pubs/win/contraceptive-needs-2008.pdf.
[20] *Id.*
[21] Williams D. Mosher & Jo Jones, *Use of Contraception in the United States: 1982–2008*, Nat'l Ctr. for Health Statistics, 23 Vital and Health Statistics, no. 29, 2010, at 5.
[22] Rachel K. Jones & Joerg Dreweke, Guttmacher Institute, *Countering Conventional Wisdom: New Evidence on Religion and Contraceptive Use* 4-5 (2011), http://www.guttmacher.org/pubs/Religion-and-Contraceptive-Use.pdf.
[23] *Id.*
[24] *Id.* at 4.
[25] *Id.* at 5.
[26] Lawrence B. Finer & Stanley K. Henshaw, *supra* note 12.
[27] Sheila D. Rustgi, Michelle M. Doty & Sara R. Collins, The Commonwealth Fund, *Women at Risk: Why Many Women are Forgoing Needed Health Care* 3-4 (2009),

Increased use of longer-acting, reversible contraceptive methods, which have lower failure rates, could further help reduce unintended pregnancy rates. These more effective methods of contraception, however, also have the most up-front costs, which put them outside of the reach of many women.[28] In 2008, for example, only 5.5 percent of women using contraception chose the more effective and longer-term methods.[29] As the IOM recognized, the "elimination of cost sharing for contraception . . . could greatly increase its use, including use of the more effective and longer-acting methods, especially among poor and low-income women most at risk for unintended pregnancy."[30] In this regard, the California Kaiser Foundation Health Plan's experience is informative. The California Kaiser Foundation Health Plan eliminated copayments for the most effective contraceptive methods in 2002.[31] Prior to the change, users paid up to $300 for 5 years of use; after elimination of the co-payment, use of these methods increased by 137 percent.[32]

E. PREVAILING STANDARDS OF CARE REQUIRE THAT WOMEN HAVE ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICES.

The government should make health care decisions based on scientific evidence and good economic policy, not on the religious and moral beliefs of some institutions. Health care refusals and denials of care, also known as "conscience" clauses, are based on ideological and political justifications that have no basis in scientific evidence, good medical practice, or patient needs. These policies violate the essential principles of modern health care delivery: evidence-based practice, patient centeredness, and prevention. "Standards of care" are practices that are medically necessary and the services that any practitioner under the circumstances should be expected to render. Refusal clauses and denials of care undermine standards of care by allowing or requiring health care professionals and/or institutions to abrogate their responsibility to provide services and information that would otherwise be required by generally accepted practice guidelines.

Although there is near universal agreement in medical practice guidelines that women should be given information about and access to contraceptives to prevent pregnancy, women face many barriers to contraceptive use, including institutional restrictions, physicians' denials of care, and pharmacists' refusals to fill prescriptions. Women consider a number of factors in determining whether to become or remain pregnant, including: age, educational goals, economic situation, the presence of a partner, medical condition, mental health, and whether they are taking medications that are contra-indicated for pregnancy. For example, a number of commonly

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http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/May/Women%20at%20Risk/PDF_1262_Rustgi_women_at_risk_issue_brief_Final.pdf. .

[28] Institute of Medicine, *supra* note 3, at 108.

[29] Kelly Cleland, et al., *Family Planning as Cost-Saving Preventive Health Service*, New Eng. J. Med 1 (2011), http://healthpolicyandreform.nejm.org/?p=14266.

[30] Institute of Medicine of the National Academies, *supra* note 3, at 109.

[31] Jennifer J. Frost & Jacqueline E. Darroch, *Factors Associated with Contraceptive Choice and Inconsistent Method Use*, 40 Sexual & Reprod. Health 94 (2008).

[32] *Id.*

prescribed pharmaceuticals are known to cause impairments in the developing fetus or to create adverse health conditions if a woman becomes pregnant while taking them. Approximately 11.7 million prescriptions for drugs the FDA has categorized as Pregnancy Classes D (there is evidence of fetal harm, but the potential may be acceptable despite the harm) or X (contraindicated in women who are or may become pregnant) are filled by significant numbers of women of reproductive age each year.[33] Pregnancy for women taking these drugs carries risk for maternal health and/or fetal health.[34] Women taking these drugs who might be at risk for pregnancy are advised to use a reliable form of contraception to prevent pregnancy.[35]

Unwanted pregnancy is associated with maternal morbidity and risky health behaviors. The World Health Organization recommends that pregnancies should be spaced at least two years apart.[36] Pregnancy spacing allows the woman's body to recover from the pregnancy. Further, if a woman becomes pregnant while breastfeeding, the health of both her baby and fetus may be compromised as her body shares nutrients between them. According to the American College of Obstetricians and Gynecologists, women who become pregnant less than six months after their previous pregnancy are 70 percent more likely to have membranes rupture prematurely, and are at a significantly higher risk of other complications.[37] Family planning is a focus area of the Healthy People 2010 health promotion objectives set out by the United States Department of Health and Human Services. Goal 9 of Healthy People 2010 is, "Improve pregnancy planning and spacing and prevent unintended pregnancy."[38] Specific indicators include increasing intended pregnancies from 51 percent to 70 percent; increasing pregnancy spacing to 24 months; increasing the proportion of women at risk for unintended pregnancy who use contraceptives to 100 percent, and increasing the proportion of teens that use contraceptive methods that both prevent pregnancy and prevent sexually transmitted disease.[39]

Further, millions of women live with chronic conditions such as cardiovascular disease, diabetes, lupus, and epilepsy, which if not properly controlled, can lead to health risks to the pregnant woman or even death during pregnancy. Denying these women access to contraceptive information and services does not comport with medical standards that recommend pregnancy prevention for these medical conditions. Refusal clauses impose significant burdens on the health and well-being of affected women and their families. These are burdens that fall disproportionately and most harshly on low-income women, severely impacting their health outcomes and their ability to give informed consent for medical care. Low income women, and low income women of color already experience severe health disparities in reproductive health, maternal health outcomes, and birth outcomes. Cardiovascular disease, lupus, and diabetes, for

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[33] *Id.*
[34] David L. Eisenberg, et al., *Providing Contraception for Women Taking Potentially Teratogenic Medications: A Survey of Internal Medicine Physicians' Knowledge, Attitudes and Barriers*, 25 J. Gen. Internal Med. 291, 291 (2010).
[35] *Id.* at 291-92.
[36] Cicley Marston, *Report of a WHO Technical Consultation on Birth Spacing*, World Health Organization, (June 13-15, 2005).
[37] Am. Coll. of Obstetricians & Gynecologists, *Statement of the Am. Coll. of Obstetricians & Gynecologists to the U.S. Senate, Comm. on Health, Educ., Labor & Pensions, Pub. Health Subcomm. on Safe Motherhood* (April 25, 2002).
[38] U.S. Dep't of Health & Human Servs., *Healthy People 2010: Understanding and Improving Health* (Nov. 2000).
[39] *Id.*

example, are chronic diseases that disproportionately impact women of color. The incidence rate for lupus is three times higher for African American women than for Caucasian women.[40] Similarly, although an estimated 7.8 percent of Americans have diabetes, the prevalence rate (the number of cases in a population at a specific time) is higher for women of color in all age groups, with obesity and family history being significant risk factors for Type II diabetes.[41] Women who are poor also have unintended pregnancy rates that are more than five times the rate for women in the highest income level.[42] Nearly one out of ten African American women and one in fourteen Latinas of reproductive age experience an unintended pregnancy each year.[43] Inaccessible and unaffordable contraceptive counseling and services contribute to these disparities.

Heart disease, for example, is the number one cause of death for women in the United States.[44] The American College of Cardiology and the American Heart Association Task Force on Practice Guidelines issued specific recommendations for management of women with valvular heart disease.[45] They conclude that individualized preconception management should provide the patient with information about contraception as well as material and fetal risks of pregnancy.[46] Some cardiac conditions in which the physiological changes brought about in pregnancy are poorly tolerated include vavular heart lesions such as severe aortic stenosis, aortic regurgitation, mitral stenosis, and mitral regurgitation all with III-IV symptoms, aortic or mitral valve disease, mechanical prosthetic valve requiring anticoagulation and aortic regurgitation in Marfan syndrome.[47]

The American College of Obstetricians and Gynecologists and the American Diabetes Association have developed practice guidelines for the preconception care for women with pregestational diabetes. According to the American Diabetes Association, planned pregnancies greatly facilitate diabetes care. Their recommendations for diabetic women with childbearing potential include: (1) use of effective contraception at all times, unless the patient is in good metabolic control and actively trying to conceive; (2) counseling about the risk of fetal impairment associated with unplanned pregnancies and poor metabolic control; and (3) maintain blood glucose levels as close to normal as possible for at least two to three months prior to conception.[48] The American College of Obstetricians and Gynecologists further recommends

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[40] U U.S. Department of Health and Human Services Office on Women's Health, *Lupus: Frequently Asked Questions* 2 (June 13, 2001), http://www.womenshealth.gov/publications/our-publications/fact-sheet/lupus.pdf.
[41] U.S. Department of Health and Human Services, National Diabetes Information Clearinghouse, Diabetes Overview, *http://diabetes.niddk.nih.gov/dm/pubs/overview/#scope*; Ann S. Barnes, *The Epidemic of Obesity and Diabetes*, 38 Tex. Heart Institute J. 142 (2011).
[42] Lawrence B. Finer & Stanley K. Henshaw, *supra* note 13, at 94.
[43] Susan A. Cohen, *Abortion and Women of Color: The Bigger Picture*, 11 Guttmacher Policy Review 3 (Summer 2008), http://www.guttmacher.org/pubs/gpr/11/3/gpr110302.html.
[44] Lori Mosca, et al., *Tracking Women's Awareness of Heart Disease: An American Heart Association National Study*, 109 J. Am. Heart Ass'n 573 (Feb. 4, 2004).
[45] Robert O. Bonow, et al., *Guidelines for the Management of Patients with Valvular Heart Disease*, American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee on Management of Patients with Valvular Heart Disease), 98 J. Am. Coll. of Cardiology 1949-1984 (Nov. 1998).
[46] *Id.*
[47] *Id.*
[48] American Diabetes Association, *Standards of medical care in diabetes-2006*, 29 Diabetes Care S4, S28 (2006).

that "[a]dequate maternal glucose control should be maintained near physiological levels before conception and throughout pregnancy to decrease the likelihood of spontaneous abortion, fetal malformation, fetal macrosomia [excessive birthweight], intrauterine fetal death, and neonatal morbidity."[49]

Similarly, contraception plays a critical role in preparing a woman with lupus for pregnancy. Lupus is an auto-immune disorder of unknown etiology which can affect multiple parts of the body such as the skin, joints, blood, and kidneys with multiple end-organ involvement. Often labeled a "woman's disease," nine out of ten people with lupus are women.[50] Women with lupus who become pregnant face particularly increased risks. A large review of United States hospital data found the risk of maternal death for women with lupus is twenty times the risk of non-lupus pregnant women.[51] These women were three to seven times more likely to suffer from thrombosis, thrombocytopenia, infection, renal failure, hypertension, and preeclampsia.[52] Women who suffer from moderate or severe organ involvement due to lupus are at significantly higher risk for developing complications during pregnancy, and the guidelines discussed above regarding chronic disease apply to women with those co-morbidities.[53] This should be taken into consideration in the decision to become pregnant or to carry a pregnancy to term.[54]

Historically, women with lupus were discouraged by the medical community from bearing children. While this is no longer always true, pregnancy for women with lupus is always considered high risk, and should be undertaken when, if at all possible, the disease is under control. The National Institute of Arthritis and Musculoskeletal and Skin Diseases ("NIAMS") recommends that a woman should have no signs or symptoms of lupus.[55] In addition, NIAMS directs women as follows: "Do not stop using your method of birth control until you have discussed the possibility of pregnancy with your doctor and he or she has determined that you are healthy enough to become pregnant."[56]

F. DENYING WOMEN ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICES UNDERMINES QUALITY OF CARE FOR WOMEN.

Ideological restrictions occur at three levels: the individual health professional level, the institutional and health system level, and the political level. Refusal clauses are statutory or regulatory "opt out" provisions that impede patient access to necessary and desired health care services and information. At the institutional level, the restrictions that have the greatest impact on access to care are those imposed by institutions controlled by religious entities. In particular,

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[49] The American College of Obstetricians and Gynecologists, *ACOG Practice Bulletin No. 60: Pregestational diabetes mellitus*, 115 Obstetrics & Gynecology 675 (2005).
[50] U.S. Department of Health and Human Services Office on Women's Health, *supra* note 40, at 2.
[51] Megan E. B. Clowse, et al., *A national study of the complications of lupus in pregnancy*, 199 Am. J. Obstet. & Gynecol. 127e. 1, e.3 (Aug. 2008).
[52] *Id.* at 127e.3-e.4.
[53] *Id.*
[54] National Institute of Arthritis and Musculoskeletal and Skin Diseases, *Lupus: A Patient Care Guide for Nurses and Other Health Professionals* 27-62, Patient Information Sheet 4-5 (3d ed. Sept. 2006).
[55] *Id.* at 45-46, Patient Information Sheet No. 11.
[56] *Id.* at Patient Information Sheet No. 4.

the Catholic health system has the broadest religion-based health care restrictions. The U.S. Conference of Catholic Bishops has issued *The Ethical and Religious Directives for Catholic Health Care Services* for all Catholic medical institutions. The Directives specify a range of services that are prohibited, including contraception. At the political level, legislation enacting refusal clauses impose restrictions unrelated to health and safety on women's ability to access reproductive health care services. These restrictions are driven by political ideology, electoral politics, and other political considerations that have nothing to do with evidence-based medicine.

G. HRSA'S PROPOSED RELIGIOUS EMPLOYER EXEMPTION WOULD UNDERMINE WOMEN'S HEALTH, WELL-BEING, AND AUTONOMY.

Statutory refusal clauses that impede women's access to contraceptive counseling and services jeopardize women's health and well-being, and rob women of their autonomy. HRSA's proposed religious employer exemption, 45 C.F.R. § 147.130(a)(1)(iv)(A)-(B), which allows certain employers to deny women access to effective, necessary, and desired preventive health care, unreasonably impedes the ability of a woman to obtain appropriate and timely medical care, limits the availability of health care services to affected women, and violates standards of care. HRSA's proposed exemption would permit employers to impose their religious doctrines on women who do not share them and at the expense of affected women's health. The clause gives institutions the right to make health care decisions—based on ideology, not science—about and for an individual woman.

Most women are covered by health insurance offered by their employer.[57] According to a 1998 Guttmacher Institute study, while three-fourths of American women of reproductive age rely on private insurance, the extent to which they have contraceptive coverage can differ dramatically depending on their type of insurance.[58] The Affordable Care Act recognizes the importance of preventive services to the health and well-being of individuals, their families and their communities. Preventive services are required to be covered without cost-sharing in order to ensure that all foreseeable barriers to access to preventive services are removed. Allowing employers or insurers to erect new barriers in the form of refusal clauses vastly undermines the promise of the ACA to improve the health of the nation.

All employers should be required to provide coverage for contraception without cost-sharing. Requiring all employers—including religious employers—to provide contraceptive insurance coverage does not force the employer to use, or even to condone, contraceptive use. Nor does requiring all entities to provide insurance coverage of health care services vital to a woman's health and well-being impinge on the conscience rights of individual providers. Allowing an employer, however, to refuse to cover contraception creates substantial barriers to affected women's ability to prevent pregnancy, and subordinates an affected woman's health needs—and her autonomy—to her employer's ideological beliefs. All women, regardless of where they work, should have access to the care they need. Every woman should be able to

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[57] Usha Ranji & Alina Salganicoff, The Henry J. Kaiser Family Foundation, *Women's Health Care Chartbook: Key Findings from the Kaiser Women's Health Survey* 10 (2011), http://www.kff.org/womenshealth/upload/8164.pdf.
[58] Rachel B. Gold, *The Need for and Cost of Mandating Private Insurance Coverage of Contraception*, The Guttmacher Report on Pub. Policy 5-6 (Aug. 1998), http://www.guttmacher.org/pubs/tgr/01/4/gr010405.pdf.

make her own decisions about whether or when to prevent pregnancy based on her own beliefs, not the beliefs of her employer.

H. H.R. 1179 WOULD DANGEROUSLY EXPAND RELIGIOUS REFUSALS.

H.R. 1179, misleadingly titled "Respect for Rights of Conscience Act of 2011," is an extreme and far-reaching refusal provision. H.R. 1179 introduces broad, poorly defined and confusing language, and fails to account for the significant burdens that broad refusals have on patients. These are burdens that fall disproportionately and most harshly on low-income women, severely impacting their health outcomes and their ability to give informed consent for medical care. There are already ample statutory protections for health care providers who object to providing certain services based on their religious or moral beliefs in existing law, which seeks to establish a delicate balance between protecting health care providers and meeting the needs of patients.

H.R. 1179 dangerously expands what a health plan or provider can refuse to do. First, it provides that a health plan could refuse to provide coverage (or, in the case of a sponsor of a group health plan, paying for coverage) "of such specific items or services" based on its "religious beliefs or moral convictions." Similarly, it requires that an individual be able to purchase a policy that does not contain any "specific items or services" which, are contrary to the "religious beliefs or moral convictions of the purchaser or beneficiary of the coverage." Under H.R. 1179, a health plan could refuse to provide coverage for virtually *any* service otherwise required by the ACA. Corporations could, for example, refuse to cover screening and counseling for HIV and other sexually transmitted infections. H.R. 1179 would undermine access to essential health services, and create significant and unreasonable barriers for patients seeking access to vital health care.

Second, H.R. 1179 states that the ACA does not obligate an "individual or institutional health care provider, or authorize a health plan to require a provider, to provide, participate in, or refer for a specific item or service contrary to the provider's religious beliefs or moral convictions."[59] The law suggests that virtually any worker, paid or volunteer, in any health care setting can refuse to assist in the performance of any health care service or in any health care program. The law also is unclear as to whether a worker can assert his or her moral belief in refusing to treat a particular patient. Can a technician refuse to participate in dialysis for an alcoholic? Can someone opposed to blood transfusions refuse to change a patient's hospital gown? Can a health provider refuse to treat a patient who is gay or lesbian? The law is subject to misuse and abuse by creating a health care environment that invites large numbers of workers and health professionals to refuse to participate in the orderly delivery of health care services.

* * * * *

[59] H.R. 1179 also states that a health plan has not "failed to provide timely or access to items or services . . . or fulfill any other requirement" under the ACA because it has "respected the rights of conscience" of a "provider."

Refusal clauses and denials of care should be evaluated using the same measurements used to evaluate quality generally, with the goal of providing care that is evidence-based, patient-centered, and preventative. All women should have access to the health care services they need based on medical evidence, their personal health needs, and their own beliefs. Employers, insurers, and hospital corporations should not be allowed to impose their ideology on women.

For more information or questions, please contact Susan Berke Fogel, Director of Reproductive Health at fogel@healthlaw.org or 818.621.7358.

Thank you.

PHYSICIANS FOR
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Testimony of Douglas Laube, MD, MEd
Board Chair, Physicians for Reproductive Choice and Health
Submitted to the House Energy and Commerce Committee
Subcommittee on Health
November 2, 2011

Physicians for Reproductive Choice and Health (PRCH) is a doctor-led national advocacy organization that relies upon evidence-based medicine to promote sound reproductive health policies. PRCH welcomes the opportunity to submit testimony to the House Energy and Commerce Subcommittee on Health for the hearing entitled "Do New Health Law Mandates Threaten Conscience Rights and Access to Care?"

PRCH supports the recent recommendation of the Institute of Medicine (IOM) to include contraception in the preventive health benefits[1] for women under the Patient Protection and Affordable Care Act (ACA)[2] and the decision of the Department of Health and Human Services (HHS) to adopt this recommendation in its draft regulations.[3] As physicians, we know that access to contraception is essential to the health and well-being of our patients.

About half of all pregnancies in the United States are unintended.[4] Regular use of contraception prevents unintended pregnancy and reduces the need for abortion.[5] Contraception also allows women to determine the timing and spacing of pregnancies, protecting their health and improving the well-being of their children.[6] Contraceptive use saves money by avoiding the costs of unintended pregnancy and by making pregnancies healthier, saving millions in health care expenses.[7] Several contraceptives also have non-contraceptive health benefits, such as decreasing the risk of certain cancers and treating

[1] Institute of Medicine, Clinical Preventive Services for Women: Closing the Gaps (July 19, 2011).
[2] Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (Mar. 23, 2010) and Health Care and Education Reconciliation Act, Pub. L. 111-152 (Mar. 30, 2011).
[3] Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 Fed. Reg. 46621 (proposed Aug. 3, 2011) (to be codified at 45 CFR Part 147).
[4] Finer LB, Kost K. "Unintended pregnancy rates at the state level." Perspectives on Sexual and Reproductive Health
2011;43:78-87.
[5] Deschner, A., Cohen, S.A. (2003). "Contraceptive Use Is Key to Reducing Abortion Worldwide." The Guttmacher Report on Public Policy 6(4): 7-10.
[6] Testimony of the Guttmacher Institute, submitted to the Committee on Preventive Services for Women, Institute of Medicine, 2011, available for download at http://www.guttmacher.org/pubs/CPSW-testimony. pdf .
[7] Gold, R.B. (2011). "Wise Investment: Reducing the Steep Cost to Medicaid of Unintended Pregnancy in the United States." Guttmacher Policy Review 14(3): 6-10.

debilitating menstrual problems.[8] Making contraception more affordable is a significant step forward for the health of women and their families.

PRCH appreciates the decision of HHS to include in the draft regulations the coverage of all forms of birth control,[9] allowing patients to access to the method that best meets their needs. Contraceptive methods vary and women with their health care providers need to be free to select from the full range of FDA-approved contraceptives. Not all contraceptives are clinically appropriate for every woman.[10] We also know that women and couples are more likely to use contraception successfully when they are given their contraceptive method of choice, be it a birth control pill, a vaginal ring, or an intrauterine device (IUD).[11] The draft regulations hold the promise of making contraception more affordable and easier to access for millions of women.

While we strongly support the inclusion of contraception as preventive care, we are deeply troubled by the provisions that exempt certain employers from compliance. The draft regulations threaten to compromise the very important protections they would put in place. As physicians who care for patients who may be deprived of the affordable contraceptive coverage that all women deserve, we outline our concerns in the comments below.

I. Women employed by religious employers should be ensured the same preventive reproductive health care coverage as all other women.

The draft regulations allow certain religious employers to refuse to provide access to essential reproductive health care coverage for contraception.[12] That means that some women, because they work for religious employers that fail to allow this benefit, will be denied access to affordable birth control coverage. That is grossly unfair to these women, and from a medical perspective would constitute indefensible health policy. All women deserve access to affordable birth control—an important component of preventive health care, as the Department and the IOM have recognized—no matter where they work.

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[8] Burkman, R., Schlesselman, J.J., Zieman, M (2004). "Safety concerns and health benefits associated with oral contraception." American Journal of Obstetrics and Gynecology 190(4): S5-22.

[9] The draft regulations properly include forms of emergency contraception in the birth control coverage provisions. Some groups have claimed this is a violation of federal law, arguing that emergency contraception is an abortifacient. This is medically inaccurate. Emergency Contraception. Practice Bulletin No. 112. American College of Obstetricians and Gynecologists. Obstet Gynecol 2010;115:1100–9.

[10] Bonnema, R.A., McNamara, M.C., Spencer, A.L. (2010). "Contraception choices in women with underlying medical conditions." American Academy of Family Physicians 82(6): 612-8.

[11] Frost, J. J. and J. E. Darroch (2008). "Factors Associated with Contraceptive Choice and Inconsistent Method Use, United States, 2004." Perspectives on Sexual & Reproductive Health 40(2): 94-104.

[12] The Interim Final Rules define an employer that can invoke the exemption 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 Code. 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.

Some of the most vocal opposition to the inclusion of birth control as a preventive service comes from the United States Conference of Catholic Bishops (USCCB).[13] It is worth noting that virtually all women, including 98 percent of Catholic women, use contraception at some point during their lifetimes.[14] Moreover, the decision to use birth control should be left to the *individual.* Employers should not have the power to interfere in private health care decisions by withholding coverage for care. A key promise of the ACA is that women will no longer be subjected to extra charges for necessary preventive prescriptions and treatments. Birth control should not be treated any differently. Employers should remain entirely free to express their opposition to birth control, but that opposition should never translate into substandard preventive medical care coverage.

One of our physicians had a patient we will call Susan.[15] Susan worked in administration at a Catholic Archdiocese and her employer provided health insurance that did not cover contraception because of the employer's belief that birth control is immoral. Susan was in a relationship and did not want to become pregnant. Her partner refused to use condoms and the burden to prevent pregnancy fell on her. Because of her high blood pressure, Susan could not take birth control pills, and she and her doctor decided that an IUD was her best preventive health care option. But Susan could not afford the hundreds of dollars for the device and insertion. She went without any birth control, became pregnant and then had an abortion that should have never become necessary.

Susan was a victim of second-class preventive medical care. Susan and women in similar employment situations deserve access to affordable contraception. As physicians, we believe that medical evidence should govern healthcare and that every one of our patients should have access to high quality preventive reproductive health services.

II. Women employed by organizations affiliated with religious institutions should be assured access to the same preventive reproductive health care coverage as all other women.

Opponents of contraceptive coverage without co-pays have argued for an expansion of employers who could refuse to provide coverage.[16] In their view, hospitals and social service agencies should have the ability to deny preventive reproductive health care coverage for their employees. These exclusions of care translate into significant hardships for our patients. Broadening the definition of a religious employer would make an already medically unsound policy even worse, depriving more women of essential preventive coverage.

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[13] "HHS Mandate for Contraceptive and Abortifacient Drugs Violates Conscience Rights," USCCB press release, August 1, 2011. See also, comments from USCCB submitted to the Centers for Medicare & Medicaid Services, August 31, 2011.

[14] Jones. R.K. and Joerg Dreweke, "Countering Conventional Wisdom: New Evidence on Religion and Contraceptive Use," Guttmacher Institute, April 2011. Among all women who have had sex, 99% have used a contraceptive method other than natural family planning.

[15] Names of patients have been changed to protect privacy.

[16] In their August 1 press release, supra, note 13, USCCB noted their displeasure with the interim rules stating "Although this new rule gives the agency the discretion to authorize a 'religious' exemption, it is so narrow as to exclude most Catholic social service agencies and health care providers."

One of our physicians has a patient we will call Melanie. Melanie has worked for many years as an emergency room nurse at a Catholic hospital. She wanted a long-acting, reversible contraceptive, specifically an IUD. But the hospital's health insurance did not cover birth control. Melanie paid for birth control pills out-of-pocket, but she had experienced an unintended pregnancy while on the pill and knew that an IUD would be more effective. However, Melanie could not afford the nearly one thousand dollars for the IUD and its insertion. Instead, Melanie obtained an IUD from a nearby study of a new, experimental type of IUD. Her need for an IUD plainly outweighed her worries about using a contraceptive without FDA approval.

Another one of our physicians has a patient we will call Kristen. Kristen worked as a nursing assistant at a Catholic hospital. Like Melanie, her insurance did not cover contraception. Kristen, who is not Catholic, did not know about this policy until after she started working at the hospital. When Kristen first refilled her prescription for birth control pills, she discovered that she would need to pay fifty dollars per month, a new expense for which she had not budgeted as her last employer had covered contraceptives. Kristen was able to afford her prescription for a few months, but could not continue. She later had an unintended pregnancy and needed an abortion.

Yet another one of our physicians takes care of many women who are employees and students at a large, well respected, Catholic college. These women have no objections to birth control—they are either not Catholic, or among the ninety-eight percent of Catholic women who have used birth control. Most have no idea their insurance does not cover birth control pills or any other contraceptive until they begin working or studying there. When they find out, some panic because they cannot afford the full cost.[17] These amounts can be prohibitive for a student or family on a budget. The college educates and employs thousands of women; they should not be denied affordable birth control as a condition of studying or working there.

As illustrated by our colleagues, it is important to the health of patients that affordable preventive reproductive health coverage be available to every woman in the American workforce without regard to the reproductive health position of their employers.

III. All women deserve access to contraceptives prescribed for purposes other than birth control in addition to family planning.

Several states make clear that religious exceptions for contraceptive coverage do not apply to contraceptives that are prescribed for purposes other than birth control. For example, California mandates that employers, including religious employers, cover birth control when prescribed for the purposes of lowering the risk of ovarian cancer, eliminating symptoms of menopause, or for prescription contraception necessary to preserve the life or health[18] of an

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[17] For instance, per year, the pill ranges from $180 to $600 out of pocket, the vaginal ring from $180 to $840. An IUD, which lasts much longer and saves money over time, requires an initial investment of $500 to $1,000.

[18] An unintended pregnancy may have significant implications for a woman's health, sometimes worsening a preexisting health condition such as diabetes, hypertension, or coronary artery disease. Institute of Medicine, supra note 1.

insured woman.[19] Hormonal birth control, in addition to preventing unintended pregnancies, helps address several menstrual disorders, helps prevent menstrual migraines, treats pelvic pain from endometriosis, and treats bleeding from uterine fibroids.[20] Oral contraceptives have been shown to have long-term benefits in reducing a woman's risk of developing endometrial and ovarian cancer, and short-term benefits in protecting against colorectal cancer.[21]All women, including women who have religious employers, women in ministerial roles, and women employed by organizations affiliated with religious institutions need insurance coverage that will cover effective treatments, including hormonal contraception, for these conditions. The acceptance of inadequate health care coverage should not be a condition of working for a religious employer or agency.

IV. Conclusion

The Centers for Disease Control and Prevention recognized family planning as one of the singular public health achievements of the twentieth century.[22] Yet the proposed "Respect for Rights of Conscience Act of 2011" (H.R. 1179) would allow companies a broad right to deprive women and their families of necessary medical coverage and services such as contraception. It elevates the "consciences" of corporations above the needs of individual patients, allowing a business entity to make personal, private decisions that should be left to women and their families. H.R. 1179 would have extreme consequences – not only allowing the refusal of care, but even coverage to people or groups that a corporation finds objectionable. This is medically unacceptable.

The ACA holds the promise of expanding health care coverage for millions of Americans and ensuring that all of our patients live healthier lives. Allowing religious employers and organizations affiliated with them to interfere with the personal reproductive health care decisions of their employees is poor public health policy that could harm too many American women and families.

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[19] Cal. Health & Safety Code §1367.25(b)(2)(c) (enacted 1999): "Nothing in this section shall be construed to exclude coverage for prescription contraceptive supplies ordered by a health care provider with prescriptive authority for reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause, or for prescription contraception that is necessary to preserve the life or health of an enrollee."

[20] Burkman, supra note 8.

[21] Id.

[22] Centers for Disease Control and Prevention, "Achievements in Public Health 1900-199: Family Planning," MMWR Weekly, December 03, 1999, 48(47);1073-1080.

November 2, 2011

Chairman Fred Upton
Committee on Energy and Commerce
United States House of Representatives
Washington, D.C. 20515

Ranking Member Henry Waxman
Committee on Energy and Commerce
United States House of Representatives
Washington, D.C. 20515

Chairman Joe Pitts
Energy and Commerce Subcommittee on Health
United States House of Representatives
Washington, D.C. 20515

Ranking Member Frank Pallone, Jr.
Energy and Commerce Subcommittee on Health
United States House of Representatives
Washington, D.C. 20515

Dear Chairmen Upton and Pitts and Ranking Members Waxman and Pallone:

As advocates for young people's health and rights and students currently attending religious affiliated colleges and universities, we are pleased that the Department of Health and Human Services adopted the Institute of Medicine's recommendations laid out in "Clinical Preventive Services for Women: Closing the Gaps." These recommendations are an important step forward in women's health and well-being. We are especially excited to see that starting in August of 2012, just before school starts, women will be able to access all FDA approved methods of contraception available on their private health plans, without a co-pay.

However, we are concerned by statements made by certain organizations and members of Congress that wish to undo this important advancement.

According to the recent report "TECHsex USA: Youth Sexuality and Reproductive Health in the Digital Age," birth control is one of the most important health issues for young women.[1] The United States has one of the highest teen pregnancy rates in the developed world with 71.5 pregnancies per 1000 women ages 15-19. That number is nearly three times that of Germany and France and four times the rate in the Netherlands.[2] In 20-24 year olds, more than half of all pregnancies are unintended.[3] According to the Guttmacher Institute, unintended pregnancies cost the United States $11.1 billion in 2006.[4]

Contraception is a basic part of women's health care. The Centers for Disease Control and Prevention states that more than 98 percent of U.S. women between the ages of 15 and 44 who have ever had sexual intercourse with a male have used at least one contraceptive method before. However, there are many barriers to accessing contraception, especially among young women. In a review published by the National Campaign to Prevent Teen and Unplanned Pregnancy, cost was cited as one of many barriers faced by young

[1] Boyar, R, Levine, D, Zensius, N. TECHsex USA: Youth Sexuality and Reproductive Health in the Digital Age. Oakland, CA: ISIS, Inc. April, 2011.
[2] Advocates for Youth. (March 2011). *Adolescent Sexual Health in Europe and the US.* Retrieved from http://www.advocatesforyouth.org/publications/419?task=view September 20, 2011.
[3] Ibid.
[4] Sonfield, A, Kost, K, Gold, R. B. and Finer, L.B. (2011), The Public Costs of Births Resulting from Unintended Pregnancies: National and State-Level Estimates. Perspectives on Sexual and Reproductive Health, 43: 94-102. Doi: 10. 1363/4309411

women and adolescents when attempting to access contraception.[5] In fact, a recent study published in *Contraception* found that young women are significantly more likely than women of all ages to pay higher out-of-pocket costs for birth control and are less likely to buy multiple packs of pills at a time.[6]

Despite some limited success, the reality is that, even today, women with health insurance still do not have the ability to access the contraception they need because it is left up to individual health plans to decide which methods of contraception to cover or whether to even cover contraception *at all*.

The new preventive health guidelines serve to help resolve this issue; however, we are concerned that the religious exemption language may be expanded to prevent more women, and young women in particular, from accessing these services.

Deference to the conscience of others is fundamental to religious freedom. While we respect individuals' choices and their consciences, claims that refusal clauses are needed for institutional employers are indefensible. The availability of contraception in no way compels those who oppose it to use it. Individuals with religious conflicts can simply exercise their right not to access contraception. The conscience of one individual or one institution cannot, and must not, override a woman's basic right to necessary and timely medical care.

We have heard from too many young people who attend Catholic universities who have either had to lie to their doctor about their reason for accessing contraception (non-contraceptive purposes), or use local family planning clinics with already stretched resources, to access birth control.

> "When I was a student at Georgetown Law, I watched women lie to their doctors about needing birth control for non-contraceptive reasons. This is just wrong. Students shouldn't be limited by their school's religious beliefs, especially when colleges are offering secular education to students of all faiths."
>
> "I attended Boston College for law school and was denied contraception through the student health services. This must change."
>
> "I am a student at Georgetown Law, and I am forced to go to Planned Parenthood to receive basic health care, as my insurance doesn't cover birth control pills. If I have a question or a problem with my medication, I can't ask my Georgetown doctor. It is absolutely outrageous that young, old, single, and married women alike at Georgetown Law cannot get basic health services."
>
> "I went to a Catholic university, and saw first hand the terrible impact a lack of birth control had on the students. It doesn't stop college students from having sex. It just makes them think it's okay to do so unsafely."

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[5] National Campaign to Prevent Teen and Unplanned Pregnancy. (2009). Unlocking the Contraception Conundrum. Retrieved September 29, 2011, from http://www.thenationalcampaign.org/resources/pdf/pubs/Unlocking_Contraceptive.pdf

[6] Contraception. 2011 Jun;83(6):528-36. Epub 2010 Nov 6. Women's out-of-pocket expenditures and dispensing patterns for oral contraceptive pills between 1996 and 2006.

In fact, in 2009, almost 90% of students at Boston College voted for changes to the school's sexual health education and resources. By voting for this referendum, the large majority of students called for not only prescriptions for contraception from their student health services, but also the availability of condoms on campus.[7] Almost 70% of students at Boston College identify as Catholic, and like the majority of Catholics nation-wide, they support access to contraception.

The fact remains that, "Among all women who have had sex, 99 percent have ever used a contraceptive method other than natural family planning. This figure is virtually the same, 98 percent, among sexually experienced Catholic women."[8] When almost 80 percent of unmarried young women between the ages of 20 and 24 have had sex, access to contraception cannot be ignored. Women should not be punished for making the responsible decision to access contraception when they wish to prevent an unintended pregnancy. We encourage you to stand with young women and ensure that they have access to contraception, regardless of where their private health insurance comes from.

Sincerely,

Advocates for Youth
Washington, DC

All Education Matters
Nationwide

American Medical Student Association
Reston, VA

Boston College Students for Sexual Health
Chestnut Hill, MA

Campus Progress
Washington, DC

Choice USA
Washington, DC

DC Federation of College Democrats Women's Caucus
Washington, DC

Feminist Majority Foundation
Arlington, VA

Generational Alliance
Washington, DC

H*yas for Choice
Washington, DC

Law Students for Reproductive Justice
Oakland, CA

Medical Students for Choice
Philadelphia, PA

Spiritual Youth for Reproductive Freedom
Washington, DC

[7] Sweas, Megan. (8 March 2009). Students vote for expanded sex ed resources at Boston College. *U. S. Catholic* Retrieved from: http://www.uscatholic.org/life/2009/03/students-vote-expanded-sex-ed-resources-boston-college

[8] Jones RK and Dreweke J, *Countering Conventional Wisdom: New Evidence on Religion and Contraceptive Use*, New York: Guttmacher Institute, 2011.

Mr. PITTS. The Chair now is pleased to welcome the panel of witnesses to our hearing today. We would ask them to please take their seats at the witness table. And I will introduce them at this time.

Today, our witness panel includes David Stevens, CEO of the Christian Medical Association; Mark Hathaway, Director of OB/GYN Outreach Services for Women's and Infants' Services at Washington Hospital Center and Title X Medical Director at the Unity Healthcare, Inc.; Jane Belford, Chancellor and General Counsel of the Archdiocese of Washington; Jon O'Brien, President of Catholics for Choice; and Bill Cox, President and CEO of the Alliance of Catholic Health Care.

We are happy to have each of you here today and ask that you summarize your statements in 5 minutes. We will enter your written testimony into the record.

And at this point, we will start with Dr. Stevens. You are recognized for 5 minutes.

STATEMENTS OF DAVID L. STEVENS, CHIEF EXECUTIVE OFFICER, CHRISTIAN MEDICAL ASSOCIATION; MARK HATHAWAY, DIRECTOR, OBSTETRICS AND GYNECOLOGY OUTREACH SERVICES FOR WOMEN'S AND INFANTS' SERVICES, WASHINGTON HOSPITAL CENTER; JANE G. BELFORD, CHANCELLOR, ARCHDIOCESE OF WASHINGTON, DC.; JON O'BRIEN, PRESIDENT, CATHOLICS FOR CHOICE; AND WILLIAM J. COX, PRESIDENT AND CHIEF EXECUTIVE OFFICER, ALLIANCE OF CATHOLIC HEALTH CARE

STATEMENT OF DAVID L. STEVENS

Mr. STEVENS. I am testifying on behalf of the over 16,000 members of the Christian Medical Association, a professional membership organization that helps healthcare professionals to integrate their faith and their profession. I am a diplomat of the American Board of Family Medicine and hold a master's degree in bioethics.

Our members include physicians who hold a range of conscience convictions on controversial ethics and moral issues, including contraception, healthcare reform, participation in the death penalty, and other conscience issues that span the political spectrum.

Virtually all medical professionals and student members we recently surveyed say it is "important to personally have the freedom to practice healthcare in accordance with the dictates of his or her conscience." Over 9 of 10 say they would not prescribe FDA-approved contraceptives that might cause the death of a developing human embryo.

Many physicians today conscientiously profess allegiance to life-affirming ethical standards such as the Hippocratic Oath. Pro-life patients want to retain the freedom to choose physicians whose professional judgments reflect their own life-affirming values.

The Health and Human Services interim final regulation would force insurance plans nationwide to cover all Food and Drug Administration-approved contraceptive methods and sterilization procedures. This mandate does not exempt controversial drugs such as Ella and the morning-after pill, which according to the FDA have

post-fertilization effects that may inhibit implantation of a living human embryo.

The potential religious exemption in the contraception mandate—exempting only a nano-sector of religious employers from the guidelines—is meaningless to conscientiously objecting healthcare professionals, insurers, and patients. The contraception mandate can potentially trigger a decrease in access to healthcare by patients in medically underserved regions and populations.

The administration's policies on the exercise of conscience in healthcare, including the gutting of the only Federal conscience-protecting regulation, actually threaten to worsen a growing physician shortage. A national survey of over 2,100 faith-based physicians revealed that over 9 of 10 are prepared to leave medicine over conscience rights. Eighty-five percent of our medical professionals and students say that the policies that restrict the exercise of conscience in healthcare make it less likely they will practice healthcare in the future.

The contraception mandate further contributes to an increasingly hostile environment in which pro-life physicians, residents, and medical students face discrimination, job loss, and ostracism. Seventy-nine percent of our members surveyed said the new contraception mandate will have a negative impact on their freedom to practice medicine in accordance with the dictates of their conscience. One out of five faith-based medical students surveyed said they will not go into OB/GYN as a specialty because of abortion-related pressures.

The contraception mandate creates a climate of coercion that can prompt pro-life healthcare professionals to limit the scope of their medical practice. Over half of the medical professionals and students we surveyed said the new contraception mandate might cause them to restrict their practice of medicine.

The contraception mandate can potentially cause a decrease in the provision of health insurance for employees of pro-life healthcare employers who want to avoid conflicts of conscience regarding controversial contraceptives. Sixty-five percent of the medical professionals and students we surveyed said the contraception mandate will make them less likely to provide insurance for their employees.

The contraceptive mandate rule sweepingly tramples conscience rights, which have provided a foundation for the ethical and professional practice of medicine. The administration should rescind this mandate entirely for the ethical and practical reasons I have noted and also for the constitutional and statutory reasons outlined in our official comment letter of September 29 to HHS, which I am submitting separately and ask to be included in the record.

We encourage Members of Congress to uphold conscience rights by passing the Respect for Rights of Conscience Act. Upholding a respect for conscience and our First Amendment freedoms protects all Americans, conservatives and liberals, capitalists and socialists, atheists and people of faith.

Thank you for your consideration of these views.

[The prepared statement of Mr. Stevens follows:]

Written Statement by

David L. Stevens, MD, MA (Ethics)
CEO
Christian Medical Association

Committee on Energy and Commerce, Subcommittee on Health
United States House of Representatives

November 2, 2011

Re: U.S. Dept. of Health and Human Services (HHS) preventive services rule

Summary of arguments

1. The potential "**religious exemption**" in the contraception mandate--exempting only a nano-sector of "religious employers" from the guidelines--is *meaningless* to conscientiously objecting health care professionals, insurers and patients.

2. The contraception mandate can potentially **trigger a decrease in access to health care** by patients in medically underserved regions and populations.

3. The contraception mandate further **contributes to an increasingly hostile environment** in which medical students, residents and graduate physicians face discrimination, job loss and ostracism for holding pro-life views on abortion, controversial contraceptives and other ethical issues.

4. The contraception mandate **creates a climate of coercion** that can prompt pro-life health care professionals to limit the scope of their medical practice and can discourage pro-life medical students and residents from choosing careers in Family Medicine, Obstetrics and Gynecology and other specialties likely to involve conflicts of conscience.

5. The contraception mandate can potentially **cause a decrease in the provision of health insurance for employees** of pro-life health care employers who want to avoid conflicts of conscience regarding the subsidy and implied endorsement of controversial contraceptives.

Testimony

Mr. Chairman, I am testifying on behalf of the over 16,000 members of the Christian Medical Association, a professional membership organization that helps healthcare professionals to integrate their faith and profession and to care for patients according to longstanding ethical and moral principles. I am a Diplomate of the American Board of Family Medicine and hold a master's degree in bioethics.

Our members include physicians who hold a range of conscience convictions on controversial ethical and moral issues including contraception, health care reform, participation in the death penalty, and other conscience issues that span the left-right political spectrum.

- Virtually all medical professionals and student members we recently surveyed[1] say it is "important to personally have the freedom to practice health care in accordance with the dictates of [his or her] conscience."
- Even more specific to our topic today, over nine of ten say they "would not prescribe FDA-approved contraceptives that might cause the death of a developing human embryo."

The principle of physicians practicing professional judgment regarding both medical options and ethical standards is neither novel nor new; in fact, it has guided the practice of medicine for millennia.

Many physicians today conscientiously profess allegiance to life-affirming ethical standards such as the Hippocratic oath, which was first adopted over two millennia ago to protect the interests of patients and establish objective professional standards. It is especially important today for pro-life patients to retain the freedom to choose physicians whose professional judgments reflect the patient's own life-affirming values.

The HHS interim final regulations would force insurance plans nationwide to cover "*all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.*"

The contraception mandate does not exempt controversial drugs such as Ella and the "morning-after pill," which according to the FDA have post-fertilization effects that "may inhibit implantation" of a living human embryo. That is an issue of weighty moral concern for many pro-life and faith-based health care professionals, individuals and groups.

The potential "religious exemption" in the contraception mandate--exempting only a nano-sector of "religious employers" from the guidelines--is *meaningless* to conscientiously objecting health care professionals, insurers and patients.

The HHS rule implementing provisions of the Patient Protection and Affordable Care Act fits a pattern of this administration's extremely narrow and limiting view of conscience rights. The HHS rule has the potential to negatively impact patients and health care professionals in the following ways:

1. The contraception mandate can potentially **trigger a decrease in access to health care** by patients in medically underserved regions and populations.
    - The *New York Times*[ii] reports that "Health policy experts have long expressed concern about a shortage of primary care doctors, including family physicians and internists. The shortage, they say, could become more serious if, as President Obama hopes, more than 30 million people gain insurance coverage under the health care law passed last year."

- Ironically, the administration's own policies on the exercise of conscience in health care, including the gutting of the only federal conscience-protecting regulation, actually threaten to *worsen* the physician shortage.
- A national survey[iii] of over 2,100 faith-based physicians revealed that over nine of ten are prepared to leave medicine if pressured to compromise their ethical and moral commitments.
- The recent survey of our members revealed that 85 percent of medical professionals and students said that "policies that restrict the exercise of conscience in health care" make it less likely that they will "practice health care in the future."

2. The contraception mandate further **contributes to an increasingly hostile environment** in which medical students, residents and graduate physicians face discrimination, job loss and ostracism for holding pro-life views on abortion, controversial contraceptives and other ethical issues. This administration's gutting of the only conscience-protecting federal regulation only serves to reinforce such intolerance.
    - Seventy-nine percent of our members surveyed said the new contraception mandate will have a negative impact on their "freedom to practice medicine in accordance with the dictates of [their] conscience."
3. The contraception mandate **creates a climate of coercion** that can prompt pro-life health care professionals to limit the scope of their medical practice and can discourage pro-life medical students and residents from choosing careers in Family Medicine, Obstetrics and Gynecology and other specialties likely to involve conflicts of conscience.

- Over half of the medical professionals and students we surveyed said the "new contraception mandate might cause [them] to restrict [their] practice of medicine."
- One out of five faith-based medical students surveyed say they will not go into an Ob-Gyn specialty because of abortion-related pressures.

4. The contraception mandate can potentially **cause a decrease in the provision of health insurance for employees** of pro-life health care employers who want to avoid conflicts of conscience regarding the subsidy and implied endorsement of controversial contraceptives.
    - Sixty-five percent of the medical professionals and students we surveyed said the contraception mandate will make them "less likely to provide insurance for their employees."

The contraceptive mandate rule sweepingly tramples conscience rights, which have not only provided a foundation for American civil liberties but also a foundation for the ethical and professional practice of medicine.

The administration should rescind this mandate entirely, for the ethical and practical reasons I have noted that especially impact faith-based and pro-life health care professionals and patients. The rule should also be rescinded for the constitutional and statutory reasons outlined in our official comment letter of September 29 to HHS, which I am submitting separately and ask to be included in the record.

We encourage Members of Congress to uphold conscience rights by passing the Respect for Rights of Conscience Act, which will ensure that

> "health care stakeholders retain the right to provide, purchase, or enroll in health coverage that is consistent with their religious beliefs and moral convictions, without fear of being penalized or

> discriminated against … and to ensure that no requirement in [the new health care law] creates new pressures to exclude those exercising such conscientious objection from health plans or other programs…."

Upholding a respect for conscience and our First Amendment freedoms protects all Americans: conservatives and liberals, capitalists and socialists, atheists and people of faith.

Thank you for your consideration of these views.

Addendum

September 29, 2011 - *Submitted Electronically*

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-9992-IFC2
PO Box 8010
Baltimore, Maryland 21244-8010

Re: Interim Final Rule on Preventive Services. File Code CMS-9992-IFC2.

Dear Sir or Madam:

I am writing on behalf of the 16,000 members of the Christian Medical Association, a professional membership organization that helps healthcare professionals to integrate their faith and profession and to care for patients according to longstanding ethical and moral principles.

We offer comments on the amendments to the interim final regulations (76 Fed. Reg. 46621 (Aug. 3, 2011)) regarding mandatory coverage nationwide of certain preventive health services under provisions of the Patient Protection and Affordable Care Act.

Key components of the mandate that especially impact faith-based health care include the following:

- The new rule would force insurance plans to cover "*all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.*"

- The Amended Regulations only consider for *potential* exemption a "religious employer" to be 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]." Conscientiously objecting individuals and religiously affiliated health insurers are not exempted.

- The new rule does not exempt drugs that according to the FDA have post-fertilization effects that "may inhibit implantation" of a living human embryo--an issue of weighty moral concern for many faith-based health care professionals, individuals and groups.

The administration should rescind this mandate entirely, for the following reasons:

1. Pregnancy is not a disease to be prevented; therefore, mandating contraceptives has no place in preventive disease policies.

2. The federal mandate imposes a radical ideological stance--unprecedented in and inconsistent with federal law--regarding conscience, contraception and abortion, on the vast majority of states that have taken a far less coercive and far more balanced approach.

3. The mandate violates the Constitution, federal law and the administration's stated policies:

    a. The mandate violates the religion and free speech clauses of the First Amendment of the Constitution, by coercing faith-based health care ministries to not only violate the very faith-based tenets that have motivated patient care for millennia, but also to *pay for* that violation.

    b. The mandate violates the Weldon amendment, passed every year by Congress since 2004.

    c. The mandate violates the abortion and non-preemption provisions of the Patient Protection and Affordable Care Act (PPACA).

    d. The mandate violates the Administration's own public assurances that PPACA would not be construed to require coverage of abortion; it also violates the related presidential Executive Order to secure passage of the Act.

4. The *potential* "religious exemption" is meaningless:

    a. The preamble to the Amended Regulations offers no actual exemption but merely allows "additional discretion" to exempt a nano-sector of "religious employers" from the guidelines regarding contraception.

    b. The potential exemption provides no protection to conscientiously objecting individuals or insurers.

    c. The narrow potential exemption is far more restrictive than any other genuine religious exemption in federal health care law.

    d. HHS is not constitutionally empowered--especially absent a compelling state interest--to simply make up its own definition of religious ministry.

5. Such conscience-violating mandates will ultimately reduce patients' access to faith-based medical care, especially depriving the poor and medically underserved populations of such care. A national survey (available at www.Freedom2Care.org) of over 2,100 faith-based physicians revealed that over nine of ten are prepared to leave medicine if pressured to compromise their ethical and moral commitments.

Thank you for your consideration of these views.

Sincerely,

David Stevens, MD, MA (Ethics)
CEO

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[i] Christian Medical Association online survey of membership conducted Oct. 24-29, 2011, N=1,177.
[ii] *New York Times*, "Administration Halts Survey of Making Doctor Visits, June 28, 2011.
[iii] Available online at http://www.freedom2care.org/learn/page/polls-april-2009.

Mr. PITTS. The Chair thanks the gentleman and recognizes Dr. Hathaway for 5 minutes.

STATEMENT OF MARK HATHAWAY

Mr. HATHAWAY. Chairman Pitts, Ranking Member Pallone, and members of the committee, thank you for the opportunity to testify before you today.

Good morning. My name is Dr. Mark Hathaway. I am a board-certified OB/GYN. I am the director of OB/GYN Outreach Services for Women's and Infants' Services at the Washington Hospital Center. I am also the Title X director at Unity Health Care, Washington, DC's, largest Federally qualified health center.

I work in several medical facilities here in Washington, DC. My patients tend to be women of color, primarily African American and Latina, and of lower socioeconomic status. Many of the patients I see are uninsured, underinsured, and seeking prenatal care or family planning services. Despite these obstacles, they desire to improve their lives and to have and raise healthy children.

I see every day how increasing women's ability to plan their pregnancies makes a difference in their lives. And by the same token, I also see the negative consequences of unintended and unplanned pregnancy, late prenatal care, uncontrolled medical problems, poor nutrition, and sometimes depression. I see firsthand how cost can be a barrier. That is why the Institute of Medicine's recommendation is so critically important. Contraceptive counseling and methods should be covered under the Affordable Care Act without cost-sharing. Any attempts to broaden exemptions to that coverage requirement would mean leaving in place insurmountable obstacles to contraceptive services for far too many women.

I know from my day-to-day experience what it means for patients who cannot afford to pay for their health services. The cost of a birth control method is frequently prohibitive for many of my patients. This is especially true for the more cost-effective, long-acting reversible contraceptive methods, also known as LARC.

Women face many challenges in using contraception successfully. Too many women using methods like birth control pills, condoms and even injectables will experience an unplanned pregnancy during their first year of "typical use." Long-acting reversible contraceptive methods, including intrauterine contraceptives and implants, are the most cost-effective methods because they have an extremely low failure rate and are effective at preventing pregnancy for several years. The up-front costs of these methods, however, are several hundred dollars, placing them out of the reach of millions of women who would otherwise use them.

Three recent studies have found that lack of insurance is significantly associated with reduced use of prescription contraceptives. In St. Louis, researchers at Washington University have recently found that over 70 percent of women will choose a longer-acting method if cost and barriers are eliminated.

There are those who assert that unintended pregnancy is not a health condition and therefore prevention of unintended pregnancy is not a preventive healthcare. From my personal practice I can say that I cannot disagree more. Just last week I met "Sarah." She is

22 years old, has 2 children under the age of 3, one a recent newborn. She came in for a pregnancy test. Her diabetes had gone unchecked, which would put her in a category of a high-risk pregnancy. She was visibly shaking waiting for her pregnancy test results. She is working over 40 hours a week at 2 different jobs and was told by her primary care clinic that she would need to pay a copay of $40 and a $300 fee for the intrauterine device that she so desperately wants. She would have been devastated by a positive pregnancy test. She was incredibly relieved to learn she was not pregnant. She was also uninsured but we used our rapidly shrinking safety-net resources to provide her with long-acting contraception lasting up to 7 years.

The evidence is also conclusive regarding pregnancy spacing. It is directly linked to improved maternal and child health. Numerous U.S. and international studies have found a direct causal relationship between birth intervals, low birth weight, as well as preterm births. In other words, we need to help women plan their pregnancies for their health as well as their children's.

Using contraception is the most effective way to prevent unintended pregnancy. Again, I have seen the success of contraceptive services in my own practice, and again the evidence on this is clear. Ninety-five percent of all unintended pregnancies occur among women who use contraception inconsistently or use no method at all. Indeed, couples who do not practice contraception have an 85 percent chance of experiencing an unintended pregnancy within the first year.

For all these reasons, the Institute of Medicine's recommendations are groundbreaking. Finally, all women will gain access to insurance coverage of family planning services regardless of income. All women will be able to get the counseling, education, and access to the most effective and medically appropriate contraceptive for them. This breakthrough has the potential to bring about major benefits for the health and well-being of women and their families.

Most women will contracept for approximately 3 decades during their reproductive years. The adoption of the IOM's recommendations holds so much promise for millions of women who currently lack basic resources like health insurance coverage. All of my training and experience tells me that what we are striving for is healthy women. We are also working to ensure that if and when they are ready to have a child that they have a healthy pregnancy. The best way to achieve this is to help women and couples become as healthy as possible before pregnancy. This includes financial health, emotional health, and physical health. We should trust women and empower women to make the appropriate decisions for themselves. Therefore, I hope we can agree that guaranteeing contraceptive coverage and removing cost barriers should be at the forefront of preventive care so that women can achieve their own goals.

Thank you very much.

[The prepared statement of Mr. Hathaway follows:]

Testimony of Dr. Mark Hathaway
Before the U.S. House of Representatives
Energy and Commerce Committee, Subcommittee on Health
November 2, 2011

Chairman Pitts, Ranking Member Pallone and members of the Committee. Thank you for the opportunity to testify before you today.

Good morning, my name is Dr. Mark Hathaway and I am a board certified OB/Gyn. I am the director of OB/Gyn outreach services for Women's and Infants' Services at Washington Hospital Center. I am also the Title X Medical Director at Unity Health Care Inc.; Washington D.C.'s largest federally qualified health center system and the Title X grantee for the District.

I work in several medical facilities here in Washington, D.C. My patients tend to be women of color, primarily African American and Latina, and of lower socioeconomic status. Many of the patients I see are uninsured or underinsured and seeking family planning services. Despite their obstacles, they desire to improve their lives, and to have and raise healthy children.

I see every day how increasing women's ability to plan their pregnancies makes a difference in their lives. And by the same token, I also see the negative consequences of unintended and unplanned pregnancy, late prenatal care, uncontrolled medical problems, poor nutrition, and sometimes depression. I see firsthand how cost can be a barrier when it comes to utilizing preventive care in general and using contraceptive services in particular.

That is why the IOM's recommendation is so critically important. Contraceptive counseling and methods should be covered under the Affordable Care Act without cost-sharing. Any attempts to broaden exemptions to that coverage requirement would mean leaving in place insurmountable obstacles to contraceptive services for far too many women.

Cost is a barrier

I know from my day-to-day experiences what it means for patients who cannot afford to pay for their health services. The cost of a birth control method is frequently prohibitive for many of my patients. This is especially true for the more effective long-acting reversible contraceptive methods, aka LARC or "forgettable methods". Women face many challenges in using contraception successfully. Too many women using methods like birth control pills, condoms and even injectables will experience an unplanned pregnancy during the first year of "typical use." Indeed up to 50 percent of pill users will discontinue that method within the year,

significantly increasing their chances of an unintended pregnancy.[1] Long-acting reversible methods, including intrauterine contraceptives and implants, are the most cost-effective methods because they have an extremely low failure rate and are effective at preventing pregnancy for several years. However, the up-front costs of these methods can costs several hundred dollars, placing them out of the reach of millions of women who would otherwise use them.

Three recent studies have found that lack of insurance is significantly associated with reduced use of prescription contraceptives.[2] And several other studies have shown that when out-of-pocket costs are eliminated, women's use of long-acting methods increases substantially. In St. Louis, researchers at Washington University have found that over 70 percent of women will choose a longer acting method if cost and barriers are eliminated.[3]

Preventing unintended pregnancy is critical preventive health care

There are those who assert that unintended pregnancy is not a health condition and therefore prevention of unintended pregnancy is not preventive health care. From my personal practice I can say that I cannot disagree more.

Just last week I met "Sarah." She's 22, has two children under the age of three, one a newborn, and came in for a pregnancy test. Her diabetes had gone unchecked which would put her in a medically high-risk category for pregnancy. She was visibly shaking waiting for her pregnancy test results. She's working over 40 hours a week at 2 jobs, and was told by her primary clinic that she would need to pay a copay of $40 and a $300 fee for the intrauterine device that she so desperately wants and needs. She would have been devastated by a positive pregnancy test. She was incredibly relieved to learn she was not pregnant. Unfortunately she is uninsured but we used our rapidly shrinking safety-net resources to provide her with long acting contraception.

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[1] Ruth Lesnewski and Linda Prine, "Initiative Hormonal Contraceptive," *American Family Physician,* Vol 1 No 74, July 2006.pp 105-112.

[2] KR Culwell and J. Feinglass, "Changes in prescription contraceptive use, 1995-2002: the effect of insurance status," *Obstetrics & Gynecology*, 2007, 110(6):1371-1378. KR Culwell and J. Feinglass, "The association of health insurance with use of prescription contraceptives," *Perspectives on Sexual and Reproductive Health*, 2007, 39(4): 226-230. J. Nearns, "Health insurance coverage and prescription contraceptive use among young women at risk for unintended pregnancy," *Contraception*, 2009, 79(2):105-110.

[3] Washington University in St. Louis, School of Medicine, Department of Obstetrics and Gynecology, "Preliminary Study Findings," *The Contraceptive Choice Project*, September 2011.

The evidence is also conclusive regarding pregnancy spacing. It is directly linked to improved maternal and child health, aka infant mortality rate and maternal mortality rate. Numerous US and international studies have found a direct causal relationship between birth intervals and low birth weight as well as preterm births. A 2008 literature review also shows that throughout the US and Europe, there is an association between pregnancy intention and delayed initiation of prenatal care as well as reduced breastfeeding after a child is born. In other words, we need to help women plan their pregnancies for their health as well as their children's.

Birth control is the most effective way to prevent unintended pregnancy

Using contraception is the most effective way to prevent unintended pregnancy - and ultimately to reduce the need for abortion. Again, I have seen the success of contraceptive services in my own practice, and again the evidence on this is clear. According to a recent Guttmacher Institute study, the two-thirds of women at risk of unintended pregnancy who use contraception correctly and consistently account for only 5% of the 3 million unintended pregnancies that occur each year. Put another way, 95% off all unintended pregnancies occur among women who use contraception inconsistently or use no method at all. Indeed, couples who do not practice contraception have an 85 % chance of experiencing an unintended pregnancy within the next year.

Importance of the IOM Recommendation/Coverage

For all these reasons, the Institute of Medicine women's health recommendations are ground-breaking. Finally, all women will gain access to insurance coverage of family planning services regardless of income. All women will be able to get the counseling, education, and access to the most effective and medically appropriate contraceptive for them. This breakthrough has the potential to bring about major benefits for the health and well-being of women and their families. This comes from giving women the information and services necessary to enable them to plan and space their pregnancies.

Most women will contracept for approximately three decades during their reproductive years. The adoption of the IOM's recommendations holds so much promise for millions of women who currently lack basic resources like health insurance coverage.

All of my training and experience tells me that what we are striving for is healthy women. We are also working to ensure that if and when they are ready to have a child that they have a

healthy pregnancy to increase the chances of a healthy child. The best way to achieve this is to help women and couples become as healthy as possible before pregnancy. This includes financial health, emotional health, and physical health. We should trust women and empower women to make the appropriate decisions for themselves. Therefore, I hope we can at least agree that guaranteeing contraceptive coverage and removing cost barriers to being able to utilize contraceptive services should be at the forefront of preventive care so that women can achieve their own goals.

Thank you.

Mr. PITTS. The Chair thanks the gentleman and now recognizes Ms. Belford for 5 minutes.

STATEMENT OF JANE G. BELFORD

Ms. BELFORD. Mr. Chairman and distinguished members of the subcommittee, thank you for the opportunity to testify before you today on an issue of vital importance to religious organizations like the one I serve.

My name is Jane Belford, and I serve as chancellor of the Catholic Archdiocese of Washington, which includes 600,000 Catholics and includes 140 parish church communities in the District of Columbia and portions of Maryland.

The Archdiocese is one of 195 dioceses of the Catholic Church in the United States which represents more than 70 million Catholics. Throughout this country's history, the Catholic Church has been one of the leading private providers of charitable educational and medical services to the poor and vulnerable. The Archdiocese continues that tradition of service today through its Catholic schools, medical clinics, maternal and pregnancy resource programs, social service agencies, senior and low-income housing, job training programs, and a vast number of other programs and services for persons in need regardless of their faith or no faith, without question, without exception.

The late former Archbishop of Washington, Cardinal Hickey, once said, "We serve them not because they are Catholic but because we are Catholic. If we don't care for the sick, educate the young, care for the homeless, then we cannot call ourselves the Church of Jesus Christ." Until now, Federal law has never prevented religious employers like the Archdiocese of Washington from providing for the needs of their employees with a health plan that is consistent with the Church's teachings on life and procreation. The Archdiocese provides excellent health benefits to its nearly 4,000 employees, consistent with Catholic teaching, and subsidizes most of the cost.

We would lose this freedom of conscience under the mandate from the Department of Health and Human Services that the health plans of religious organizations like ours cover sterilization, contraceptive services, and drugs that in some cases act as abortifacients. This is not in line with the policy that has governed other Federal health programs.

The HHS mandate provides a radically narrow test to be eligible for exemption. Essentially, under this test Catholic organizations like ours would be considered religious enough only if we primarily served Catholics, only if we primarily hired Catholics, and only if the whole purpose of our service was to inculcate our religious values.

Under this analysis, organizations like ours would be only free to follow Catholic teaching on life and procreation if we stopped hiring and serving non-Catholics. However, as in the parable of the Good Samaritan, Catholic organizations serve people of all different faiths without question or condition and without knowing their faith.

Just last year, Catholic Charities of the Archdiocese served over 100,000 people. I could not tell you what their faith is. Our 98

Catholic schools educate 28,000 students in the District of Columbia and Maryland, and in some locations, more than 80 percent of the students are non-Catholic.

HHS has drafted an exemption that is so narrow that it will exclude virtually all Catholic hospitals; Catholic schools, colleges, and universities; and charitable organizations, none of which impose a litmus test on those they serve. Why does the government want to have us do that?

In my written testimony, I allude to the vast array of services being provided right now in the Archdiocese of Washington—the medical care, educational services, and social services that are made available. This narrow religious exemption drafted as it has would burden our deeply held belief not only in life and procreation but in the belief that God calls us to serve our neighbors. Both those beliefs—our beliefs in life and procreation and our belief in service—are grounded in a fundamental teaching that upholds the dignity of human life of whatever race, status, or creed from the beginning of life to the end.

It is part of our central mission and religious identity to be a witness in the world through acts of service to all who are in need, regardless of religion or creed. When we are fortunate enough to be able to partner with the government in providing these services, our devotion to the cause and our institutional resources can make each dollar of funding go further. Unfortunately, the mandate poses a threat to our rights of conscience in our services for our neighbors. At a time when local, State, and Federal governments have had to consider drastic cuts to their healthcare and social service programs and when our citizens' need for support is so great, it is difficult to understand why the Federal Government would impose requirements that are designed to undermine and restrict access to these services.

We believe in the value and dignity of all human life from beginning to end, and we believe that we are called to serve our neighbors, all of them. We will continue to honor these beliefs. We have served, we serve now, and we will continue to serve, but I urge the committee to consider our Nation's historical commitment to religious liberty and the value and importance of the Church's service to the poor and vulnerable and to permit us to practice our faith consistent with the teachings of our church.

Mr. Chairman and members of the committee, thank you for the opportunity to address you.

[The prepared statement of Ms. Belford follows:]

United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

Hearing on the Respect for Rights of Conscience Act of 2011
"Do New Health Law Mandates Threaten Conscience
Rights and Access to Care?"

November 2, 2011

Testimony of
Jane G. Belford
Chancellor
Roman Catholic Archdiocese of Washington

Mr. Chairman and distinguished members of the Subcommittee, thank you for the opportunity to testify before you today in support of the Respect for Rights of Conscience Act. I deeply appreciate the attention you have devoted to this issue of vital importance to religious organizations and individuals across our country.

My name is Jane Belford, and I represent the Archdiocese of Washington, for which I serve as Chancellor and General Counsel. I will summarize my remarks and ask that my written testimony be admitted to the record.

The Archdiocese of Washington is a nonprofit corporation which was chartered by an Act of Congress in 1948. It is home to nearly 600,000 Catholics and includes 140 parishes located in Washington, D.C. and five counties in Maryland: Montgomery, Prince George's, Calvert, Charles and St. Mary's. As just one of the 195 local dioceses of the Roman Catholic Church in the United States, we exist to spread the Gospel and to serve the needs of our neighbors. Throughout history, the Catholic Church and other religious institutions have been the leading private providers of charitable, educational and medical services to the poor and vulnerable. The Archdiocese of Washington continues that tradition of service today through its schools, medical clinics, social service agencies, senior and low income housing, job training programs, and vast number of programs and services for persons in need, regardless of their faith or lack of faith. As the late Archbishop of Washington, James Cardinal Hickey said, "We serve [them] not because they are Catholic, but because we are Catholic. If we don't care for the sick, educate the young, care for the homeless, then we cannot call ourselves the church of Jesus Christ."[1]

[1] Murphy, Caryle. "A Steadfast Servant of D.C. Area's Needy." *The Washington Post (2004-10-25).*

I join with others in support of the Respect for Rights of Conscience Act, HR 1179. As you know, the proposed legislation would address the Department of Health & Human Services' ("HHS") regulations that mandate that private health care plans cover sterilization, contraceptive services, and abortifacient drugs, and aims to correct the radically narrow religious exemption that those regulations provide. The HHS mandate,[2] which effectively categorizes pregnancy as a disease, is irretrievably flawed and should be rescinded in its entirety. The United States Conference of Catholic Bishops has thoroughly addressed this issue in the comments it submitted to HHS on August 31, 2011 and they are incorporated by reference here.[3]

If the mandate is not rescinded, then its religious exemption, which would be the narrowest exemption of its kind ever enacted in federal law, would fail to protect the vast majority of religious stakeholders in the process of providing health insurance. Until now, federal law has never prevented religious employers, like the Archdiocese of Washington, from providing for the needs of their employees with a health plan that is consistent with the Church's moral teachings.

This would change under the HHS mandate. For this reason, the Respect for Rights of Conscience Act is needed to bring the health care reform law in to line with the policy that has governed other federal health programs for years. It would proactively protect religious employers and others who have moral or religious objections to the drugs and procedures for which the HHS regulations would mandate coverage.[4] HR 1179 would not change any past laws.

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[2] By "the mandate," I am referring only to the requirement that health plans cover contraceptives, sterilization, and related education and counseling. I am not referring to the entire list of preventive services for women.

[3] The USCCB's comments are available at http://www.usccb.org/about/general-counsel/rulemaking/upload/comments-to-hhs-on-preventive-services-2011-08-2.pdf

[4] The Catholic Church's moral and religious objections to contraception are set forth in the Catechism of the Catholic Church. It is the Church's belief that there is an "inseparable connection, established by God, which

Its approach to conscientious objection in this context is the norm, bringing the Patient Protection and Affordable Care Act into line with standards of conscience protection in health care long agreed upon at the federal level.

The inadequate exemption at issue sets forth a four-part test for an entity to be identified as a religious organization. According to HHS, an organization is religious, and therefore free to exclude contraception and sterilization from its health plan only if it: (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 as described in section 6033(a)(1) and section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code. 76 Fed. Reg. 46621 (Aug. 3, 2011).

Under this test, archdiocesan Catholic organizations would be free to act in accord with Catholic teaching on life and procreation only if they were to stop hiring and serving non-Catholics. However, following the example set forth by the parable of the Good Samaritan, these Catholic organizations serve people of all different faiths without question or condition. HHS has drafted a religious exemption that is so narrow that it excludes virtually all Catholic hospitals, elementary and secondary schools, colleges and universities, and charitable organizations, none of which impose a litmus test on those they serve, as the HHS mandate would have them do.

A brief snapshot of some of these organizations and who they serve may help to better illustrate the point. In the Archdiocese of Washington, there are three Catholic hospitals that last year provided millions of dollars of free or low cost care for uninsured men, women and children. So, too, the Archdiocesan Health Care Network, a volunteer program of Catholic

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man on his own initiative may not break, between the unitive significance and the procreative significance which are both inherent to the marriage act." Pope Paul VI, 1968, *Humanae Vitae*, 12.

Charities, connects low-income and uninsured patients with specialized, pro bono health care services through a network of 300 volunteer doctors, dentists and health care professionals representing all practices. Catholic Charities and our Catholic Services Network, with a staff of 800 and volunteers numbering 3,400, is the largest private provider of social services in the metropolitan DC area and last year served more than 100,000 children, adults and families through 77 programs offering a wide range of services that include health care, maternity programs and residential care for children in crisis, emergency shelter, food, housing, education, job training, counseling, support for persons with development disabilities, services for new immigrants, legal aid, and more. The Spanish Catholic Center, in four locations in the Archdiocese, operates two medical clinics, a dental clinic, a pediatric clinic and provides social services, employment services, ESOL, and other services and had 38,000 client visits last year. Affordable housing is provided to several thousand low and moderate income senior adults, families with children, and others with special needs by Victory Housing, the development arm of the Archdiocese. Victory Housing has built and manages seven senior assisted living communities, five low-to-moderate income and 11 very low income independent senior communities, as well as three workforce housing communities, with two new facilities scheduled to open in 2012.

This social services effort is supplemented by parish-based outreach services. Nearly every one of our 140 parishes has some outreach ministry, including such programs as soup kitchens, a community health clinic, food pantries, outreach support to the disabled, grants for emergency services, assistance to pregnant women, and twinning programs. In addition, church-based service organizations such as the Knights of Columbus, the St. Vincent de Paul Society,

Christ Child Society and the Order of Malta, help to respond to the needs of the poor and vulnerable across the Archdiocese.

In addition to its health care and social services ministries, education is central to the mission of the Catholic Church. The Archdiocese has 98 Catholic elementary and secondary schools that are educating just over 28,000 students. These schools produce an annual cost savings to taxpayers in the District of Columbia and Maryland conservatively estimated at more than $380,000,000 annually. Finally, through the annual Cardinal's Appeal and other archdiocesan fundraising efforts, and through the generosity of donors, the Archdiocese annually provides millions of dollars to support our ministries of health care, education and social services. If not for these ministries and the service of religious organizations, more of the work of caring for the sick, the poor and the marginalized would fall to government, or simply go undone.

The Archdiocese of Washington employs approximately 3,800 full and part time employees to run its operations and ministries. We provide these employees with health care coverage through a self-funded, church-sponsored, health benefit plan. We provide excellent health benefits consistent with Catholic beliefs, and substantially subsidize the costs of coverage. Currently, the Archdiocese is free under federal law to offer health benefits coverage that excludes contraception and sterilization. We would lose this freedom of conscience under the HHS mandate's current definition of an exempted religious organization. We believe the Archdiocese of Washington and other religious employers should be permitted to continue to extend health benefits to our employees without violating our moral or religious convictions.

It is common to think of the HHS mandate as implicating only one religious belief that the Catholic Church holds—that sterilization and contraception are immoral. However, because

of the narrow scope of its religious exemption—specifically, its condition that qualifying organizations must primarily serve only members of their own faith—the HHS mandate would also significantly burden our deeply held belief that God calls us to serve our neighbors. Both beliefs are grounded in the fundamental Church teaching that consistently upholds the dignity of all human life, of whatever race, status, or creed, from the very beginning to the very end.

It is our belief that God calls us to respect all life and to serve all others—not just Catholics, but the whole community. It is part of the Archdiocese's central mission and religious identity to be a witness in the world through its acts of service to all who are in need, regardless of religion or creed. We strive to care for the sick, to aid the poor, and to teach children how to lead a good life. We believe that service to others is part of our baptismal calling and our employees care deeply about their work. In addition to our committed employees, we have thousands of dedicated volunteers, who expand the reach of the Church to the most vulnerable throughout our communities. When we are fortunate enough to be able to partner with the government in providing these services, our devotion to the cause and our institutional resources can make each dollar of funding go further.

Unfortunately, the mandate poses an unprecedented threat to rights of conscience for religious organizations that aim to serve their neighbors. One consequence of maintaining this narrow exemption would be that Catholic schools that teach abortion is morally wrong could have to pay for abortifacient drugs for their employees; and Catholic health clinics that refuse to provide contraception or sterilization for patients could have to subsidize contraception and sterilization for their employees. In comments submitted on August 31 by the U.S. Conference of Catholic Bishops to HHS, it was noted: "When a religious organization in particular pays for private conduct, the inescapable message is that it does not disapprove of that conduct. ... [A]

religious organization cannot communicate an effective message that conduct is morally wrong at the same time that it subsidizes that conduct. In particular, Catholic organizations cannot effectively and persuasively communicate the Church's teaching that contraception and sterilization are immoral if they simultaneously pay for contraceptives for their employees or (in the case of colleges and universities) for their students."[5]

Diocesan organizations would not be the only ones to suffer under the proposed mandate. As Cardinal Daniel Dinardo noted in his letter to Congress on September 7 of this year, "individuals, insurers, and the sponsors of non-employee health plans (e.g., student health plans in Catholic schools) would have no exemption at all." This omission jeopardizes the free speech rights of such individuals, insurers, and sponsors by forcing them to offer or subsidize, and thereby to endorse, the practice of sterilization and contraception. For the Church's position on these and other threats posed to religious freedom by these regulations, I would respectfully refer the Committee to the USCCB's August 31, 2011 Comments submitted to HHS.

Therein, the USCCB asserts that the HHS mandate would be subject to challenge in court on a number of other grounds. It would violate the Weldon amendment's prohibition of government discrimination against health plans that do not cover abortions (see Consolidated Appropriations Act, 2010, Pub. L. 111-117, Div. D, § 508(d) (Dec. 16, 2009); it would contravene the abortion and non-preemption provisions of the Patient Protection and Affordable Care Act (see §§ 1301(b)(1)(A) and 1303(c)(1); it would run afoul of protections established in the Religious Freedom and Restoration Act (42 U.S.C. 2000bb-1(c)); and it would infringe on the rights and freedoms guaranteed in the Free Exercise and Establishment Clauses of the First

[5] The USCCB comments are available at http://www.usccb.org/about/general-counsel/rulemaking/upload/comments-to-hhs-on-preventive-services-2011-08-2.pdf.

Amendment (see, e.g., *Church of the Lukumi Babalu Aye v. City of Hialeah*, 508 U.S. 520 (1993) (Free Exercise Clause); *Larson v. Valente*, 456 U.S. 228, 244-45 (1982) (Establishment Clause). The best way to fix these legal deficiencies is to rescind the mandate in its entirety. The next best solution is to pass HR 1179.

Aside from being unconstitutional, the mandate's narrow exemption represents a massive error in policy making by excluding Catholic institutions that provide health care, education and charitable services to the general public. At a time when local, state, and federal governments have had to consider drastic cuts to their health care and social service programs, and when our citizens' need for support is so great, it is difficult to understand why the federal government would impose requirements that are designed to undermine and restrict access to these services.

Regardless of one's beliefs about the specific issues of contraception and abortion, people of faith should not be compelled to act in a manner inconsistent with their moral convictions in order to receive or provide health coverage. This mandate would impose such a compulsion on any religious institution that wishes to continue to employ and serve people of all faiths, and to provide health coverage to those who work in their institutions. Our Catholic schools, hospitals, clinics, and social service programs serve tens of thousands of non-Catholics. No one is required to become Catholic in order to receive these services. Yet this mandate would require us to violate our religious beliefs to serve them.

We believe in the value and dignity of all human life from beginning to end, and we believe that we are called to serve our neighbors—all of them. We will continue to honor these beliefs. But I implore the Committee to consider our nation's historical commitment to religious liberty and the value and importance of the Church's service to the poor and vulnerable, and to allow us to continue to observe our beliefs without interference by the law.

Mr. PITTS. Thank you. The Chair thanks the gentlelady, recognizes Mr. O'Brien for 5 minutes.

STATEMENT OF JON O'BRIEN

Mr. O'BRIEN. Mr. Chairman, Member Pallone, and members of the subcommittee, thank you for this opportunity to present testimony on this important question of conscience rights and access to comprehensive healthcare.

For nearly 40 years, Catholics for Choice has served as a voice for Catholics who believe that Catholic teaching means that every individual must follow his or her own conscience and respect the rights of others to do the same. This hearing seeks to answer the question: Do new health law mandates threaten conscience rights and access to care? I firmly believe the requirements under the Affordable Care Act and the slate of regulations being created to implement it infringe on no one's conscience, demand no one change his or her religious beliefs, discriminate against no man or woman, put no additional economic burden on the poor, interfere with no one's medical decisions, compromise no one's health—that is, if you consider the law without refusal clauses.

When the question is asked in light of these unbalanced and ever-expanding clauses, the answer becomes yes, it would do all those things. When burdened by such refusal clauses, the new health law absolutely threatens the conscience rights of every patient seeking care for these restricted services and of every provider who wishes to provide comprehensive healthcare to patients. These restrictions go far beyond their intent of protecting conscience rights for all by eliminating access to essential healthcare for many, if not most patients, especially in the area of reproductive health services. This will make it harder for many working Americans to get the healthcare they need at a cost they can afford.

Like many Catholics, I accept that conscience has a role to play in providing healthcare services, but recent moves to expand conscience protections beyond the simple right for individual healthcare providers to refuse to provide services to which they personally object to go too far. It is incredible to suggest that a hospital or an insurance plan has a conscience. Granting institutions—or entities like these—legal protection for the rights of conscience that properly belong to individuals is an affront to our ideals of conscience and religious freedom.

Respect for individual conscience is at the core of Catholic teaching. Catholicism also requires deference to the conscience of others in making one's own decisions. Our faith compels us to listen to our consciences in matters of moral decision-making and to respect the rights of others to do the same. Our intellectual tradition emphasizes that conscience can be guided, but not forced, in any direction. This deference for the primacy of conscience extends to all men and women and their personal decisions about moral issues.

Today, the 98 percent of sexually active Catholic women in the United States who have used a form of contraceptive banned by the Vatican have exercised their religious freedom and followed their consciences in making the decision to use contraception. Thus, they are in line with the totality of Catholic teaching if not with the

views of the hierarchy. Having failed to convince Catholics in the pews, the United States Conference of Catholic Bishops and other conservative Catholic organizations are now attempting to impose their personal beliefs on all people by seeking special protection for their conscience rights. They claim to represent all Catholics when in truth theirs is a minority view. The majority of Catholics support equal access to contraceptive services and oppose policies that impede upon that access.

Two-thirds of Catholics, 65 percent, believe that clinics and hospitals that take taxpayer money should not be allowed to refuse to provide procedures or medications based on religious belief. A similar number, 63 percent, also believes that all health insurance, whether private or government-run, should cover contraception. Sweeping refusal clauses and exemptions allow a few to dictate what services many others may access. They disrespect the individual capacities of women to act upon their individual conscience-based decision. They impede the rights of women and men to make their own decisions about what is best for them, their health and their families.

Lawmakers of all political hues can come together to support a balanced approach to individual conscience rights and access to comprehensive healthcare. It makes sense for all those who want to provide more options to women seeking to decide when and whether to have a child. It makes sense for those who want to keep the government's involvement in healthcare to a minimum. Above all, it makes sense for a society that believes in freedom of religion, a right one can't claim for oneself without extending it to one's neighbor.

The bottom line is that protecting conscience rights and preserving access to care shouldn't just be about protecting those who seek to dictate what care is and is not available, nor should it be for those who would dismiss the conscience of others by imposing their view of which consciences are worth protecting. Protecting individual conscience and ensuring access to affordable, quality care is not just an ideal, it is a basic tenet of our society and it is the right thing to do.

I thank the subcommittee for inviting me today.

[The prepared statement of Mr. O'Brien follows:]

Testimony of

Jon O'Brien
President
Catholics for Choice

Submitted to
US House of Representatives Committee on Energy and Commerce
Subcommittee on Health

Written Testimony for the Hearing Record on
"Do New Health Law Mandates Threaten Conscience Rights and Access to Care?"

November 2, 2011

Mr. Chairman, Ranking Member Pallone and Members of the Subcommittee, thank you for this opportunity to present testimony on behalf of Catholics for Choice on this important question of conscience rights and access to comprehensive healthcare.

For nearly 40 years, Catholics for Choice has served as a voice for Catholics who believe that the Catholic tradition supports a woman's moral and legal right to follow her conscience on matters of sexuality and reproductive health. Throughout the world, we strive to be an expression of Catholicism as it is lived by ordinary people. We are part of the great majority of the faithful in the Catholic church who disagrees with the dictates of the Vatican on matters related to sex, marriage, family life and motherhood. We represent those who believe that Catholic teachings on conscience mean that every individual must follow his or her own conscience—and respect others' right to do the same.

Certainly, at Catholics for Choice, we are no strangers to the intersection of religion, sex and politics. While religious voices and traditions are a vital part of public discourse, religious views should not be given disproportionate weight in public policy discussions. When this happens the lives of men and women can suffer greatly. We believe in a world where all voices, the voices of the religious and of the secular, of Catholics and non-Catholics alike, are heard in public policy discussions.

This hearing seeks to answer the question: Do new health law mandates threaten conscience rights and access to care? I firmly believe the requirements under the Affordable Care Act, and the slate of regulations being created to implement it, infringe on no one's conscience, demand no one change her or his religious beliefs, discriminate against no man or woman, put no additional economic burden on the poor, interfere with no one's medical decisions, compromise no one's health—that is, if you consider the law without refusal clauses. When the question is asked in light of these unbalanced and ever-expanding clauses, the answer becomes yes, it would do all these things. When burdened by such refusal clauses, the new health law absolutely threatens the conscience rights of every patient seeking care for these restricted services and of every provider who wishes to provide comprehensive care to their patients. These restrictions go far beyond their intent of protecting conscience rights for

all by eliminating access to essential healthcare for many, if not most patients, especially in the area of reproductive healthcare services. This will make it harder for many working Americans to get the healthcare they need at a cost they can afford.

The Affordable Care Act has many positive elements to it. Millions will now be able to access insurance coverage for their health needs and, with the basic level of coverage required under the new law, these newly insured and the millions of those better insured will now have greater access to a wider range of services than ever before. However, the law includes a refusal clause which has been expanded in the past decades to threaten the consciences of both those who seek to receive and those who want to provide services. Advocates of these expansive refusal clauses claim these are necessary to protect conscience rights. Others believe that refusal clauses such as these are simply part of attempts to derail the Affordable Care Act and to curb access to reproductive healthcare services entirely. Moreover, proposals to expand existing refusal clauses increase threats to the conscience rights of patients and providers by including not just abortion but also family planning services and, should some get their way, any other service deemed "unacceptable" by a tiny minority.

In recent years, under the guise of protecting religious freedom and "conscience rights" we have seen a dramatic upswing in attempts to expand the scope of refusal clauses, their application, and the entities able to utilize them. These new, ever-broader refusal clauses do far more than allow those healthcare professionals or social service providers with conscience objections to opt out. Instead, they are effectively being used as a means to refuse some treatments, medications, benefits and services to all comers.

These expansions have increased not only the services that may be refused—including reproductive health services as well as insurance coverage for those services and even training for medical professionals—but they have also the number of those who may claim these protections. Almost everyone, including most Catholics, agrees that it is reasonable to allow healthcare professionals, including doctors, nurses and pharmacists, to opt out of providing essential reproductive healthcare

services and medications to which they conscientiously object. There is no doubt that there are times when the conscience of an individual doctor, nurse or pharmacist may conflict with the wishes or needs of a patient. This often happens in cases related to abortion. Except in emergency situations, it is reasonable and indeed prudent to allow those who are opposed to abortion to opt out of providing the service. In these situations, women seeking these services should not have to worry about the religious and moral beliefs of their healthcare providers interfering with the provision of the best possible care. Therefore, it is in the best interests of all that only medical professionals committed to providing such services do so. Women need support and compassionate care when they access reproductive healthcare services, not judgment and disdain.

When this is not possible, a reasonable ethical fallback is for the institution to guarantee timely referrals to ensure that patients receive continuity of care without facing an undue burden, such as traveling long distances or encountering additional barriers to obtaining the desired services. Moreover, good practice should also compel a religious institution to make sure that the consciences of both the healthcare (or social services) provider and the patient (or client) are accommodated by having policies in place that enable individuals to receive whatever medications they are prescribed, procedures they require or services they seek.

Like many Catholics, I accept that conscience has a role to play in providing healthcare services, but recent moves to expand conscience protections beyond the simple right for individual healthcare providers to refuse to provide services to which they personally object go too far. Increasingly, demands and regulatory proposals attempt to grant that option to an institution or any individual along the spectrum of care, funding and coverage. It is incredible to suggest that a hospital or an insurance plan has a conscience. Granting institutions, or entities like these, legal protection for the rights of conscience that properly belongs to individuals is an affront to our ideals of conscience and religious freedom.

Allowing religious institutions to dictate the medical care available to their employees or religiously-affiliated organizations to dictate what services their beneficiaries are allowed to access would encroach on the individual consciences of those seeking care and assistance. Refusal clauses such as these fly in the face of true religious freedom by promoting the interests of certain elements of particular religions over the consciences and beliefs of individuals. They ignore the moral agency of the many who do not share the beliefs of a particular religious ideology. If allowed to stand, these refusal clauses do nothing but endanger many women's access to the healthcare they need. When codified into law at the federal or state level, these "protections" actually constitute state-sponsored discrimination against women based on where they are employed, where and how they buy health insurance and where they seek to receive care.

Today, the 98 percent of sexually active Catholic women in the US who have used a form of contraception banned by the Vatican have exercised their religious freedom and followed their consciences in making the decision to use contraception. Thus, they are in line with the totality of Catholic teachings, if not with the views of the hierarchy. The problem is very clearly with the Catholic hierarchy and not the Catholic church, which includes the vast majority of the 68 million Catholics in the United States who use and support the availability of comprehensive reproductive healthcare services for all those who choose to utilize them.

Having failed to convince Catholics in the pews, the United States Conference of Catholic Bishops (USCCB) and other conservative Catholic organizations are now attempting to impose their personal beliefs on all people by seeking special protection for their "conscience rights." They claim to represent all Catholics when, in truth, theirs is the minority view. The bishops have identified several sympathetic high-profile allies in healthcare, education and social service provision to assist them in promoting their demands, but these allies are heavily reliant on the bishops for funding and prestige. Hospitals and colleges can lose their Catholic designation at the bishop's whim, as happened recently in Phoenix, Arizona.

At a Catholic hospital in Phoenix, medical professionals acted to save the life of a pregnant woman by performing a life-saving abortion on a mother of four. The local bishop decided that his authority over the hospital allowed him to second-guess the medical decisions they made and he stripped the hospital of its Catholic designation. This is antithetical to the Catholic social justice tradition, which would not leave a woman's life out of any healthcare equation.

What occurred in Phoenix helps to illustrate the problem with the bishops' intrusion into medical decisions. The personal and professional freedom to make healthcare decisions is being threatened by expansive refusal clauses. The exemptions that the USCCB and other conservative Catholic organizations are demanding do not offer any more protection for religious freedom, but rather impede the religious freedom of millions of Americans, taking reproductive healthcare options away from everybody.

The USCCB and some Catholic organizations, many that receive taxpayer money, are asking to be allowed to:

- deny condoms as part of HIV outreach;
- ban employees and their dependents from getting the benefit of no-cost contraceptive coverage that other insured Americans enjoy;
- opt out of providing emergency contraception to victims of sexual violence who come to Catholic hospitals for help; and
- deny abortion care to everybody—even those women whose lives are threatened by their pregnancy.

They claim that they are representing all Catholics, but this is not true. The majority of Catholics support equal access to contraceptive services and oppose policies that impede upon that access. Two-thirds of Catholics (65 percent) believe that clinics and hospitals that take taxpayer money should not be allowed to refuse to provide procedures or medications based on religious beliefs. A similar

number, 63 percent, also believes that health insurance, whether private or government-run, should cover contraception.[1] A strong majority (78 percent) of Catholic women prefer that their hospital offer emergency contraception for rape victims, while more than half (55 percent) want their hospital to provide it in broader circumstances.[2] This support for the full range of contraceptive services is unsurprising, as restrictions such as refusal clauses or prohibitive costs affect Catholics just as often as non-Catholics—98 percent of sexually active Catholic women have used a modern method of birth control, mirroring the rate of the population at large (99 percent).[3]

Advocating for expansive refusal clauses in healthcare delivery regulations would affect all patients—whether those patients are Catholic or not. Seeking exemptions for religious organizations to cover essential health benefits, such as full coverage of recommended preventive services including contraception, under the Affordable Care Act will only serve to endanger many women's access to the healthcare they need—whether those employees share those religious beliefs or not. In reality, these exemptions would deny the right of everyone seeking comprehensive healthcare.

When religious voices are allowed to direct policymaking, the best interests of those seeking healthcare services can be ignored. This is clear in the case of the Catholic healthcare industry which, despite providing much valuable service, persists in refusing to provide a full range of reproductive healthcare services, even to those who are in desperate need of them.

Respect for individual conscience is at the core of Catholic teaching. Catholicism also requires deference to the conscience of others in making one's own decisions. Our faith compels us to listen to our own consciences in matters of moral decision-making and to respect the rights of others to do the same. Our intellectual tradition emphasizes that conscience can be guided, but not forced, in any

[1] Belden Russonello & Stewart, "Catholic Voters' Views on Health Care Reform and Reproductive Health Care Services: A National Opinion Survey of Catholic voters conducted for Catholics for Choice," September 2009.
[2] Ibis Reproductive Health. Second chance denied: Emergency contraception in Catholic hospital emergency rooms. A report for Catholics for Choice, 2002.
[3] US Department of Health and Human Services, National Center for Health Statistics, "National Survey of Family Growth," 2008.

direction. This deference for the primacy of conscience extends to all men and women and to their personal decisions about moral issues.

Our faith also compels us to respect religious pluralism and religious freedom. Religious freedom is an expansive rather than restrictive idea. It has two sides: freedom of religion and freedom from religion. It is not about telling people what they can and cannot believe or practice, but rather about respecting an individual's right to follow his or her own conscience in religious beliefs and practices, as well as in moral decision making. The protections we put in place to preserve religious freedom do not permit religious institutions or individuals to obstruct or coerce the exercise of another's conscience.

Sweeping refusal clauses and exemptions allow a few to dictate what services many others may access. They disrespect the individual capacities of women to act upon their individual conscience-based decision. They impede the rights of women and men to make their own decisions about what is best for their own health, and that of their families, as well as restricting their right to act upon those decisions without undue and unjust burdens.

One woman who saw these burdens placed on her conscience rights is "Sandra," a science teacher at a Catholic school in the Midwest. Her story is an example of the many Americans who fall under these types of expansive refusal clauses being pushed by the bishops and their allied organizations. What is a reality for Sandra today is what many women can look forward to in their future.

As with almost all Catholic schools, Sandra's employers follow diocesan rules regarding employees' insurance—meaning no contraceptive coverage, regardless of medical necessity. When she first learned of the refusal clause proposed in the recent regulation to implement the preventive health services under the Affordable Care Act, she was outraged. As she explained to us, they added "insult to injury" by ignoring the healthcare needs of women like her and allowing her employers to continue to deny her coverage.

"I just never assumed that in 2011 I would be denied birth control," she said. "I'm in my mid-twenties. I have no intention of having kids at the moment. I like teaching kids, but it's a whole other thing having them."

Sandra lost coverage when she began working under the jurisdiction of her local diocese. "I went to fill my birth control prescription like I always do. I say 'Here's my new insurance card,' and they say I'm not covered," she related. "They thought that it was weird and asked where I worked. As soon as I said I worked in a Catholic school, they said, 'Oh, 99 percent of Catholic schools will not cover it. We've never had it covered before.' I had no clue."

For Sandra, this posed a significant hardship. She had taken a salary reduction in order "to go to work every day saying that it's what I love." She and her husband had carefully considered their insurance plans and determined that it was more economical for them to remain on separate policies, but once she had to pay out of pocket for the birth control that was best for her, a non-generic prescription, their careful financial planning was all for naught.

"Birth control is a lot of extra money on top of the salary reduction, but the principle of it is really what gets me," she told us. "I don't like being told by some guy that I've never met that I can't use it. The bishops are not even having sex in the first place. How are they supposed to know how to tell me what to do in that situation?"

Her story, as she recognized, is all too common and reflects the repeated marginalization of many women by the Catholic hierarchy—the same women whose voices have been deemed unimportant by those on both sides of the recent debates. Sandra is just one of the many individuals whose conscience is not being protected by refusal clauses exempting entire institutions from covering their employees for services guaranteed to everyone else by the new law.

Catholic teachings on conscience require due deference to the conscience of others in making decisions—that the employer should not be allowed to dismiss the conscience of the employee

seeking coverage for the healthcare services guaranteed to any other. In light of this precept, the public policy efforts of the hierarchy should take into account the experiences of individual Catholics as well as the beliefs of patients and clients, workers in social services and healthcare providers of other faiths and no faith, so that patients will not be refused any legal and medically appropriate treatment or be denied services they seek.

You have heard from some conservative Catholics on this issue, but it would be a grave mistake to confuse the individual positions of a few powerful interest groups with the majority view of the more than 68 million Catholics in the United States. For Catholic employers to claim to be the arbiter of any person's good conscience is clearly disingenuous. When medical professionals refuse to provide legal reproductive health services, or provide timely referrals to other providers, they violate the right to conscience of the person seeking those services. This does not fall under anybody's definition of a good conscience. Catholics for Choice and the majority of Catholics respect everybody's individual conscience and their ability to act in accordance with their personal beliefs. However, we expect the hierarchy and their allied organizations, in keeping with the teachings of our shared Catholic faith and our American tradition, to respect our consciences and the consciences of the patients and clients who seek the services they need. We hope that those who serve to represent all of us in public service and in government will respect our consciences, too.

Protecting the freedom of conscience for all Americans no matter what their beliefs may be—for the atheist, for the employee of a Catholic institution, for the sexual assault victim who seeks care at a Catholic hospital—is indeed the job of the government. Expanding individual refusal clauses to include institutions and exemptions for religious institutions to deny the rights of all would sacrifice these people's rights. Public policy should be implemented to further the common good and to enable people to exercise their conscience-based healthcare decisions.

Lawmakers of all political hues can come together to support a balanced approach to individual conscience rights and access to comprehensive healthcare. It makes sense for all those who want to

provide more options to women seeking to decide when and whether to have a child. It makes sense for those who want to keep the government's involvement in healthcare to a minimum. And it makes sense for those who think that it is the government's role to facilitate the healthcare decisions that people want to make. Above all, it makes sense for a society that believes in freedom of religion—a right one can't claim for oneself without extending it to one's neighbor. The bottom line is that protecting conscience rights and preserving access to care shouldn't just be about protecting those who seek to dictate what care is and is not available to all. Nor should it be for those who would dismiss the conscience of others by imposing their view of which consciences are worth protecting. Protecting individual conscience and ensuring access to affordable, quality care is not just an ideal, it is a basic tenet of our society and it is the right thing to do.

I thank the Subcommittee for inviting me today and for your attention. I look forward to any questions Members may have.

Mr. PITTS. The Chair thanks the gentleman and recognizes Mr. Cox for 5 minutes for an opening statement.

STATEMENT OF WILLIAM J. COX

Mr. COX. Good morning, Mr. Chairman and members of the committee, and thank you for convening a hearing on this critically important matter. My name is Bill Cox and I am president and CEO of the Alliance of Catholic Health Care, which is based in Sacramento, California. We represent 4 Catholic systems in California that operate 54 hospitals.

My testimony focuses on the exceedingly narrow definition of religious employer in HHS's interim final rule.

You have a copy of my extended remarks, so I will summarize them by making four brief points about the definition and the mandate.

First, in order to benefit from the definition, a religious institution must primarily employ and serve its coreligionists and it must proselytize. As an essential element of the religious missions Catholic hospitals, universities, and social services hire and provide services to a broad array of people and they do not proselytize those they serve. Thus, the definition, together with the mandate, will require Catholic hospitals, universities, and social service agencies to cover in their health insurance plans contraceptives, abortifacients, and sterilizations in direct violation of their religious beliefs.

Mr. Chairman, Catholics have been providing healthcare services in California since 1854 when eight Sisters of Mercy arrived in San Francisco from Ireland. The following year, a cholera epidemic broke out and the Sisters went to work in the county hospital. According to San Francisco's "The San Francisco Daily News" of that time, "the Sisters of Mercy did not stop to inquire whether the poor sufferers of cholera were Protestant or Catholic, American or foreigners, but with the noblest devotion, applied themselves to their relief."

Mr. Chairman, had HHS's definition of religious employer been in effect in 1854, the ministry of the Sisters of Mercy in San Francisco would not have been considered by the Federal Government to be a religious ministry.

Second, I think it is very important to emphasize this morning that neither the propriety nor the wisdom of nor the government's authority to impose a contraceptive mandate on all employers is at issue here. The question is actually a very narrow one related to the First Amendment, and that is whether the HHS definition of religious employer contravenes the First Amendment by putting the Federal Government in the position of determining what parts of a bona fide religious organization are religious and what parts are secular.

In particular, it allows the government to make such distinctions in order to infringe the religious freedom of that portion of the organization the government declares to be secular. This is exactly what the founders of this country sought to avoid by adopting the First Amendment to the Constitution.

Third, the definition is discriminatory in that it tracks identical language first enacted in a California statute that was deliberately

designed to contravene the religious conduct of religious organizations such as Catholic hospitals, universities, and social services. At the time, one of the principal proponents of that definition of religious liberty said our purpose and intent here is to close the Catholic gap. That is, we want to compel these religious institutions by force of law to provide these services regardless of what they may think of them in terms of their religious belief.

Fourth, there is no escape from the HHS mandate. Unlike most State contraceptive mandates that have a similar definition of religious employer, religious employers cannot avoid the HHS mandate by either dropping coverage of prescription drugs or by self-insuring through an ERISA plan.

In conclusion, I would just like to note that Catholic hospitals provide a broad array of services not always available in other institutions. For example, in California 86 percent of our hospitals have palliative care programs compared to only 43 percent of all California hospitals. Our palliative care programs address the physical, emotional, and spiritual needs of chronically ill and dying patients and their families.

Moreover, a recent Thomson Reuters study found that on 8 key metrics Catholic healthcare systems in the United States were significantly more likely to outperform their nonprofit and investor-owned counterparts on quality, efficiency, and patient satisfaction. It would be a great loss to the Nation and the communities we serve if our hospitals were compelled by Federal law to forgo their religious mission and consciences in order to comply with the HHS contraceptive mandate.

I would be happy to answer any questions.

[The prepared statement of Mr. Cox follows:]

Testimony of William J. Cox
President & CEO, The Alliance of Catholic Health Care

Before the Energy & Commerce Committee's Subcommittee on Health
"Do New Health Law Mandates Threaten Conscience Rights and Access to Care?

Wednesday, November 2, 2011
2123 Rayburn House Office Building

Good morning. Mr. Chairman, thank you for convening a hearing on this critically important topic, and for your longstanding leadership defending the right to life and protecting the conscience rights of health care providers. The title of this hearing asks if new health law mandates threaten conscience rights and access to care. The answer to this question is an unequivocal yes; and, if left unaddressed, these mandates will force providers and others of conscience to choose between violating their consciences or no longer providing or paying for health care and other services, and curtailing access to care, particularly for some of the most vulnerable among us.

My name is Bill Cox. For the past 12 years, I've had the privilege of serving as President and CEO of the Alliance of Catholic Health Care. Based in Sacramento, the Alliance represents four hospital systems that operate 54 hospitals and more than 40 nursing homes, hospices, assisted living and other facilities and services throughout the state of California. Catholic providers account for about 16 percent of all California hospitals and provide three quarters of a billion dollars annually in charity care and community benefits.

This proud Catholic legacy of providing health care to California's most vulnerable extends nearly 160 years to the 1854 arrival of eight Sisters of Mercy in San Francisco, who created a safe haven for abandoned women, prostitutes and young girls and provided care to the city's elderly and ill residents. When a cholera epidemic struck San Francisco the following year, the Sisters of Mercy went to work in the county hospital. According to San Francisco's *The San Francisco Daily News* of that time, "The Sisters of Mercy ...did not stop to inquire whether the poor sufferers were Protestant or Catholic, Americans or foreigners, but with the noblest

devotion applied themselves to their relief."[1] The San Francisco board of supervisors subsequently petitioned the Sisters to operate the first county hospital.[2] Two years later, the Sisters of Mercy founded St. Mary's Hospital. Communities of Catholic sisters have repeated this type of selfless commitment to serve all in need countless times throughout our nation's history and today more than 600 Catholic hospitals serve patients, families and communities across the United States.

Health Care Provider Conscience Rights Under Attack

Recently, the United States Department of Health and Human Services (HHS) turned its back on the contributions of Catholic health care and undid centuries of religious tolerance by adopting an Interim Final Rule on Preventive Health Services, which includes an exceedingly narrow definition of religious employer.

My testimony focuses on the definition of religious employer in HHS's interim final rule. This definition tracks identical language first enacted in a California statute, and was deliberately designed to contravene the religious conduct of religious organizations, such as Catholic hospitals, universities and social services. Specifically, both the California statute and HHS's interim final rule exempt a religious employer only if the employer meets all of the following criteria:

1) Its purpose is the inculcation of religious values;
2) It primarily hires people who share its religious tenets;
3) It primarily serves persons who share its religious tenets; and
4) It is a non-profit organization under Internal Revenue Code section 6033(a)(3)(A)(i) or (iii), (i.e., it is a "church" or "integrated auxiliary of a church").[3]

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[1] Fialka, John J. Sisters Catholic Nuns and the Making of America. Page 85
[2] http://www.stmarysmedicalcenter.org/Who_We_Are/History/index.htm
[3] The legislative record from the California General Assembly clearly establishes that the authors and sponsors of the California religious employer exemption specifically designed it to exclude Catholic religious institutions, especially Catholic hospitals, universities and social service agencies. (*Catholic Charities of Sacramento Inc. v Superior Court* 32 Cal. 4th 527, 541-47 (2004).)

The first thing to be noted about this definition is that had it been operative in 1854 it would not have recognized the health care ministry of the eight Sisters of Mercy in San Francisco as religious: the Sisters of Mercy neither proselytized the cholera victims they cared for, nor did they limit their care to Catholics only.

HHS's definition of religious employer raises a fundamental question: may the government determine what parts of a bona fide religious organization are religious and what parts are secular? And, in particular, may the government make such distinctions in order to infringe the religious freedom of that portion of the organization the government declares to be secular?

Neither the propriety, nor the wisdom of, nor the government's authority to impose a contraceptive mandate on U.S. employers is at issue here. "The question is a very narrow one. May the government impose a mandate on a religiously affiliated employer that requires the employer to pay for contraceptives – in violation of a an acknowledged religious tenet – or to redefine what constitutes religious conduct?"[4]

As former California State Supreme Court justice Janice Brown aptly noted, "A strong argument can be made that it was the primacy of religious liberty in the early history of this country, with its acknowledgement of the separate spheres of church and state, that gave rise to our notions of limited government and equal protection – the constitutional precursors of our anti-discrimination laws. '[T] he division between temporal and spiritual authority gave rise to the most fundamental features of liberal democratic order: the idea of limited government, the idea of individual conscience and hence of individual rights, and the idea of civil society, as apart from government, bearing primary responsibility for the formation and transmission of opinions and ideas.'[5]

"Our ability to create a space for religious perspectives is both instrumental and regenerative for democracy. Religious institutions enhance individual autonomy 'by challenging the power of the

[4] Dissenting opinion, J. Brown, *Catholic Charities of Sacramento v California.*
[5] McConnell, *Why is Religious Liberty the "First Freedom?" (2000).*

liberal state'[6] and by articulating alternative visions – 'counter-cultural visions that challenge and push the larger community in ... directions unimagined by prevailing beliefs.'[7] By protecting religious groups from gratuitous state interference, we convey broad benefits on individuals and society. By underestimating the transformative potential of religious organizations, we impoverish our political discourse and imperil the foundations of liberal democracy."[8]

This is certainly true of Catholic hospitals, which fulfill their religious mission by providing valuable health services not always available in other hospitals. For instance, Catholic hospitals in California are leaders in the provision of palliative care programs that promote quality of life for patients living with serious, chronic or terminal illness – 86 percent of Catholic hospitals have palliative care programs compared to 43 percent of all California hospitals. Other services that are more often found in Catholic hospitals include neonatal intensive care units (NICU), pediatric care beds, maternity care and coronary care units. Furthermore, a recent independent national study by Thompson Reuters found that on eight key measures Catholic-owned systems are "significantly more likely to provide higher quality performance and efficiency to the communities served" than their nonprofit and investor-owned counterparts.[9]

HHS's Definition of Religious Employer is Discriminatory

The definition of religious employer created in California and now being utilized by HHS did not occur in a vacuum. As the legislative history of the California contraceptive mandate makes clear, the highly flawed definition of religious employer was painstakingly crafted by the American Civil Liberties Union (ACLU) to specifically exclude religious institutional missions like health care providers, universities and social service agencies. In fact, in testimony before a state Senate committee, the head of Planned Parenthood in California at the time went so far as to say that the wording was designed to close the "Catholic gap" when it comes to contraceptive coverage. And in a floor statement, the principal legislative author of the state senate definition of religious employer argued, "59 percent of all Catholic women of childbearing age practice

[6] Noonan, *The End of Free Exercise? (1992) 42 De Paul L.R. 567, 579-580.*
[7] Brady, *Religious Organizations and Mandatory Collective Bargaining Under Federal and State Labor Laws: Freedom From and For* (2004) 49 Vill. L.Rev. 77, 156.
[8] J. Brown, Dissenting Opinion, *Catholic Charities of Sacramento v California.*
[9] *Differences in Health System Quality By Ownership Type*, Thomson Reuters, August 2010).

contraception [and] 88 percent of Catholics believe ... that someone who practices artificial birth control can still be a good Catholic, " and then stated, "I agree with that. I think it's time to do the *right thing*" (italics added).[10]

HHS's Contraceptive Mandate Is More Radical than California's

As bad as the California contraceptive mandate it, it is less onerous than HHS's mandate, as its reach is limited to employers that provide an outpatient prescription drug benefit, it does not cover sterilizations and it does not preclude a religious employer from opting out of the mandate by self-insuring under *ERISA*. By contrast, HHS is proposing a far more radical approach by requiring that all types of health plans include all FDA-approved contraceptive methods as well as sterilization procedures and related patient "education and counseling." In requiring the coverage of all FDA-approved contraceptive methods, the interim final rule mandates at least one drug that is analogous to RU-486 and can cause an abortion when taken to avoid pregnancy. This specific component of the mandate is in direct violation of longstanding federal conscience law, the Hyde-Weldon amendment, which protects health care providers from discrimination by government entities for refusing to perform, participate in, pay for or refer for abortions. Moreover, the HHS mandate precludes religious employers from opting out of its requirements by self-insuring as *ERISA* plans.

HHS's Contraceptive Mandate is the Most Radical in the Nation

The HHS proposed rule is not only more radical than California's; it is the most radical of the 28 state contraceptive mandates.

- Not a single state requires that all plans cover contraceptives. Every state, rather, specifically exempts *ERISA* self-insured plans.
- Only two states require that contraceptives be covered in plans that do not provide prescription drug coverage.
- Only one state requires that sterilizations be covered.

[10] Remarks of Senator Speier, Sen. Floor Debate on Assem. Bill No 39 (1999-2000 Reg. Sess.) Sept. 7, 1999, p. 7.

When compared to these 28 state mandates, the facts are clear: The HHS contraceptive mandate is designed to institute the most stringent of mandates – including sterilization and plans that do not offer other prescription coverage –and the narrowest of conscience-rights exemptions. If not corrected, this will create a perfect storm that will violate the religious freedom and right to conscience of an untold number of employers – institutional and individual – and jeopardize access to vital health, education, and social services.

Disproportionate Impact on Catholic Institutions

While many employers of conscience – both religious and others – will be negatively affected by the rule, Catholic institutional ministries, such as hospitals, universities and social services, will suffer disproportionately. These Catholic institutional ministries all share distinct characteristics that include:

- An unqualified commitment to Christian service not calculated to inculcate religious values;
- A commitment to invite all people of goodwill, regardless of their religious beliefs, to serve with them in the operation of these ministries; and
- A commitment to serve all people in need, regardless of race, creed, national origin, or economic status.

A fundamental principle of religious freedom is the right of religious institutions to autonomy in their self-definition and governance. Simply stated, churches and religious institutions have the right to define and govern themselves free from government interference and entanglement. The HHS exemption violates this right by redefining Catholic institutional ministries in a manner that excludes central elements of their faith. HHS simply lacks the constitutional capacity to establish a definition of religious ministry that runs counter to a religious organization's understanding of it – absent a compelling governmental interest that warrants state interference in a manner narrowly tailored to avoid burdening the exercise of this right. The interim final rule has identified no such compelling interest.

The extremely narrow character of the HHS's definition of religious employer offers Catholic institutional ministries a Hobson's choice: cooperate under governmental compulsion with conduct that is inconsistent with their religious and moral beliefs, or cease functioning altogether. It is particularly ironic that HHS is substantially burdening Catholic institutional ministries because they respectfully avoid inculcating religious beliefs, and compassionately serve persons of all faith traditions and those having no faith tradition at all. It is the latter population that will be the co-victim, along with Catholic ministries, if this rule is left unchanged:

- The single mother seeking to better life for her family by pursuing a GED at Catholic Charities;
- The family who finds itself homeless because of the economic downturn and reliant upon Catholic social services for food and shelter;
- The young child living in a dangerous community who is able to free himself of the shackles of poverty by attending a Catholic school; and
- The poor woman in need of urgent and expensive health care services without ability to pay for them.

As I noted earlier, our members in California alone provided $765 million – more than three quarters of a billion dollars – in charity and related unreimbursed health care alone in 2007. Each of us should seriously weigh the impact on society that would arise if all of these institutions were forced to abandon their religious missions.

Fixing the Problem

HHS can solve this specific problem immediately by changing its rule to expand the definition of religious employer. I specifically suggest that HHS start by borrowing from the definition of religious employer included in Title 26, Section 414 of the Internal Revenue Code. Additionally, while such a change would address institutional employers, HHS should also amend the rule to ensure that individuals and non-religious employers are similarly protected. On that point, the

Illinois Health Care Right of Conscience Act would be a worthy model because of the broad-based level of conscience protection it provides.

Should HHS decline to make such substantive changes, it is incumbent upon Congress to take appropriate action including, if necessary, measures to prevent the Department from moving forward to implement its discriminatory mandate absent broad and effective conscience protections.

Conclusion

Nearly 160 years ago, the Sisters of Mercy responded with compassion and care when government was unable to tend to the victims of the San Francisco cholera epidemic. Today, it is time for government to honor this noble legacy by strengthening once and for all federal conscience protections so all health care providers today, tomorrow and well into the future can carry out their vocations absent the threat of government discrimination.

Thank you for your time. I look forward to answering questions members of the Committee may have.

Mr. PITTS. The Chair thanks the gentleman and thanks all the witnesses for their opening statements.

I will now begin the questioning and recognize myself for 5 minutes for that purpose.

Mr. Cox, the Church amendment which became part of the Public Health Service Act in 1973 declares that hospitals' or individuals' receipt of Federal funds in various health programs will not require them to participate in abortion and sterilization procedures if they object based on moral or religious convictions. Also, no State in the country except Vermont requires insurance coverage of sterilization. How is the interim final rule on preventive services issued by HHS subsequent to passage of the healthcare law different in respect to conscience protections and sterilization mandates?

And what are the implications for Catholic healthcare providers?

Mr. COX. Well, these are requirements that would force Catholic healthcare providers, Catholic universities, and social service agencies to include contraceptive services, sterilization, and other things in their health insurance plans in violation of their religious beliefs. And that is how it would affect them.

Under most State laws there are options that we have available to us. One, if for instance in California a religious employer can drop prescription drug benefits entirely in their health insurance plan and get out from under California's contraceptive mandate. We have chosen not to do that because that would make absolutely everyone else worse off in our employ. But what we have done is moved to ERISA plans in order to self-insure and get out from under the mandate.

Now, under the HHS mandate and definition of religious employer, as I said in my testimony, there is no escape. ERISA plans will be covered. All employers are required, regardless of religious views, to cover these services.

Mr. PITTS. The supporters of the interim final rule on preventive benefits argue the substance of the rule is similar to contraceptive mandates imposed by States on health plans operating within their State. Just as you said, the question was do State contraceptive mandates apply to self-insured plans governed under ERISA? And does the HHS rule differ in this respect? You spoke to that.

Do State contraceptive mandates typically require coverage of sterilization procedures?

Mr. COX. They do not. I think Vermont is the only State that does.

Mr. PITTS. Do State contraceptive mandates force plans to cover such products even if they do not provide coverage for prescriptive drugs generally?

Mr. COX. I think the laws in the various States differ with respect to that, and many of the States that have a contraceptive mandate also have pretty strong and effective conscience legislation that allows religious employers and providers with a moral perspective on this to opt out of the mandates.

Mr. PITTS. Thank you.

Let me go to Dr. Stevens. You said that the contraceptive mandate "violates the religion and free speech clauses of the First Amendment of the Constitution by coercing faith-based healthcare ministries to not only violate their very faith-based tenets that

have motivated patient care for millennia but also to pay for that violation. Such conscience-violating mandates will ultimately reduce patients' access to faith-based medical care, especially depriving the poor and medically underserved population of such care." Do you believe that the particular mandate could contribute to faith-based providers leaving the medical profession, reducing access to medical care, and are you concerned that faith-based providers might leave certain areas of medical care?

Mr. STEVENS. We are seeing a pattern from this administration to restrict conscience rights, including stripping regulations, deregulation. We actually surveyed our membership and 88 percent of them say the problem is getting much worse. The issues we are talking about today I never talked about during my training. And we are also seeing people coming under increasing discrimination in the workplace.

One of my staff member's wife, a family practice doc, worked in Texas. She did not distribute contraceptives to single women, referred them across the hallway to another physician, and it wasn't even an inconvenience for them, and she was told she was going to lose her job and she had to go find other employment within a week. We have seen this with anesthesiologists; we have seen this with the family practice docs. Just this week, 12 nurses in New Jersey have been forced to participate in abortion in the workplace and there is a suit being brought at the medical school there. This is a pattern that concerns all of us because we have 16,000 members. They have over 125,000 doctors that we are in regular communication with. They are very concerned about this and it could affect healthcare in this country.

Mr. PITTS. Thank you. My time has expired.

The Chair recognizes the ranking member, Mr. Pallone, for 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman.

I would ask unanimous consent to insert in the record statements from the following organizations: Concerned Clergy for Choice; National Council of Jewish Women; Religious Institute; United Church of Christ—Justice and Witness Ministries; Women's Alliance for Theology, Ethics, and Ritual, or WATER; Physicians for Reproductive Choice; Religious Coalition for Reproductive Choice; General Board of Church and Society of the United Methodist Church. I believe you have all these.

Mr. PITTS. Without objection, so ordered.

[The information follows:]

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Statement on Religious Refusals for Providers

October 31, 2011

Concerned Clergy for Choice, a network of 1,000 religious leaders from a wide spectrum of denominations, is distressed by the call to expand religious refusals for providers. We emphasize the moral priority of ensuring access to basic, preventive health care services –including reproductive care, contraception and medically accurate information. As pastors providing support to women and families facing medical need and decisions, we underscore the ethical high ground in protecting the conscience of the patient.

Many faiths honor the moral wisdom of making contraception available, so that women and families can plan their pregnancies for when they believe the time is right, with outcomes of stronger, healthier children and households. As pastoral counselors, we witness the urgency in protecting each woman and man weighing personal beliefs, faith teachings and the needs of those who rely on them; the conscience of the patient comes first.

We are deeply troubled that some groups are turning to refusal policies as an opportunity to impose their religious restrictions on people in medical need. We well understand that some communities oppose certain medical procedures, as when Jehovah's Witnesses reject blood transfusions and in the Orthodox Jewish history of shunning organ transplants. However, leaders of those communities do not advocate for public policies that would establish their particular faith strictures as law. Thus, we are distressed by the efforts to impair access to reproductive health care – through insurance restrictions, defunding attempts, and in this case, religious refusal protections – that, from our perspective, conceal an unwavering passion to elevate one set of faith restrictions above all others, including ours.

In considering the proposed expansion of religious refusal protections for providers, we urge our policy makers to firmly resist the pressures to single out and favor any single faith among the many. Instead, we call upon our leaders to ensure that women and families across our nation can obtain the essential care they believe to be right for them, including basic, preventive and essential medical services– such as contraception – thereby contributing to stronger households and the moral fabric of our communities.

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Statement of National Council of Jewish Women on Proposed Religious Restrictions to Health Care

Written Testimony Prepared for Hearing Titled,
"Do New Health Law Mandates Threaten Conscience Rights and Access to Care?"

Submitted by Nancy K. Kaufman, CEO, National Council of Jewish Women

US House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

November 2, 2011

The National Council of Jewish Women (NCJW) is a grassroots organization of ninety-thousand volunteers and advocates who turn progressive ideals into action. Inspired by Jewish values, NCJW strives for social justice by improving the quality of life for women, children, and families and by safeguarding individual rights and freedoms. Founded in 1893, NCJW is among the oldest Jewish organizations for women in the US; and we are proud of our long history of support for the protection of every woman's right to reproductive choices.

NCJW believes strongly that comprehensive, quality, affordable healthcare services for women are essential to their well-being, health, and economic security. NCJW applauds the US Department of Health and Human Services (HHS) for supporting the Institute of Medicine's (IOM) July 2011 guidance on expanding access to key clinical preventive services for women; yet, we are troubled by the inclusion of the proposed "religious employer exemption," or refusal clause. Ensuring that all new insurance plans offer first-dollar coverage for women's preventive health services under the Patient Protection and Affordable Care Act (ACA) will, in our view, enable more women to access critical care, leading to improved health, well-being, and economic security. NCJW believes that this expanded access must ensure that every woman, regardless of where or for whom she works, has the right to exercise her own moral judgment when making personal decisions, including family planning choices.

NCJW's principles to protect all women's access to health care and every woman's right to moral agency in healthcare decision-making compel us to strongly oppose the Respect for Rights of Conscience Act (HR 1179/S 1467) introduced by Representative Jeff Fortenberry (R-NE) and Senator Roy Blunt (R-MO). This measure would expand the right of health workers, health insurance plans, hospitals, and other healthcare institutions to refuse to cover, provide, or refer for *any* service they deem morally objectionable. NCJW is deeply concerned about the dangerous implications of such a vast refusal policy, which would not only deny women's access

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to the full range of reproductive health care, but also obstruct other patient populations from obtaining needed care.

What follows is an articulation of the particular provisions of the HHS ruling we support; as well as our concerns about the "religious employer exemption" component of the Interim Final Rule and the similar policy contained in the Respect for Rights of Conscience Act.

NCJW strongly supports each of the eight preventive services recommended by the IOM, and we are pleased that HHS chose to adopt all recommendations including, in particular, contraceptive services and supplies. We are also particularly gratified by the inclusion of screenings for intimate partner violence. Our organization has long worked for laws, policies, programs, and services that protect every woman from all forms of abuse, exploitation, harassment, and violence. Providing a pathway for women to be screened for current or past abuse in the health care setting will better ensure that victims of violence obtain the care and assistance they need.

For NCJW, the protection of women's access to the full range of family planning services is a moral imperative. We have long supported comprehensive, confidential, accessible family planning and reproductive health services, regardless of age or ability to pay, because we believe that these services are an essential element of health care and preventive health. As Secretary Sebelius noted in an op-ed in the Huffington Post in which she announced the HHS decision about the insurance guidelines for these key services, "[w]hen half of pregnancies in the US are unplanned, we know family planning services are an essential preventive service for women. These services are critical to appropriately spacing and ensuring intended pregnancies which results in improved maternal health and better birth outcomes."[3] We agree, and would add that *all* women require accurate information and access to services in order to prevent unwanted pregnancies.

Recent data show that the number of underinsured adults — those who face unaffordable medical costs despite having health insurance — rose by eighty percent between 2003 and 2010. This population's reported rate of foregone care was twice as high as those with more adequate coverage[4]. In keeping with these trends, underinsured women face difficult choices when it comes to family planning, balancing needed health care with economic security. While some states have passed contraceptive equity laws requiring that insurers offering coverage for prescription drugs also cover FDA-approved contraceptive drugs or devices[5], and many employers cover birth control to some degree, financial barriers still impede insured women's access. Not all employers offer coverage for the full range of FDA-approved drugs. As such, too many women have found that cost barriers have prevented them from accessing the contraceptive supplies and related services that would be most effective for them[6]. Removing these financial obstacles would support women's health and economic security by ensuring they no longer need to forego or delay needed care in order to afford other basic needs. Moreover, it

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would enable more women to truly plan their families, allowing them to become pregnant when they are financially prepared to do so. NCJW believes that every woman must have the right to exercise her own moral judgment when making personal decisions, including those that impact her reproductive life and her economic security. Making contraception widely available and affordable, as the new women's preventive health benefits are intended to do, will allow women to be the decision makers about the preventive care services they wish to access.

While we are pleased that HHS chose to adopt all of the IOM recommendations, we are deeply troubled by the Interim Final Rule's amendment proposing to exempt "certain religious employers" from the requirement to offer the contraceptive preventive health benefit to their workers. Restrictions that would prevent even one female worker from accessing affordable preventive care, as the proposed refusal clause would do, are unacceptable. Ensuring that all women, regardless of their employer, have access to key preventive contraceptive services is essential not only to women's health but also to women's equality, religious liberty, and economic security.

Denying female employees their right to the contraceptive benefit — without an alternative means to affordably access these services — risks their health, well-being, and economic security by maintaining the status quo where family planning services and supplies are inaccessible due to cost. The exemption in the interim final rule would unnecessarily harm a population of working women, from religious studies teachers and administrative professionals to lay leaders and clergy, who may not personally agree with the tenets of their faith-based employer when it comes to contraception.

A recent study by the Guttmacher Institute showed that "most sexually active women who do not want to become pregnant...practice contraception. ...This is true for women of all religious denominations, including Catholics, despite the Church's formal opposition to contraceptive methods other than natural family planning."* Women who work at religious institutions, irrespective of the doctrine espoused by those institutions, still need access to affordable, effective birth control to avoid unintended or mistimed pregnancy. These women and their families deserve to have the same access to health care promised by the ACA as do women in other professional fields. And yet, the proposed religious exemption would deny them this benefit, leaving burdensome out of pocket costs in place, and leaving women to make choices that may risk their health and well-being. As such, NCJW submitted comments to HHS, urging the agency to revoke the proposed religious exemption from these insurance regulations.

It is for similar reasons that NCJW strongly urges Congress to oppose the Respect for Rights of Conscience Act (HR 1179/S 1467). This extreme proposal seeks to enact overly broad language to allow a range of health care "stakeholders" — including health insurance plans, hospitals, healthcare workers, and employers — to refuse to cover or provide any medical service or preventative service otherwise required by the ACA, if those stakeholders believe the care to be

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morally troubling. The bill allows these stakeholders legal recourse for violations of their right to refuse, but does not offer such a path for patients who are denied access to care. NCJW is concerned that this measure would both drastically restrict access to basic medical services, including sexual and reproductive health care, and permit discrimination against certain patient populations. Each of these consequences is egregious in and of itself — though each becomes more dangerous because the legislation does not provide adequate protections for the patients seeking such care.

The Respect for Rights of Conscience Act would restrict access to basic, preventive services, setting patients up for burdensome costs and other onerous barriers to care. As an example, under this proposal, a health worker could refuse to provide or refer for screening and treatment for HIV or other sexually transmitted infections. Patients enrolled in health insurance plans which require referrals for such care to be covered by the plan will be left without any legal recourse or access to affordable, covered services. NCJW believes that this refusal clause would endanger patients by not ensuring alternative routes to care once access is denied. This outcome would impose discriminatory financial hardships on individuals seeking comprehensive health care, and greatly impinge on patients' religious freedoms by restricting their ability to access care in keeping with their own religious or moral views. Moreover, should a patient needing emergency treatment be denied service, such as a woman with a life-threatening pregnancy complication, this refusal rule could potentially threaten a patient's life if an immediate referral is not made or alternative provider not found.

In addition, the overly broad refusal language of this legislation suggests that health plans, providers, and other entities could discriminate against patients whose characteristics, presentation, or illness they find morally offensive or objectionable. This bill could allow healthcare workers the ability to refuse to treat patients who are gay, lesbian, bisexual, or transgender; or for a plan to refuse coverage of pre-natal or pregnancy services for a woman who is unmarried. NCJW believes every individual has the right to quality, comprehensive, confidential, nondiscriminatory healthcare coverage and services, including mental health, that are affordable and accessible for all. We have long been committed to advancing the enactment and enforcement of laws and regulations that protect civil rights and individual liberties. By setting up a health system that would legally institutionalize discrimination by the healthcare infrastructure against classes of patients, we believe the Respect for Rights of Conscience Act violates principles of equality and individual religious freedom.

NCJW is deeply disturbed by this proposed expansion of so-called "conscience protections," which do not include safeguards or recourse for patients seeking care. Health professionals and the organizations that support them have an obligation to ensure access to necessary services, whether directly or by referral to an accessible alternative healthcare provider.

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As a faith-based women's organization, we understand that those who would restrict the services health entities can provide or cover, including limiting women's access to contraception or to other reproductive healthcare services, are often motivated by their religious beliefs — seeking to impose them on others. NCJW volunteers and advocates are inspired by their Jewish values, and have longed worked for the elimination of obstacles that limit reproductive freedom and religious freedom. For NCJW, these two principles are closely linked; women must be able to make healthcare decisions and choices about their reproductive health based on their *own* needs, beliefs, and moral judgment, in consultation with their doctor or whomever they wish to involve.

We also understand the desire of religious organizations to preserve their identity — and are fierce advocates for religious freedom in the workplace. Yet the refusal clause proposed in both the HHS regulation and in the Respect for Rights of Conscience Act would deny individuals their rights, in favor of institutional doctrine; or deny one individual their right *in favor of* another individual's belief system. **We oppose these suggested religious exemptions and believe they go against our nation's guarantee of equal rights and religious freedom.** They would erode an individual's moral agency and religious liberty by impeding one's ability to make decisions about the healthcare they wish to access based on their own conscience, moral values, or faith traditions — regardless of an employer or health plan's view of what is morally right or wrong.

NCJW is one of the oldest faith-based organizations for women in the United States working to advance the well-being and status of women; improve the quality of life for women, children, and families; and safeguard individual rights and freedoms. NCJW applauds the HHS decision to make preventive health care more affordable for more women. We believe this is a step forward for justice in health care. For far too long, financial barriers have prevented women from gaining access to the care they need to stay healthy, plan their families, and support healthy pregnancies. However, NCJW opposes the "religious exemption" offered in the amended Interim Final Rule because it would harm women's health, equality, economic security, and religious liberty. We also oppose the drastic, dangerous and unnecessary expansions of refusal policies as proposed by the Respect for Rights of Conscience Act. Such refusal policies would unfairly preserve the cost barriers that the ACA was designed to overcome and would threaten women's health and access to care. NCJW believes that *all* individuals, wherever and for whomever they work, deserve equal access to affordable preventive health care, including contraceptives, and to the historic new benefits set forth under the ACA. We believe that all individuals, regardless of their employer, health insurer, provider, or health history, deserve access to quality, comprehensive, non-discriminatory and affordable health care coverage and services.

We appreciate the subcommittee's consideration of our testimony.

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RELIGIOUS INSTITUTE

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Letter Submitted as Written Testimony for the Record

TO: Members of the House Committee on Energy and Commerce, Subcommittee on Health
RE: Hearing titled, "Do New Health Law Mandates Threaten Conscience Rights and Access to Care?"
DATE: November 2, 2011

Thank you for considering the Religious Institute's testimony on the proposed addition of a religious exemption to the Affordable Care Act.

The Religious Institute is a multifaith advocacy organization with a network of over 5,300 clergy and religious leaders across the country that support sexuality issues, including a woman's right to make her own decisions about contraception and reproductive health.

More than 1,500 of those religious leaders have endorsed our *Open Letter on Abortion as a Moral Decision* which states that they "...respect women and men's moral agency to make decisions about their sexuality and reproductive health without governmental interference or legal restrictions," and that "Women must have the right to apply or reject the principles of their own faith without legal restrictions."

We are heartened that the Affordable Care Act, supported by the Institute of Medicine's recommendations, recognizes that women should have access to contraception as part of well-woman care, without regard to income or employer. For the same reason, we oppose the proposed religious exemption because where a woman works should not impact her ability to obtain insurance for basic services she may choose to use based on her own informed conscience.

Rev Debra Haffner

The Rev. Debra W. Haffner,
Executive Director

UNITED CHURCH OF CHRIST

Justice and Witness Ministries

STATEMENT FROM THE UNITED CHURCH OF CHRIST
CONCERNING THE PROPOSED EXPANSION OF RELIGIOUS EXEMPTIONS
ON MANDATED CO-PAYS FOR CONTRACEPTION
UNDER THE AFFORDABLE CARE ACT
Submitted by the Rev. Lois M. Powell
Justice & Witness Ministries, United Church of Christ
November 2, 2011

The United Church of Christ came into being when two mainline Protestant denominations merged in 1957. One of those denominations, the Congregational Church, traces its roots in this country back to the landing of the Pilgrims at Plymouth Rock. These Christians fled their homeland seeking a new place where they could freely exercise their religious beliefs. Those who drafted the Constitution of the United States of America were strongly convinced that the newly formed United States of America would be a place where all could freely follow the tenants of their religious beliefs.

Today we live in a political and cultural reality far more diverse than that small band of Pilgrims and we have been guided by – and have amended to reflect new realities – that same Constitution and Bill of Rights. But sadly, the religious views of the majority of U.S. citizens are not respected when it comes to highly charged issues like reproductive health care. Only a very narrow religious perspective is heard – a perspective that is well-funded and politically motivated.

The vast majority of Americans approve of the use of contraception as a method of family planning and to prevent unintended pregnancies, including 98% of Catholic women whose church hierarchy opposes the use of contraception. When politicians bend under the influence of those who want to restrict its access, a serious problem exists, especially for American women.

The United Church of Christ has long supported full access to all methods of birth control and regards its use as a matter for couples to privately decide as they determine when and how many children to bring into this world. The Affordable Care Act includes coverage for contraception without a co-pay, a significant advance for women with limited economic means. The proposed regulation from the Department of Health and Human Services to exempt religious employers from providing this coverage to their employees – who may or may not be adherents to the faith tradition of the organization – denies to some women a service they need during their childbearing years. It is not the responsibility of employers, even faith-based employers, to monitor the private behavior of their employees or to force conformity to religious beliefs which may or may not be held by the employee.

These same principles apply to the United Church of Christ's decision to oppose the Hyde Amendment which restricts the use of public funds to pay for abortion services because it unfairly places a burden on low-income women to access a legal medical procedure available to other women. All women covered by insurance plans available through the Affordable Care Act should have equal access to contraception and to any essential or preventive health service guaranteed under the Act. Whether or not they chose to use birth control should be determined by them - not by politicians or employers.

God is still speaking,

To: House Committee
From: Mary E. Hunt, Ph.D.
Re: Religious exemptions
October 31, 2011

Below is the letter to HHS Secretary Sebelius that I drafted and signed along with a dozen Roman Catholic theologians. We believe that health care is the right and responsibility of each person such that no religious exemptions are necessary or good when it comes to reproductive health care. Ours is a thoroughly grounded Catholic opinion shared by millions of American Catholics.

Thank you for considering my faith-based view on this important matter.

Mary E. Hunt, Ph.D.
Co-director, Women's Alliance for Theology, Ethics and Ritual (WATER)

September 14, 2011

Dear Secretary Sebelius,

We Catholic theologians appreciate the provision of preventive services and the elimination of cost sharing in the Affordable Care Act of 2010. This is a major step toward the goal of affordable, accessible health care for all. We respectfully request that you eliminate the proposed religious exemptions because they are unnecessary and unjust. Instead, we suggest that you let citizens make their own choices about which medical services they use. In our opinion, this is the best way to respect the variety of religious views within and among our faith traditions and to live responsibly in a pluralistic democracy.

Let us clarify several Catholic dimensions of this discussion. First, the ***sensus fidelium***—the graced and experience-fed wisdom of the faithful which has always been one of the sources of truth in the Catholic tradition—among American Catholics is clear on the matter of contraception, the only area that is covered by the exemptions. The overwhelming majority of Catholics favor contraception and use it. The majority of Catholic moral theologians hold that artificial contraception is a moral option and, in some instances, even a moral mandate.

We understand that the United States Conference of Catholic Bishops continues to hold a public position in opposition to most birth control methods. Catholic theologian Christine Gudorf notes that "when Humane Vitae, the papal encyclical retaining the ban on artificial contraception, was issued in 1968, the Episcopal conferences of 14 different nations issued pastoral letters assuring their laity that those who could not in good faith accept this teaching were not sinners." While the bishops have every right to speak for themselves and to make their own medical choices, most rank and file Catholics simply disagree with them and make differing choices on this matter. No one is forced to use contraception, but all deserve access to it as part of regular medical care. To permit exemptions that adversely affect countless women based on the views of a tiny religious minority seems to us unfair and unwise.

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Second, Catholic teachings respect and encourage the exercise of **conscience.** Thomas Aquinas wrote that conscience is "reason attempting to make right decisions." The Second Vatican Council called conscience a person's "most secret core and sanctuary." We expect ourselves and our fellow Catholic to form our consciences in ways that are consistent with the Christian tradition. But we do not coerce one another, nor do we tolerate the coercion of others, whether Catholic or not.

Regulations that would allow religious institutions to dictate the medical care of their employees encroach on conscience. We are especially concerned about regulations that would allow employers to penalize persons who make choices that go against certain debated religious teachings. This is taking the conscience of another into one's own hands, decidedly not a Catholic teaching.

Third, the **well being of women**, including reproductive health care, is a Catholic value. We are gratified that the U.S. Department of Health and Human Services recognizes "the need to take into account the unique health needs of women." We trust that the guidelines developed by the Institute of Medicine reflect the best way to meet those needs. Consequently, we see no medical or religious justification for exempting employers from paying for some necessary aspects of women's health care. Just as HIV testing and mammograms are part of women's health care, so, too, is contraception recognized as an integral component by most other modern democratic societies.

Fourth, **workers' rights** are a sacred part of a Catholic commitment to justice. These include the right to receive fair compensation. We would prefer that health care be available to all and not simply to those with jobs. But because the covered medical services in question are employer supported, medical coverage without exemptions is simply a fair labor practice. There is no Catholic teaching to support selective fairness.

Finally, health care is conducive of the **common good**, a hallmark of Catholic social teaching. We see the Affordable Care Act as a step in the right direction, one of many steps toward narrowing the wealth gap and equalizing opportunities for all Americans. We strongly urge you to erase the asterisks that taint the proposed regulations with exemptions that will cost some women more to make healthy choices and will violate our covenant of "justice for all." That is both Catholic and catholic.

As Catholic theologians, we are pleased to partner with you in the creation of a just American society. We look forward to the new guidelines going into effect for everyone.

Sincerely,

Mary E. Hunt

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PRO-FAITH • PRO-FAMILY • PRO-CHOICE

Statement of Reverend Dr. Carlton W. Veazey, President and CEO, Religious Coalition for Reproductive Choice, on Hearing, "Do New Health Law Mandates Threaten Conscience Rights and Access to Care?"

US House of Representatives
Committee on Energy & Commerce
Subcommittee on Health

November 2, 2011

On behalf of the Religious Coalition for Reproductive Choice, thank you for this opportunity to comment on conscience clauses in health care law.

The Religious Coalition for Reproductive Choice was founded in 1973 and is the national organization of Christian, Jewish and other denominations and traditions with official positions in support of a woman's moral right to make decisions about childbearing according to the dictates of her conscience and religion. Member organizations are the Episcopal Church, Presbyterian Church (USA), General Board of Church and Society of the United Methodist Church, Women's Division of the United Methodist Church, United Church of Christ, Unitarian Universalist Association, the Reform, Conservative and Reconstructionist movements of Judaism, and other religious and religiously affiliated organizations.

In October 1974, the board of directors of the Religious Coalition adopted a policy position opposing conscience clauses that remains in place today. It states: *"All religious health institutions upon accepting public funds assume a public trust to affirm in practice the legal options for abortion."*

Religious Coalition for Reproductive Choice member organizations hold that medical institutions that 1) employ a diverse workforce, 2) serve a diverse population, 3) have a secular purpose such as the provision of medical care, 4) receive public funds, and 5) are major service providers must be held to their responsibility to serve the public rather than restricting services to conform to their own religious beliefs. Continuously since 1973, the Religious Coalition has opposed religious exemptions for public institutions as a violation of both the separation of church and state and the exercise of individual conscience.

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As a religious coalition that honors individual conscience, we hold that, in keeping with the constitutional right to exercise one's religious beliefs without government interference, individuals should have the right to opt out of performing health care services to which they are religiously or morally opposed. Truly religious institutions—a church, a monastery, a seminary—should also be able to act in accordance with their belief systems.

However, in this pluralistic nation, we are committed to protecting the rights of all. Patients have the right to legal health care services and their access to these services must not be affected by physicians who opt out of providing them. As well, health care providers must not be prohibited from performing services that are legal and necessary.

Institutions operating with public funds and serving the public should not be allowed to impose beliefs about health care on entire communities and all of their patients. This is especially critical in communities where a religiously affiliated institution is the only or main service provider. Such is the case in geographically isolated areas where a growing number of Catholic hospitals have been federally designated as "sole providers," even though Catholics constitute a minority of the population. Nevertheless, Catholic restrictions on reproductive health care apply to all patients, regardless of their beliefs.

Unnecessary: The proposed religious exemption in the Patient Protection and Affordable Care Act is unnecessary because the right to refuse to perform services that an individual objects to on moral or religious grounds has been enacted in law since 1973 with the Church Amendment. The Church Amendment prevents the government from requiring health care providers or institutions to perform or assist in abortion procedures against their moral or religious convictions. It also prevents institutions that receive federal funds from taking action against employees because of their participation, nonparticipation or beliefs about abortion. In 2004, Congress passed and the president signed the Weldon Amendment, under which a physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility may refuse abortions, counseling, or referrals, even in cases of rape, incest, or medical emergency.

Unconstitutional: By failing to offer an equivalent protection for service providers and patients, the religious exemption unconstitutionally restricts the ability of women to obtain services and medical personnel to provide services. It is important

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to note that many religions support a woman's right to access reproductive health care, including abortion and contraception, as a matter of free exercise of conscience protected under the law. Thus, this religious exemption infringes the rights of individuals to act according to the dictates of their faith.

We appreciate the subcommittee's time and consideration of our statement.

Carlton W. Veazey

Reverend Dr. Carlton W. Veazey
President and CEO, Religious Coalition for Reproductive Choice

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November 1, 2011

TO: Members of the Health Sub-Committee, Energy and Commerce

FROM: General Board of Church & Society of The United Methodist Church

I am writing to strongly support the inclusion of family planning information and services into the Patient Protection and Affordable Health Care Act and make such services accessible at health care institutions such as hospitals and clinics. We support the recommendations from the Institute of Medicine (IOM) regarding coverage of women's preventive health services and urge you to adopt its recommendations.

The United Methodist Church, a 12 million member Christian denomination, historically affirms that health care is a basic human right and has worked diligently to ensure all men, women and children have access to needed services. This includes women and men seeking contraceptive information and services in order for them to decide whether or not to have children and/or for timing and spacing of children. We know that family planning saves lives and also reduces the need for abortion. Voluntary family planning and contraception is essential in reducing unintended pregnancies, to helping women stay healthy, and bear healthy children.

We affirm the principle of responsible parenthood, and support the right for men and women to have the ability to choose when, or if, to have children. Each couple has the right and the duty to prayerfully and responsibly control conception according to their circumstances. Ensuring that affordable options are available under insurance plans, as the IOM suggests, would go a long way to helping individuals meet these obligations.

Thank you for your attention to this critical issue.

Sincerely,

James E. Winkler
General Secretary

Mr. PALLONE. Thank you.

I am going to start with Mr. O'Brien. Your testimony discusses use of contraceptive services among both Catholic and non-Catholic women. Is it your understanding that surveys and studies have shown virtually all Catholic women have used contraceptive services at some point in their lifetimes?

Mr. O'BRIEN. Yes, Congressman, that is correct.

Mr. PALLONE. Thank you. Is it true that the use of contraceptive services among Catholic women mirrors that of non-Catholics?

Mr. O'BRIEN. It is.

Mr. PALLONE. And I am going to go to Dr. Hathaway. I saw a recent poll of registered voters about their views on contraceptive services. I want to ask you a few questions about public support for contraception. Do the vast majority of Americans support access to contraceptive services?

Mr. HATHAWAY. Yes.

Mr. PALLONE. And is this same view also held by people who are opposed to abortion?

Mr. HATHAWAY. Yes, indeed.

Mr. PALLONE. And back to Mr. O'Brien, if you would chime in. Does research indicate that the majority of Catholics support access to contraceptive services?

Mr. O'BRIEN. Yes, during the health insurance reform debate, Catholics were surveyed, and 6 in 10 Catholics believe that contraception should be covered as part of health insurance.

Mr. PALLONE. Thank you. For both gentlemen, your answers underscore an important point, and that is that improved access to contraceptive services is supported by the majority of Americans, and I certainly agree with some of the comments made by my colleagues and the witnesses about ensuring that individual health providers not be compelled to act against their conscience, but the subject of today's hearing is regulations that address what plans are required to do. Given what we have heard today, I think we should support coverage for contraceptive services and make these services available to the millions of women who would benefit from it.

Now, I want to go to Dr. Hathaway again. In your testimony, you discuss the importance of making sure that women have access to contraceptive services and information that will help them better plan and space their pregnancies. Can you briefly describe the benefits of using contraceptive services?

Mr. HATHAWAY. Briefly would be difficult. There are multiple, multiple benefits towards contraception. A woman's ability to maintain and get herself healthy before pregnancy is incredibly important—taking folate to reduce anomalies, getting her medical conditions under control. Many women have multiple medical conditions that are out of control before they get pregnant.

Mr. PALLONE. What about in terms of babies' health?

Mr. HATHAWAY. Also. Birth spacing is incredibly important. We know from research that birth spacing, the shorter the interval, the greater likelihood of low weight births as well as preterm births, an incredible burden to both the family as well as society and the health industry.

Mr. PALLONE. Well, you know there are over 60 million women of reproductive age in the country but there are many women who do not use contraception regularly or at all. Could you elaborate on the extent to which cost is a barrier to the use of contraceptive services?

Mr. HATHAWAY. It is an incredible barrier. Many women have to jump hoops to get contraceptives. If they have some insurance, perhaps it doesn't cover all of their contraceptive methods. And as I pointed out in my testimony, the longer-acting methods are the most cost-effective and yet the most cost-prohibitive up front and those are the methods that we ought to be turning towards to provide better contraception in our country.

Mr. PALLONE. And what about when you have insurance coverage for contraception? I mean does that impact the ability of women to access those health services?

Mr. HATHAWAY. In many cases, yes. Even insurance there are restrictions regarding copays, as well as additional fees for these, as I said, most effective methods.

Mr. PALLONE. And based on your clinical experience, do you believe that elimination of out-of-pocket costs for birth control pills and other forms of contraception would increase their use?

Mr. HATHAWAY. Most definitely. Most definitely.

Mr. PALLONE. All right. I just want to thank you, Dr. Hathaway. I mean it is clear from your testimony and responses that there are compelling policy reasons why we should promote access to contraception and also limit cost-sharing associated with those services.

Thank you and thank you to Mr. O'Brien.

I yield back, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and recognizes the vice chair of the subcommittee, Dr. Burgess, for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman.

Dr. Hathaway, along the lines as Mr. Pallone was just exploring, they said that there are valid policy reasons to consider providing contraception, but you also allude to the fact that in your world cost is a consideration. Is that correct?

Mr. HATHAWAY. I am not sure I understand the question. Cost as a consideration for an individual patient?

Mr. BURGESS. You talk about the individual in your clinic who wanted a long-term method of contraception but it nearly exhausted your safety net dollars——

Mr. HATHAWAY. Right.

Mr. BURGESS [continuing]. And cost is an issue whether we like it or not. Money has got to come from somewhere, has it not?

Mr. HATHAWAY. Indeed. And yet if you look at a lot of the research, including Guttmacher Institute's research on cost savings for contraception overwhelmingly——

Mr. BURGESS. Yes, let us hold that. We will get to that in a minute because I am not quite sure we have delivered on the promise of the cost savings. And of course, we are Members of the House of Representatives. We live under the rule of the Congressional Budget Office and as all of us on both sides of the dais know, we are not allowed to score savings. We can only talk about cost. That is an important point; I do want to get to it.

But here is my beef with this thing. I mean it came to us as an interim final rule. There was obviously a rush. There were some calendar considerations. We have got to get it done within some certain time constraints, but it didn't really allow for the proper input and transparency of the normal Federal agency process. The Affordable Care Act is a lot of pages of very densely worded instructions to Federal agencies, and whether you agree with or not, going through the process at the Federal agency, there is a reason that it does that because it allows the public to comment. Before the rule is put forward, it allows for the people to weigh in on it.

But in an interim final rule, that is kind of a different world because although it sounds like, well, it is only interim. Either you come back and do—you really can't. I mean this thing comes out of the agency with the force of law and you see right now in this environment how difficult it is for Congress, the House and Senate to get together and pass any law that the President will sign, but this thing can come out with the force of law in a relatively condensed period of time with maybe public input but maybe it ignores public input.

Now, I worked my residency with Parkland Hospitals—a long time ago I grant you—but we provided a lot of healthcare to women who were very, very poor and I never wrote a prescription for an oral contraceptive except Ortho-Novum 1/50 for 4 years' time because that was the formulary that Parkland Hospital used. In order to provide the services for the vast numbers of people that they had to serve, they got a deal with the contraceptive manufacturer, and that was the birth control pill. It was a learning experience for me to be out in private practice and see all of the choices that were out there.

But those choices come with a cost, don't they?

Mr. HATHAWAY. Yes. Yes, indeed.

Mr. BURGESS. Can you give us an idea of what kind of the range of cost? Let us just stick with oral contraceptives for right now. I know you are interested in long-term contraception, but just for oral contraceptives right now, there is a pretty wide variation of cost, is there not?

Mr. HATHAWAY. Yes, the brand name contraceptives probably run in the neighborhood of upwards of $50 per month.

The generics have probably in the neighborhood of 30 or somewhere in that neighborhood.

Mr. BURGESS. Well, through the miracle of the iPad and Leslie's List, I can tell you that there is a cost differential of about $20 a month for a generic Ortho-Novum 1/35, Necon—funny name for that pill—and there is another one called Seasonique that is, according to research done by my staff, $1,364 a year, so about $110 a month. So that is a pretty wide discrepancy, isn't it?

Mr. HATHAWAY. Indeed, and yet if we were able to help a woman with a longer-acting method for that year, you would save——

Mr. BURGESS. Let us not go there just yet because——

Mr. HATHAWAY [continuing]. A lot of dollars right there——

Mr. BURGESS [continuing]. The Institute of Medicine and the interim final rule says without regard to cost, we have to provide all methods now across the board. And this is the problem with having an interim final rule. I didn't get to go to the Federal agency and

say you know what? This is a pretty wide cost discrepancy here. You can provide 5 women with the same type of oral contraceptive protection that one woman gets for Seasonique. And there are reasons that patients want to take that. I get that. Perhaps it should be available with a copay or paying a little extra for that premium contraceptive coverage. This would be something that I think would have been useful to the Federal agency. But unfortunately, we didn't get to have input on that because it was promulgated as an interim final rule.

Mr. Chairman, you have been generous with my time. If we have time for a second round, I do want to talk about the cost-benefit stuff.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the ranking member emeritus, Mr. Dingell, for 5 minutes.

Mr. DINGELL. And the questions here I direct at Mr. O'Brien, and I hope that the answers will be by yes or no.

The interim rule issued by HHS on August 3, 2011, regarding coverage of preventive services under ACA included language that exempted certain religious employers from covering contraceptive services without cost sharing. A religious employer is defined by one that has religious values as the purpose of the organization, primarily employs and serves persons who share the religious tenets of the organization, and is a nonprofit organization. Isn't it true that this definition of religious employer is set forth by HRSA and the interim rule is not wholly a new definition of a religious employer? Yes or no?

Mr. O'BRIEN. Yes, Congressman.

Mr. DINGELL. Now, isn't it also true that the 20 States that exempt certain religious employers from having to cover contraceptives that they allow them to be exempt from providing contraceptive services, and at least half of these States use a definition of a religious employer similar to that in the definition used by HRSA in the interim final rule? Yes or no?

Mr. O'BRIEN. Yes.

Mr. DINGELL. Isn't it also true that 2 State Supreme Courts in California and New York upheld a definition of religious employer similar to the definition of a religious employer in the legislation as constitutional? Yes or no?

Mr. O'BRIEN. Yes.

Mr. DINGELL. So I think everybody in this room should agree that individuals have the right to decline to provide certain medical treatment if they conscientiously object to their religious beliefs. That is not interfered with under the regulations, is it?

Mr. O'BRIEN. Yes.

Mr. DINGELL. The answer is it is not interfered with.

Mr. O'BRIEN. No.

Mr. DINGELL. Thank you. And under current healthcare professionals who conscientiously object to providing certain medical services or procedures due to their religious beliefs are allowed to again not to provide those services, is that right?

Mr. O'BRIEN. That is right.

Mr. DINGELL. But isn't it true that the broadening definition of a religious employer would allow an employer, say a hospital or

health insurer, to deny coverage for contraceptives or other preventive services based on their religious beliefs? Yes or no?

Mr. O'BRIEN. Yes.

Mr. DINGELL. Now, isn't it also true that the broadening of the religious exemption would limit access to contraceptives to nearly 1 million people and their dependents who work at religious hospitals and nearly 2 million students and workers at universities with a religious affiliation? Yes or no?

Mr. O'BRIEN. Yes.

Mr. DINGELL. One of the ways the Affordable Care Act works to address the need of lowering costs in our health system is by putting renewed emphasis on prevention and wellness programs to help American families to live healthier lives and reduce the need for more costly treatments later in life. The Affordable Care Act does this by eliminating copays and cost-sharing for preventive service. Is that correct?

Mr. O'BRIEN. Yes. Yes.

Mr. DINGELL. And he doesn't have a nod button so you have got to answer yes or no. HHS has asked the Institute of Medicine, an independent organization who is convening a panel of experts to make recommendations about what preventive services for women would qualify for no cost-sharing. The Institute of Medicine identified 8 preventive services as being necessary to improving women's health and well being, including all FDA-approved contraceptive methods and patient education counseling, amongst other benefits. HHS adopted these recommendations in full, is that correct?

Mr. O'BRIEN. Yes.

Mr. DINGELL. Now, wouldn't you agree that—by the way, is that yes or no?

Mr. O'BRIEN. Yes.

Mr. DINGELL. Wouldn't you agree that broadening the religious exemption would limit or prevent access to critical preventive services that are intended to improve the health and well being of women? Yes or no?

Mr. O'BRIEN. Yes, absolutely.

Mr. DINGELL. Now, wouldn't you also agree that the limiting or preventing of access to critical preventive services is counter to the goal of the Affordable Care Act to help make prevention affordable and accessible to all Americans? Yes or no?

Mr. O'BRIEN. Yes, that is true.

Mr. DINGELL. Now, I note in the testimony that I have heard this morning, I have heard no complaints that what we have done here is to expand the right to abortion or to change the basic language of the legislation in the Affordable Care Act on that point. Am I correct in that understanding?

Mr. O'BRIEN. You are correct.

Mr. DINGELL. Thank you.

Mr. Chairman, I note I yield back 2 seconds.

Mr. PITTS. The Chair thanks the gentleman and recognizes the gentleman, Mr. Shimkus, for 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman.

About a year ago, we had some theologians here on climate change and I quoted some scripture, got myself in trouble, made myself a name. But I mean if we are going to go down the right

and talk about safe—and especially for Christians, God's word is the final arbiter of truth. Jeremiah 1:5, "before I formed you in the womb, I knew you." Psalm 71:6, "you brought me forth from my mother's womb." Those are just a few of numerous scripture references on the pro-life debate for confessional Christians, and this is where I really appreciate my fellow Christians in the Catholic Church. I am Lutheran by faith tradition, so hold a really distinct close bond. But there is a strong position on the right to life.

And what we have done in the national healthcare law has attacked the very providers of healthcare and social services for the poor in this country, which are church, faith-based institutions. And Mr. O'Brien, what we are doing is we are depriving them of their choice. That is what we are doing. And Illinois as aside has just done this in the adoption realm where now the Catholic Church is suing the State of Illinois because of now the Illinois legislation that grants same-sex couples under the State law all the rights of married couples. So when a faith-based institution like a Christian denomination—and in this case, Catholic charity does 20 percent of all adoptions in the State of Illinois—you take the other faith-based, I think it is up to 33 percent, they now have to make a moral decision of whether they are going to continue adoption services or comply with their faith-based teachings. So that is going on in Illinois. That is exactly what is going on here with the healthcare law. So I will follow up with these questions.

To Ms. Belford, Mr. Cox, Mr. Stevens, should individuals or institutions lose their rights to follow their moral and religious beliefs once they decide to enter a healthcare profession? Ms. Belford?

Ms. BELFORD. No, they should not lose that right.

Mr. SHIMKUS. Mr. Cox?

Mr. COX. Absolutely not.

Mr. SHIMKUS. Mr. Stevens?

Mr. STEVENS. We shouldn't be asking our medical schools to ethically neuter healthcare professionals based upon only what the State decides is right.

Mr. SHIMKUS. To the same three, should we compel providers to act in violation of their conscience?

Mr. COX. Absolutely not. It is a violation of the First Amendment to the Constitution.

Mr. SHIMKUS. OK. That was Mr. Cox. Ms. Belford?

Ms. BELFORD. No. No, we shouldn't. That is a right enshrined in our history, in our Constitution, in our laws the right not to violate our firmly held, sincerely held religious beliefs.

Mr. SHIMKUS. And Dr. Stevens?

Mr. STEVENS. I agree. We cannot ask people to take professional license and lay aside their personal morality.

Mr. SHIMKUS. Another question. When a provider makes a conscious objection, is there anything that prevents a patient from going to another willing healthcare provider for service? Dr. Stevens?

Mr. STEVENS. Absolutely not.

Mr. SHIMKUS. Ms. Belford?

Ms. BELFORD. No.

Mr. SHIMKUS. Mr. Cox?

Mr. COX. No.

Mr. SHIMKUS. Ms. Belford, in order to qualify for the religious employer exemption to HHS's interim final rule on preventive services, an employer would have to meet all 4 criteria delineated in the rule, including that it primarily serves persons who share its religious tenets. What would be the impact on sick and needy people in the Archdiocese in Washington if the Archdiocese organizations had to limit the provision of their services in such a manner?

Ms. BELFORD. Well, Congressman, let me just say right at the outset we have served, we are serving, and we will continue to serve the people who need help. We would hope that our government would recognize the value of those services and the importance of those services and the right that has been granted to us under the Constitution and the laws of this country to be able to provide those services without violating our religious beliefs. But we will serve. We have been here for hundreds of years in this country serving. One of our oldest agencies in the Archdiocese is St. Ann's Infant and Maternity Home. It was chartered by President Lincoln and it is still here serving. We will be here.

Mr. SHIMKUS. And let me personally thank you for your service. And I yield back.

Mr. PITTS. The Chair thanks the gentleman and recognizes the gentlelady from Illinois, Ms. Schakowsky, for 5 minutes for questions.

Ms. SCHAKOWSKY. I just wanted to note the number of religious organizations that Mr. Pallone inserted testimony into the record, and I note that one of them was the National Council of Jewish Women, which I am a proud member of.

So let me understand from Dr. Stevens and Ms. Belford and Mr. Cox. We are not talking about—as my colleague from Illinois was saying—individual healthcare providers. You are talking about healthcare systems, am I right? Institutions and networks of institutions that would be exempted from having to provide contraception, is that true, Dr. Stevens?

Mr. STEVENS. Yes.

Ms. SCHAKOWSKY. Ms. Belford?

Ms. BELFORD. In the case of the Archdiocese of Washington, we conduct our ministries through separate organizations, but in addition to what we as church do——

Ms. SCHAKOWSKY. In your testimony are you asking to expand it?

Ms. BELFORD. Excuse me?

Ms. SCHAKOWSKY. In your testimony are you saying that the narrow exemption should be broadened if not dropped and to include systems as well and broader——

Ms. BELFORD. It should include religious organizations that operate in accordance with their teachings and beliefs, yes.

Ms. SCHAKOWSKY. And Mr. Cox, hospital systems as well and hospitals?

Mr. COX. The definition puts HHS in the position of trolling through the religious beliefs and practices of religious organizations——

Ms. SCHAKOWSKY. So that would include institutions?

Mr. COX [continuing]. And determining, Congresswoman, which ones it agrees with and which ones it doesn't agree with, and if it

doesn't agree with them, then it uses the force of law to compel that organization to follow its beliefs.

Ms. SCHAKOWSKY. And let me ask the three of you, then, if this regulation were not changed, would you drop your health insurance coverage? Dr. Stevens?

Mr. STEVENS. I think it would be something we would have to consider because it is a problem when you are dispensing an abortifacient and paying for it. It is called moral complicity.

Ms. SCHAKOWSKY. OK. Ms. Belford?

Ms. BELFORD. It is unthinkable that we would drop our health insurance coverage but we would not provide coverage for contraception and sterilization as required by this law.

Ms. SCHAKOWSKY. Mr. Cox?

Mr. COX. We will have to challenge it in court if it isn't dropped.

Ms. SCHAKOWSKY. OK. So I just want to make sure that the word goes forth into the country that this is about depriving women of contraception by large hospital systems, smaller organizations, and potentially even all healthcare coverage for the employees of those organizations despite the fact, as it was pointed out, that all but perhaps 5 percent of Catholic women also use contraception, that virtually all Americans in recent surveys—women—use contraception.

Mr. O'Brien, this issue of conscience is so important because I perceive that as an individual right of conscience, can you elaborate on the difference between individuals and institutions and the right of conscience that you mentioned before?

Mr. O'BRIEN. You are absolutely correct, Congresswoman.

I think one of the things that is interesting about this is the Catholic Church is not actually asking for an exemption. The Catholic Church is all of the people in the Church, which includes the 98 percent of Catholic women who use a contraceptive. The consciences of these women, of the people in the Church, are absolutely essential. The Catholic hierarchy, the United States Conference of Catholic Bishops, represents about 350 bishops. It is the bishops and the people involved in the Catholic healthcare industry who are asking for these exemptions. The conscience of an individual within Catholicism and St. Thomas Aquinas told us very clearly that it is a mortal sin not to follow your conscience, your individual conscience, even if you have to go against church teaching. I think that Catholics do that every day on an individual basis. The idea that an institution or a health insurance plan in some way has a conscience and there is no tradition of that and the reality is that conscience is applied to real people and individuals.

Ms. SCHAKOWSKY. And since we are getting into very personal and private matters dealing with women, I am just curious from Dr. Stevens, Ms. Belford, and Mr. Cox, do you have any problem with the insurance companies providing prescription drugs for erectile dysfunction, Cialis or Viagra? Just curious.

Mr. STEVENS. I don't have any problem at all. I also don't have any trouble with contraceptives, most of them, but that doesn't mean I am going to prescribe all of them or that my Catholic brothers and sisters should not have the right to decide they are not going to pay for them.

Mr. COX. Our plans don't cover those services.

Ms. BELFORD. I think as I indicated, Congresswoman, in my testimony, our plan does not cover contraceptive coverage, sterilization, and the drugs that are mandated here.

And if I would just add I recognize that the teachings of the Catholic Church on procreation and life may not be the majority view and may not be popular, but I also understand from all the testimony that I have just heard this morning that contraception is widely available and universally used. So the issue here is not whether or not women are using it or have access to it. The issue for me and why I came here today is because the Catholic Church has a teaching about procreation and life and we are talking about whether us as an employer, the Archdiocese of Washington, would be required to provide coverage for something that we teach is morally wrong. I know not everyone——

Ms. SCHAKOWSKY. And I hope you would inform all of your women employees of that policy. Thank you.

Mr. PITTS. The Chair thanks the gentlelady and recognizes the gentleman from Pennsylvania, Dr. Murphy, for 5 minutes.

Mr. MURPHY. Thank you, Mr. Chairman.

Dr. Hathaway, in your testimony you spoke of your many uninsured patients and the cost they face to excess contraceptives, just to be clear, because this interim final rule is directed at those providing insurance, nothing in this rule would actually change your uninsured patients' ability to access contraceptives, is that correct?

Mr. HATHAWAY. I am not a legal scholar and I can't truly point to that, but I do know——

Mr. MURPHY. They would still have access to that?

Mr. HATHAWAY. Access and copays and coverage for some of the most effective methods are prohibitive for many, many, many insured and uninsured women in our country. It is——

Mr. MURPHY. I am asking under this interim rule, would nothing that would change the uninsured patient's ability to access contraceptives in this?

Mr. HATHAWAY. I think it would.

Mr. MURPHY. Excuse me. Now, there are many business owners in my district guided by their faith who are struggling with whether or not they can continue to provide health insurance to their employees in light of this new rule. Do you honestly think that thousands of individuals and families in my district who could lose their health insurance altogether are really better off as a result of this rule?

Mr. HATHAWAY. I feel that this rule, in the Institute of Medicine's evidence-based looking into this issue is pretty clear that removing copays, removing cost barriers will have a dramatic positive impact on reducing unintended——

Mr. MURPHY. And the issue before us here is also one of people's ability to practice their faith, that the government is not saying that people cannot access these at all, but the question really before us is whether or not government has the right to force faith-based hospitals or clinics or providers or employers certain services that violate their church teachings. And the question is whether the Secretary of HHS can act unilaterally to force employers, medical providers, hospitals, clinics, and others to act in ways that violate their faith and conscience.

And to that, Mr. O'Brien, I strongly disagree with your analysis of the Catholic Church. Conscience is at the core of Catholic teaching, you said, but slavery was not left to personal decisions and conscience, thank goodness.

Conscience, according to Father Anthony Fisher, tells us that "it is the inner core of human beings whereby, compelled to seek the truth, they recognize there is an objective standard of moral conduct and they make a practical judgment of what is to be done here and now in applying those standards." That and I think, too, it teaches us the moral character of actions is determined by objective criteria not merely by the sincerity of intentions or the goodness of motives. And the church of the modern world and all people are called to form their conscience accordingly and to fit with it as opposed to rewrite their image of the church and of the Lord's teachings. It is not—I repeat—it is not our duty as Catholics to tell God what he should do or the image that he should adhere to or what he should think, but it is up to us to shape our conscience to conform with the teachings he has given us.

When Moses came down with the 10 Commandments, he didn't put it up for a vote or ask for a referendum or say to people, so what do you think, folks? Our life is spent in continuous struggle to learn that which is good and conscience is not merely to declare it in terms of humanism and then form some image of God based upon some desires. Conscience, sir, is not convenience.

Father Fisher goes on to say that "deep within their conscience, human persons discover a law which they have not themselves made but which they must obey. Conscience goes astray through ignorance and the key here is to shape our conscience to conform to the laws of God, not to practicality or solecism." "Conscience," he goes on to say, "is formed through prayer, attention to the sacred, and adhering to certain teachings of the church and the authority of Christ teachings in the church." Conscience is not that which described by Shakespeare when he says in Hamlet "nothing is either good or bad but thinking makes it so."

So asking a group in a survey whether or not they have ever acted or thought of acting a certain way that runs counter to the church's teachings is no more a moral code than asking people if they ever drove over the speed limit as a foundation for eliminating all traffic laws.

With that, I end with a quote from John Adams, which he said in 1776 when he was writing our Declaration of Independence of the United States. He said, "it is the duty of all men in society, publicly and at stated seasons, to worship the Supreme Being, the Creator and Preserver of the universe, and no subject shall be hurt, molested, or restrained in his person, liberty, or estate for worshipping God in the manner most agreeable to the dictates of his own conscience or for his religious profession, or sentiments provided he doth not disturb the public peace or obstruct others in their religious worship." The foundation of our Nation is not to impose laws which restrict a person's ability to practice their faith, sir.

With that, I yield back.

Mr. PITTS. The Chair thanks the gentleman and recognizes the gentlelady from California, Ms. Capps, for 5 minutes.

Mrs. CAPPS. Thank you, Mr. Chairman.

One thing that does trouble me in today's testimony is some confusion about what the preventive service rule applies to and what it doesn't. I would like to set the record straight as I understand it. The rule we are discussing today is whether or not an employer—as in a hospital or university system—can ban the coverage of a medical service but it would not mandate that any individual prescriber's control or that any woman or man take birth control. Period. Today's hearing is yet another example of how out of touch the majority side is with the American people. My constituents tell me that we should be spending our time here considering jobs and the economy, not blocking women's access to contraceptive services. But instead here we are again poised to attack another important piece of the healthcare law to rile up an extremist constituency at women's expense.

The Institute of Medicine report illustrates the strong evidence and sound science that proper birth spacing and planning of pregnancies does improve the health of a woman and her future children. The HHS rule then translates the science into provisions to give women options to choose if, when, and how to space their pregnancies, something they should be discussing with their medical provider, not with their boss. As we have heard, especially in these tough economic times, women are sometimes forced to choose between paying for their birth control prescription or paying for other necessities. These economic concerns are the threat to public health we should be discussing, not whether or not your boss' conscience is more important than your own.

Now, Mr. Cox, I want to praise the good work of your institutions in California because many of them are serving my constituents in my congressional district——

Mr. COX. Thank you.

Mrs. CAPPS [continuing]. On the central coast. In your testimony you say that you represent Catholic healthcare organizations in California, including 54 hospitals. Is that correct?

Mr. COX. That is correct.

Mrs. CAPPS. So to be clear, you are not speaking for or representing the views of all Catholic hospitals or nursing homes in the United States?

Mr. COX. No, but I would believe that my views would be consistent——

Mrs. CAPPS. Right, but you do not represent any other than the ones in California.

Mr. COX. That is correct.

Mrs. CAPPS. As I understand it, California has a requirement for coverage of contraception that is very much like the one that HHS has now proposed, and that includes the religious exemption that you are now saying is too narrow. I also understand that this coverage requirement has been reviewed by the California Supreme Court and found not to be religious discrimination and that the United States Supreme Court refused to review that decision. So my question to you, I assume that your hospitals in their role as employers comply with the California law and do provide insurance coverage for your employees for contraceptive services. Is that correct?

Mr. COX. Most of our members have moved or are moving towards self-insurance under ERISA, which would be denied to us by the HHS rule.

Mrs. CAPPS. But they do now?

Mr. COX. Pardon?

Mrs. CAPPS. They do now?

Mr. COX. Yes, they either have or are moving towards——

Mrs. CAPPS. But they do now use it?

Mr. COX [continuing]. Self-insured ERISA plans in order to get out from under——

Mrs. CAPPS. But they do provide insurance coverage now as required?

Mr. COX. Yes, of course, we do.

Mrs. CAPPS. OK. I wondered if you would tell us all have any of your hospitals closed as the result of this requirement? Yes or no, please.

Mr. COX. We have other options.

Mrs. CAPPS. So they have not.

Mr. COX. They have not.

Mrs. CAPPS. Have any of your hospitals dropped insurance coverage for its employees as a result of this requirement?

Mr. COX. No.

Mrs. CAPPS. Have any of the Catholic bishops severed ties with your hospitals over this requirement?

Mr. COX. No.

Mrs. CAPPS. Thank you.

Now, I would like to address Mr. Hathaway. I only have a few seconds left, but if there was an expansion of refusal provisions for employers, in some estimates that would affect over a million employees and their families. Where would these women go for their care?

Mr. HATHAWAY. My guess is they would end up in a safety net system somehow and struggle to make ends meet.

Mrs. CAPPS. Like a Title X?

Mr. HATHAWAY. Right.

Mrs. CAPPS. And a clinic like the one you describe with certain patients that you serve gets Title X funding to provide these services for women who can afford them?

Mr. HATHAWAY. Correct.

Mrs. CAPPS. Thank you.

Mr. HATHAWAY. I think it should be pointed out that the areas of the United States where there is less access to healthcare are also the areas where there is higher epidemic rates of unintended pregnancies, and those are the population—if I am here representing anyone, I am representing the thousands of women that I have seen daily that just don't have access to good healthcare. And I truly hope we can move forward on this Preventive Care Act.

Mrs. CAPPS. That is exactly what I wanted to allow you the opportunity to say because as a former public health nurse in a school system I see those faces before me every single day as I serve here in Congress. Thank you very much.

Mr. HATHAWAY. Thank you.

Mrs. CAPPS. I yield back.

Mr. PITTS. The Chair thanks the gentlelady and recognizes the gentlelady from Tennessee, Ms. Blackburn, for 5 minutes.

Mrs. BLACKBURN. Thank you, Mr. Chairman, and thank the panel for their time.

Dr. Stevens, I want to talk with you for a couple of minutes, but before I do, the gentlelady from California mentioned that we should be talking about jobs. I would like to say that straightening out this Obamacare bill is a way for us—to repeal it, to replace it is a way to deal with jobs because we heard from CBO that passage of this bill would cost us about 800,000 jobs. So I appreciate that we are looking at the dynamic that this has.

But Dr. Stevens, I want to talk with you. Since you are from Tennessee and you are familiar with the impact that TennCare program had on Tennesseans, I want to look at this access-to-care issue because as I have told my colleagues here in this committee many times over the past few years that what we saw happen in Tennessee was individuals had access to the queue but they didn't have access to the care. And there is an enormous difference that is there. On the contraceptive mandate, I want to be certain that I am quoting you right. And your quote was, "it violates the religion and free speech clauses of the First Amendment of the Constitution by coercing faith-based healthcare ministries to not only violate the very faith-based tenets that have motivated patient care for millennia but also to pay for that violation. Such conscience-violating mandates will ultimately reduce patients' access to faith-based medical care, especially depriving the poor and medically underserved populations of such care."

Mr. STEVENS. That is very much the case. You know, the intention may be to expand coverage, but actually what this is going to do I believe if it is carried forward will reduce care as faith-based professionals, because they are forced into a situation, begin not providing those services or not providing insurance for the staff that are working with them. So that is a great concern because the bottom line is we want to take care of the poor, we want to provide good services, but we cannot violate our conscience.

Mrs. BLACKBURN. OK. And you also noted a national survey at FreedomToCare.org of over 2,100 faith-based physicians revealed that 9 of 10 are prepared to leave the practice of medicine if pressured to compromise their ethical and moral commitments. So do you believe that this particular mandate could contribute to more faith-based providers leaving the medical profession and thereby reducing patients' access to medical care? And are you concerned that faith-based providers might leave certain or particular areas of medical care in especially large numbers?

Mr. STEVENS. I know that is happening. We work on 222 medical and dental campuses across the country where we have student chapters and I remember meeting with 5 students down at the University of Texas, 5 girls, and I said what are you guys interested in? And they all said OB/GYN. How many of you are going into it? Only one. Why not? Because of right-of-conscience issues, because of pressures in residency, coercion to participate in abortions or do things that violate their conscience. So we are already beginning to change the face of healthcare. The sad thing, Congresswoman, is that I think that is what some people want.

I was debating a Planned Parenthood lawyer on National Public Radio on right of conscience; he said you have no business being in healthcare if you are not willing to provide legal services. And I think there are some that would love to see faith-based people out of the whole healthcare equation.

Mrs. BLACKBURN. OK. Let me go to Mr. Cox and Dr. Stevens and Ms. Belford with this one. And Dr. Stevens, starting with you and working across. Let me just ask you—this is a yes or no—and then you can explain if you would choose. We only have a minute and 45 seconds left. Does this preventive services rule adequately protect freedom of conscience?

Mr. STEVENS. Absolutely not. It is the most constrictive thing we have had in Federal law in history.

Mrs. BLACKBURN. So the fears of the students would be realized under that?

Mr. STEVENS. Absolutely.

Mrs. BLACKBURN. OK. Ms. Belford?

Ms. BELFORD. I agree.

Mrs. BLACKBURN. OK.

Mr. COX. Completely agree.

Mrs. BLACKBURN. Thank you. Thank you very much.

And with that, I will yield back my time so that we can move through the rest of the panel.

Mr. PITTS. The Chair thanks the gentlelady, recognizes the gentleman, Mr. Towns, for 5 minutes for questions.

Mr. TOWNS. Thank you very much, Mr. Chairman. Let me thank you and the ranking member for holding this hearing.

The Supreme Court and lower courts throughout this land have repeatedly ruled that a law that is applied generally is enforceable even if some religious groups oppose the action or the inaction that it requires. Let me give you a few examples. The Quakers must pay taxes that support wars. Native Americans may not use traditional drugs. Mormon men may not have multiple wives. Some courts have ruled that the Muslim women must remove their veils for photo identification cards and et cetera, et cetera, going on and on and on.

The question for the court is whether the government is pursuing a legitimate goal. Family planning is a legitimate goal. We have reams of data and medical consensus that family planning improves health outcomes for mother and child. We have shelves of studies that show that unintended pregnancies are likely to result in worse health and are much more likely to result in abortion. The government, of course, cannot require individuals to use family planning, it cannot require individuals to provide family planning, but it can require employers to pay for insurance that covers family planning, and it should.

Let me go to you, I guess, Dr. O'Brien. I fully respect the rights of an individual provider to exercise his or her conscience. However, I believe that this right must be carefully balanced by the rights of patients' access to safe, legal healthcare. We must be certain that any right of refusal provided is solely granted to an individual and not to an institution to ensure that we strike the right balance.

Dr. O'Brien, do you believe that the Affordable Care Act refusal clauses have the potential to compromise the health of women?

Mr. O'BRIEN. I believe the Affordable Care Act is an absolutely marvelous initiative that would greatly improve the lives and the healthcare of women, men, and families. I think the difficulty really comes about when what we are hearing all the time is trying to bestow conscience rights on institutions. I fully agree with you that with regards to doctors, nurses, pharmacists, individuals have a right of conscience. They have a right to refuse to provide services.

If they find themselves in that situation, obviously the onus is to ensure that somebody can access those services. Because in Catholicism—and also I believe within fair play in the United States of America—the idea that someone cannot access services, there is something wrong with that. I think there is a real difficulty that we didn't hear a lot today from some members about the conscience rights of those individuals who would be denied service. What these refusal clauses are really intending to do would be to have the State sanction discrimination against individual workers just because they happen to work in an institution that is a Catholic institution. The idea that an employer can decide what services you do or do not get, I think there is something very wrong with that, something very un-American about it.

Mr. TOWNS. Right. Thank you very much. I much admit that I agree.

Dr. Hathaway, why do you as a medical professional support the ACA preventative coverage provision? As a doctor who specializes in women's health, could you please explain why unintended pregnancies are considered by doctors a health condition? And I only have a few seconds left because I want to make a statement in reference to I know we keep using the word Obamacare. I am going to suggest for this committee, which is the Health Committee, refer to it as President Obamacare. Thank you.

Mr. HATHAWAY. Yes. Thank you, Chairman.

Mr. TOWNS. Thank you.

Mr. HATHAWAY. After I had been practicing in a public health clinic for several years, I took some time to go to public health school and it was for the exact reason as we are speaking about today that I found many, many, many women, my patients, coming in with unplanned, unintended pregnancies. And I felt as though we need to be doing something about that. And when this recommendation came out from the Institute of Medicine, many of my colleagues throughout the country, OB/GYNs, family, nurse practitioners, midwives, family medicine doctors, pediatricians all to my knowledge are overwhelmingly supportive of this recommendation that preventive healthcare should include contraception care, family planning care, as well as the multitude, 7 or 8 other points that they recommend. Public health is an incredibly important issue for our country and preventive health is paramount.

Mr. TOWNS. I yield back.

Mr. PITTS. The Chair thanks the gentleman and recognizes the gentleman from Georgia, Dr. Gingrey, for 5 minutes.

Mr. GINGREY. Mr. Chairman, thank you for yielding, and I thank our witnesses. I want them to know if they don't already know that

prior to Congress I spent 26 years practicing obstetrics and gynecology in Marietta, Georgia, my hometown.

I am going to address my first questions to Dr. Stevens, Ms. Belford, and Mr. Cox, and I will get each of you to quickly answer these questions. They are pretty straightforward yes or no.

Are you aware that President Obama promised every American that they could "keep what they have if they liked it" when referring to health insurance?

Mr. STEVENS. Yes.

Ms. BELFORD. Yes.

Mr. COX. Yes.

Mr. GINGREY. And the second question for the same three, I referenced the Catholic hospitals in my opening statement. Does this interim rule in your opinion support President Obama's promise that workers, including the 750,000 of the Catholic Hospital Association, could keep what they have if they like it?

Mr. STEVENS. No.

Ms. BELFORD. No.

Mr. COX. No.

Mr. GINGREY. Thank you. The next question I want to address to Mr. O'Brien. Mr. O'Brien, you stated that you believe in choice and Mr. Waxman referenced in his statement the need for employees to have the choice to access services. I am glad to hear that because I basically agree with the two of you. I also believe that choice is a two-way street, both to do and not to do.

In 2014, according to supporters of the new health law, President Obamacare, every single person will have numerous choices in the health plans through these exchanges. So instead of forcing every person to pay for a service they may have a moral conscience objection to, Mr. O'Brien, don't you agree it would be better to allow them to choose whether they want these services and if they want to pay for them?

Mr. O'BRIEN. I think that there is a lot of people in the United States of America who have problems with taxes, problems paying taxes, the amount of taxes they pay. But we don't get to pick and choose what we pay and what we don't pay for. Some people disagree with the wars, some people disagree with the incarceration system in the United States. Other people feel that as regards to welfare that they don't feel like paying for it. But we do. As a society, this is an important way for society to be constructed so that it can actually operate. So we don't always get to pick and choose.

I think the idea that one religious group would receive a free pass, I think that that is very unfair and I don't think that that is right.

Mr. GINGREY. Well, I am going to interrupt you because I think that your answer is no. And no matter how long you talk, the answer is going to be no. It seems to me quite honestly the only choice you believe people should have are choices that fit with your own philosophical views. The views that you espouse are not choices but rather imposing of those views on people regardless of their moral or religious views or convictions. Quite honestly, Mr. O'Brien, that doesn't sound very American to me.

I am going to go back to Dr. Stevens and Ms. Belford and Mr. Cox in the remaining time that I have. In looking at this interim

rule, I guess that Catholic hospitals and providers could limit their hires to Catholics and of course only deliver care to Catholics. Is that the healthcare system that we ultimately want, one in which Catholics treat Catholics, Protestants treat Protestants, Muslims treat Muslims, or should this government instead encourage hospitals and providers, the doctors, to treat all patients?

Mr. STEVENS. Should encourage to treat all patients.

Ms. BELFORD. That is a fundamental tenet of our faith, that we care for our neighbor and love our neighbor as ourselves. So yes, we should care for all.

Mr. COX. It would be inconsistent with our religious mission to limit our services only to Catholics.

Mr. GINGREY. Well, I thank the three of you. I certainly agree with that.

Mr. Cox, I am going to conclude with you in the half-minute I have left. Going back to previous questions, can you explain the difference between California's law on benefits and the impending HHS rule that we are discussing here today?

Mr. COX. They are very similar and particularly with respect to the definition of religious employers. HHS borrowed or utilized the definition that was first developed by California in its contraceptive mandate statute. They differ in this regard: that you can get out from under the mandate in California if you decide not to cover those prescription drug benefits in your health insurance plan, and our members are also able to self-insure under ERISA. They have been able to up until now self-insure under ERISA and get out from under the mandate. Also, the California statute does not cover sterilization, which the HHS rule does and will compel us to cover in our health insurance plans.

Mr. GINGREY. Thank you, Mr. Cox.

Mr. Chairman, I yield back. Thank you for your patience.

Mr. PITTS. The Chair thanks the gentleman and recognizes the gentlelady from Wisconsin, Ms. Baldwin, for 5 minutes for questions.

Ms. BALDWIN. Thank you, Mr. Chairman.

I have a few questions for our witnesses but I would like to first point out that here we are again, once again in the middle of what has been described as the Republican war on women. At a time when our committee and our Congress should be coming together to put America back to work, putting partisan divisions aside in the interest of the people, once again our committee is advancing issues that divide Americans, and in this case, issues that infringe on women's rights.

Today, the majority is focusing on yet another effort to limit women's access to essential and medically necessary treatment options. And in particular, my colleagues would like to limit the number of new group or individual health insurance plans that will be required to provide preventative services for women without cost-sharing requirements. The Affordable Care Act makes significant strides in expanding access and making healthcare affordable for women. Thanks to this law, being a woman can no longer be considered a preexisting condition, and thanks to a provision in the Affordable Care Act that we are discussing today, women will now have access to preventative services that have been too costly for

so many up until now. That is unless Republicans succeed in their efforts to limit the number of health plans that are required to cover such preventative services.

I would like to explore this issue further and ask our witnesses some questions. Dr. Stevens, Mr. Cox, and Ms. Belford, as you know, I believe Congressman Fortenberry has introduced a bill, H.R. 1179, the Respect for Rights of Conscience Act. This bill would amend the Affordable Care Act such that health plans would not be required to provide coverage or pay for coverage for any service that is "contrary to the religious or moral convictions of the sponsor or issuer or the plan." Just so the record is clear—and this question is for each of you—do you support this legislation? Dr. Stevens?

Mr. STEVENS. I do support that legislation.

Ms. BALDWIN. Mr. Cox?

Mr. COX. We support it.

Ms. BALDWIN. Ms. Belford?

Ms. BELFORD. Yes.

Ms. BALDWIN. Thank you. Now, Ms. Belford, as the attorney on the panel, I want to ask you some questions related to the provision of H.R. 1179. As I read it, an employer can exclude from its insurance coverage for its employees coverage of any service that is contrary to the religious or moral convictions of that employer. So if you can answer the following with a yes or no, that would be greatly appreciated with our time constraints. Under this language that I quoted, could a plan exclude coverage for certain infertility services because the plan sponsor has a religious objection to such services?

Ms. BELFORD. I can only speak to what our plan provides and what our——

Ms. BALDWIN. No, the quoted provision of Mr. Fortenberry's bill if it were to be passed into law, I am wondering if under that language I quoted could a plan exclude coverage for certain infertility services because the plan's sponsor has a religious objection to such services?

Ms. BELFORD. Hypothetically, I think it probably could.

Ms. BALDWIN. Thank you. Under that language, could a plan exclude coverage for alcohol and drug addiction services because a plan's sponsor believes that use of alcohol or drugs is sinful?

Ms. BELFORD. I honestly don't know the answer to that question because these are all services that we provide under our health plan.

Ms. BALDWIN. But under the language of the Fortenberry bill, health plans would not be required to provide coverage or pay for coverage of any service that is contrary to the religious or moral convictions of the sponsor or issuer. So under that language could a plan exclude coverage for alcohol and drug addiction because the plan's sponsor believes that the use of alcohol or drugs is sinful?

Ms. BELFORD. Theoretically. I am not aware of religions that do and I guess I would have to look with reference to what our Federal laws and constitutional cases have indicated with regard to what our moral and religious——

Ms. BALDWIN. So you don't know the answer to that question.

Ms. BELFORD. I really don't.

Ms. BALDWIN. OK. Under the language I quoted, could a plan exclude coverage for HIV and AIDS patients because the plan's sponsor expresses moral objections to homosexuality?

Ms. BELFORD. This is a hypothetical question but I just have to say in our church we care for all people and we don't——

Ms. BALDWIN. That is not the question.

Ms. BELFORD. We don't decline services——

Ms. BALDWIN. We are considering legislation that will have impacts if passed. Mr. Chairman, would I be able to be granted an additional 30 seconds?

Mr. PITTS. Without objection.

Ms. BALDWIN. Under the language that I quoted could a plan exclude coverage for blood transfusions because the plan's sponsor is religiously opposed to this medical service even in an emergency situation?

Ms. BELFORD. I don't know the answer to that.

Ms. BALDWIN. Under this language could a plan exclude coverage for unmarried pregnant women because the plan's sponsor has a religious objection to premarital sex?

Ms. BELFORD. We don't exclude such coverage so I don't——

Ms. BALDWIN. I am not asking about your plan.

Ms. BELFORD [continuing]. Know whether that would be the case.

Ms. BALDWIN. Well, I hope that you see the point that I am trying to make here. The scope of H.R. 1179 is broad enough to exclude anything to which an employer decides it is religiously or morally opposed. There is absolutely no standard, no guidelines in place for making such a decision. This bill would also undo State law and it would completely undermine the Affordable Care Act.

Mr. GINGREY. Would the gentlelady yield to me when she has a little time?

Mr. CASSIDY. I would point out she is way over 30 seconds.

Mr. PITTS. The gentlelady's time has expired.

Ms. BALDWIN. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentlelady, recognizes Dr. Cassidy for 5 minutes for questions.

Mr. CASSIDY. Folks, I got 5 minutes so if I interrupt you, it is not to be rude. It is just because I have 5 minutes.

Now, Mr. O'Brien, Dr. Stevens raised an interesting point of moral complicity, but it appears and frankly if we view the employer as merely an extension of the State, we can take Representative Baldwin's point and extend it to terrible things where the State might demand something terrible and the employer is merely an extension, a puppet being dictated by a law who would have to comply. So I think this cuts both ways, but I gather that you feel as if moral complicity is not an issue if an employer is mandated to cover a service which he particularly finds objectionable.

Mr. O'BRIEN. We think Catholicism and we think——

Mr. CASSIDY. No, no, no, just in general.

Mr. O'BRIEN. In general fairness I think that a properly formed conscience requires us to have respect for the consciences of others. So I think that——

Mr. CASSIDY. That said, we also are responsible for ourselves, so if the employer finds something objectionable, again, if you say that it is incredible to suggest that a healthcare plan has a conscience,

but it is not really the healthcare plan; it is the purchaser of the healthcare plan that has a conscience. I gather that you think it is incredible that the purchaser of that healthcare plan would manifest her conscience through the benefits covered. Is that correct?

Mr. O'BRIEN. I believe that due deference to the consciences of others is an essential element——

Mr. CASSIDY. No, but is it correct that you would find it incredible that the purchaser of a healthcare plan would manifest her conscience as regards with services she would elect to cover for employees?

Mr. O'BRIEN. I think if you are talking about individuals, I believe in the right of individual conscience.

Mr. CASSIDY. So I am thinking of a small business owner, she has got 35 employees and she is making a decision as to what benefits to cover. It is she that is making it, she is an individual, and you find it I gather incredible that she would reflect her values through the services provided.

Mr. O'BRIEN. I think an employer, a company, an institution, I think that the job of an institution is to give due deference to the consciences of all——

Mr. CASSIDY. So she is also filing as an S corp. so she is actually taking income from the business as her own income. If you will there is an identity that is respected in other aspects of the law that is recognized by the IRS and others. But again, you seem to find it incredible—I am not quite getting the yes or no. In fact let me do what Ms. Baldwin did or Mr. Pitts, which is a yes or no.

Do you find it incredible that that small business owner——

Mr. O'BRIEN. No.

Mr. CASSIDY [continuing]. Would attempt to reflect her values in the services she covers.

Mr. O'BRIEN. I don't think that an employer has a right to insist that their values—for example, if an employer——

Mr. CASSIDY. OK. That is fine. You know, you have made your point. You don't think so. Again, I have only 5 minutes.

Mr. O'BRIEN. Sorry.

Mr. CASSIDY. So at that point, the employer's conscience merely becomes an extension of what the majority party is able to put through without an open hearing through HHS. Ultimately, that is it, correct? Yes, no?

Mr. O'BRIEN. I believe that it is the job of the institution to facilitate the consciences of all people.

Mr. CASSIDY. So again all people is interesting because we are not really facilitating the conscience of that small business owner who would like her values to be reflected in the benefits she provides. And you also reject moral complicity. So if that small business owner puts out a product, somehow you have divorced her from the actions of her company. So if she puts out a product which is harmful, there is no moral complicity there?

Mr. O'BRIEN. I don't think that it is speaking to what the actual issue is.

Mr. CASSIDY. No, the question is——

Mr. O'BRIEN. The issue is whether——

Mr. CASSIDY. I only have 5 minutes.

Mr. O'BRIEN. OK.

Mr. CASSIDY. And so again if we are going to take a holistic viewpoint of what this small business owner is doing, if she put out something which was known to be harmful, we would call that—in terms of a product—we would call that morally reprehensible and we would ask her conscience to be sharper. But then we can turn around and say she has no right to judge what products should be covered by her insurance that she provides for her employees. That is a cognitive dissonance.

That said, let us also make the point, Dr. Hathaway, that this is really not about access for preventive services for those who are poor. They are currently covered through Medicaid and SCHIP, that I have been told IUDs can be placed right after delivery, which is a long-term form of birth control. I am not an OB/GYN; I am a gastroenterologist, you know, so whatever that is worth. But that said, this is not about access for the poor, and for those who have coverage, I see that the generic birth control pill can cost $14 a month through 340(b) pricing. If we are going to say through legislation that everything has to be covered equally, then really we are saying to people don't choose the $14-a-month pill; choose the $100-a-month pill, which is also bad social policy. We just run out of money at some point in our good will.

I yield back. Thank you.

Mr. PITTS. The Chair thanks the gentleman and we have——

Mr. GINGREY. Mr. Chairman?

Mr. PITTS [continuing]. Unanimous consent request from Dr. Gingrey for 1 minute to respond since our friend, Ms. Baldwin, went 1 minute over, so without objection.

Mr. GINGREY. And I thank my colleagues for allowing me the minute because Ms. Baldwin was going down a line of hypotheticals in regard to objection to blood transfusions, objection to treating AIDS patients, and I want to make sure and I want to particularly direct this to the 3 panelists that I asked questions of before in regard to the Catholic principle that the intimate relationship between husband and wife is for the purpose of procreation of children and not simply recreation as a number one principle. And the second principle, even more important, the Catholic principle is that life begins at conception and should never be deliberately terminated. I would think that this is the reason that the three of you are opposed to this interim rule and I just want to get your response on that because this is a very narrow area in which you would be opposed to sterilization, you would be opposed to abortion, you would be opposed to your hospital prescribing birth control pills or abortifacients. Is that not the crux of this problem? Very quickly yes or no.

Mr. STEVENS. Yes.

Ms. BELFORD. Yes.

Mr. COX. Yes, we have not been covering those services in our health insurance plans for a very, very, very long time. It is only now that the government comes forward and says we are going to require you to abandon that practice and violate your conscience.

Mr. GINGREY. Thank you all very much.

And Mr. Chairman, thank you for——

Mr. PITTS. The Chair thanks the gentleman. That concludes the first round of questioning. We will go to one follow-up per side. Dr. Burgess for 5 minutes.

Mr. BURGESS. Yes, Dr. Hathaway, if I could—and I won't use the entire 5 minutes to question. What I am going to ask is likely going to require a longer response, and if you wish to respond in writing, that is perfectly acceptable.

But first let me ask you, you talked a little bit in your testimony about the amount of money that is spent. Can you tell us between Title X, Medicaid, and temporary assistance for needy families how much money is spent on family planning by the Federal Government every year?

Mr. HATHAWAY. I don't know that number.

Mr. BURGESS. But it is a lot, right?

Mr. HATHAWAY. I presume so. I don't know that number.

Mr. BURGESS. Yes, I don't either. That is why I am asking you but it is likely to be well in excess of a billion dollars. In fact it may be a multiple of that. And you referenced——

Mr. HATHAWAY. Pardon me, Chairman. I think also we need to recognize that what this Institute of Medicine's recommendation has to do with is insurers would cover contraceptive family planning methods. We are not talking exclusively about public assistance programs. We are talking about insurers throughout the board. So we are now paying a tremendous amount of money, those of us that have private insurance——

Mr. BURGESS. Correct.

Mr. HATHAWAY [continuing]. For coverage and we are not talking about an incredibly——

Mr. BURGESS. Reclaiming my time. And we are going to pay more under the IOM's guidelines. Dr. Cassidy is a gastroenterologist. He doesn't prescribe birth control pills, but I would submit that if the IOM were to require that everyone who comes into his clinic be able to get whatever proton pump inhibitor that they want, regardless of cost, nobody is going to buy the generic Wal-Mart $4-a-month prescription, which is available for the generics of Tagamet and Zantac and some of the earlier products. Everyone is going to get NEXIUM because that is the best and why wouldn't you want to best? But the cost differential is substantial between $4 a month to $100 a month. That is going to have the effect of driving up the cost of the product for everyone, whether they be on public assistance or not. Everyone who is on employer-sponsored insurance is going to bear the brunt of that cost. That is the way insurance works, is it not?

Mr. HATHAWAY. My understanding is that insurers, insurance systems have formularies for just that reason, to reduce——

Mr. BURGESS. Correct. And that is a good point because that is the point I was trying to make with my experience at Parkland Hospital. But under the interim final rule, my read of the Federal Register is you don't get to use a formulary. You get to have any product that is marketed as being used for that, and that is the reason for the comparison between Necon and Seasonique. There is a vast difference in the price differential of those 2 compounds.

Mr. HATHAWAY. So can I interrupt?

Mr. BURGESS. Yes.

Mr. HATHAWAY. Let me put it this way. It is interesting sitting here——

Mr. BURGESS. Well, let me just ask you the question. I have Aetna health savings account.

Mr. HATHAWAY. Um-hum.

Mr. BURGESS. I use a formulary with them. I only go to their Web site and buy the products they tell me I can buy. But as I understand it, under the IOM guidelines, there would be no such prohibition. There would be no allowance for a formulary for contraception, is that correct?

Mr. HATHAWAY. I am not aware of that. I don't know that.

Mr. BURGESS. Well, that is my read of the Federal Register.

Now, again, this is the problem with an interim final rule. We didn't get to talk about any of that, we didn't get any transparency, and, you know, forgive me if I make the leap of faith and say the reason for the interim final rule was precisely for these conscience protections that are getting so much discussion this morning. There was a reason that they followed that trajectory. There is a reason that they went there, say, we can't wait past August because we have got this to get out there. Well, that is nonsense. This argument is going to be going on for a long time and just so you could get this year's student population covered under these rules to me was not a valid assertion unless you have a political calculation that may be geared for November 2012. And that may very well have been the case with this, but in the meantime, the individuals who claim that their conscience provisions are going to be violated—and I think they are exactly right with that—they are the ones who are suffering as a consequence of what is very bad policy and a very bad way of going about that.

Let me ask you, though, you mentioned that child spacing and that there is a societal benefit and I don't disagree with that. I am an OB/GYN myself. I agree with what you are saying but I am certainly interested with the billions that we are spending on family planning through all areas of the Federal Government, what is our return on investment for that? Now, we already know, for example, that many of the people who are counted as uninsured actually have access to SCHIP, Medicaid, maybe even a COBRA program that they don't avail themselves of. And if you really scrutinize emergency room populations, you will come across those folks. So what is the evidence that providing these dollars in the family planning area gives us that benefit in child spacing?

Mr. HATHAWAY. Lots and lots of evidence. For every dollar spent on family planning services, there is about $4 or $5 saved——

Mr. BURGESS. And I would appreciate it very much because we are out of time if you could provide me references for those, I would be anxious to look at that.

Mr. HATHAWAY. I would be delighted. Thank you so much. Thank you.

Mr. BURGESS. Thank you very much.

I will yield back, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and recognizes the gentleman, Mr. Engel, for 5 minutes for the follow-up.

Mr. ENGEL. Thank you very much, Mr. Chairman.

First of all, I want to say that I respect people's consciences. This is a sensitive issue, and it is sensitive all the way around, and while I don't think anyone should be forced to provide services that morally they feel that they cannot do, I think conversely it works the other way as well. I think that people who make their own choices and their own decisions should not be impeded from getting the services that they want and they need. I think this is an important hearing to discuss this very important issue of coverage for preventive services. And I believe there have been many significant advances that the Affordable Care Act made in access to quality and affordable care for women.

I am sorry we have another hearing which seems designed to attack the significant advances that the Affordable Care Act made for women. HHS's final interim rule is a significant step in the right direction of providing women access to coverage to a whole range of healthcare needs that are very specific to women, and I applaud their efforts. I am just concerned once again we are undermining or attempting to undermine these benefits that women have. The cost that is placed on women in order to get access to all their healthcare needs is something that we ought to be concerned with.

And again with respect to the religious exemptions, I would say that the Department of Health and Human Services has made a significant effort to allow religious organizations to opt out of the requirements, to provide coverage for contraception. I support that. I don't think anyone should be forced to do it, but I think that works again both ways. I mean you need to be sensitive both ways.

So my first question is for Dr. Hathaway. HHS's interim final rule has already accounted for the concern of providing coverage for contraception. In your testimony, you mention that cost is a barrier for many women who cannot afford access to quality medical information. In your opinion, Doctor, what will be some of the most significant benefits for women who can now have access to coverage for preventive services?

Mr. HATHAWAY. You know, I am sitting here thinking some days I feel as though I am pretty passionate about this. There are other days that I wish I could be more passionate, and the only way I think I could do that is if I were a woman or a woman of color or a woman of lower social economic strata. And since I can't do that, I have to hope that I can present the voice that I try to do as best I can. Preventive healthcare, contraception care, family planning services are incredibly important for multitudes of women in our country, and I think we are fooling ourselves if we are not looking at the cost savings and the amount of despair we have put women into for years and years and years. We have moved to a whole different era of contraception. You know, this is a 50th anniversary of oral contraceptive pills and yet they have saved and helped many, many women for years throughout our country as well as many other countries, and yet we are in a different era. If I were to ask any of us in this room how easy it is to take a pill every day, most of us would say it is pretty darn difficult. Most women would say they would like to wait at least a year or more to avoid the next pregnancy or a pregnancy at all. And therefore, we ought to be able to help them. Whether it is private insurance or no in-

surance, we need to be able to help those women space and prevent the pregnancies when they want to.

Mr. ENGEL. So let me just follow up with that because you mention in your testimony—which is consistent with what you just said—that access to coverage for counseling, education, and contraception is very important for women of all socioeconomic backgrounds, but specifically, the women who cannot afford access. So what impact would efforts to roll back this interim rule have on women's health and what would a continued cost barrier mean for women who cannot afford the access to care?

Mr. HATHAWAY. Detrimental. I feel as though, you know, the women who are currently not using the most effective methods or have no access to any method at all are still going to struggle without this moving forward. I think the Institute of Medicine's recommendations are very, very strong and I applaud them. I think it is a wonderful move for our country.

Mr. ENGEL. Thank you, Dr. Hathaway.

Thank you, Mr. Chairman, and I yield back.

Mr. PITTS. The Chair thanks the gentleman.

That concludes the final round of questioning. I would like to thank the witnesses for your testimony today and this concludes today's hearing.

I remind members that they have 10 business days to submit questions for the record, and I ask that the witnesses please agree to respond promptly to these questions.

With that, thank you. The subcommittee is adjourned.

[Whereupon, at 12:21 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Questions for the Record

Response by David L. Stevens, MD, MA (Ethics)
CEO, Christian Medical Association

Committee on Energy and Commerce, Subcommittee on Health
United States House of Representatives

Response submitted December 5, 2011

Re: U.S. Dept. of Health and Human Services (HHS) preventive services rule

The Honorable Joseph R. Pitts

1. **Please indicate whether you are aware of any of the following alleged instances ever occurring in medicine or if you believe there is any reasonable basis to assume they would occur following enactment of conscience protection legislation:**
   a. **A physician refusing to refer a patient for alcohol or drug addiction services because the physician believes that use of alcohol or drugs is sinful?**
   b. **A physician refusing to treat HIV and AIDS patients because the physician expresses moral objections to homosexuality?**
   c. **A physician refusing to participate in blood transfusions because the physician is religiously opposed to this medical service even in an emergency situation?**
   d. **A physician refusing to treat or deliver the babies of unmarried pregnant women because the physician has a religious objection to premarital sex?**

Response to question

I am not aware of any instances where these alleged instances have occurred in the past and do not find any reasonable basis to assume they would occur following enactment of conscience protection legislation.

I and all the faith-based, pro-life health care professionals and institutions I know have endeavored to provide the best medical care possible to patients addicted to alcohol or drugs, to HIV and AIDS patients, and to unwed mothers.

The peculiar speculation that patients needing blood transfusions somehow will not be able to get them because of conscience rights is groundless and sadly indicative of the spurious attacks on conscience rights. I have never heard of any patient ever being denied the ability to get a blood transfusion on the basis of a conscientious objection by a health care professional or institution. The only group I am aware of that holds objections to blood transfusions is the Jehovah's Witnesses, a small sect outside of orthodox and mainstream Christianity. To my knowledge, there are no Jehovah's Witnesses hospitals. It stretches credulity to think that somehow a (very confused) Jehovah's Witness would choose a profession that routinely requires the provision of

blood transfusions and that this Jehovah's witness would somehow end up being the only individual in an entire hospital who could facilitate a blood transfusion.

Given the commitments, values and practices of the Christian Medical Association's over 16,000 members, it is equally unreasonable to assume that any of these speculated instances would somehow occur following enactment of conscience protection legislation--including, for example, H.R. 1179 (the Respect for Rights of Conscience Act), H.R. 361 (the Abortion Non-Discrimination Act), H.R. 358 (the Protect Life Act), or H.R. 3 (the No Taxpayer Funding for Abortion Act).

The assumptions behind the questions actually demonstrate a misrepresentation of the role of conscience rights in health care and an apparent misunderstanding of the faith-based medical community.

The federal conscience rights reflected in current law and proposed in H.R. 1179 protect health care professionals from being denied the right to make moral choices by being forced to participate in *procedures and prescriptions* they consider unethical. Neither current law nor pending current conscience protection legislation contain any language permitting health care professionals refusing to treat whole classes of *patients* who require medical treatment as a result of the patients' choices that the professional considers immoral.

For example, if H.R. 1179 were passed, it would amend the Patient Protection and Affordable Care Act (PPACA, Public Law 111-148; 42 U.S.C. 18022(b)) to apply conscience protections that will protect health care professionals and entities from being forced to participate in *procedures and prescriptions* they consider unethical. The bill explicitly retains consistency with PPACA's prohibition of discrimination against *patients* based on a wide range of factors including "age, disability, or expected length of life" and "present or predicted disability, degree of medical dependency, or quality of life." The bill does not provide any new opportunities whatsoever for anyone to discriminate against *patients* whose medical condition may be caused by a moral choice or lifestyle.

Regarding the role of conscience and the faith-based medical community, this singular principle prevails:

Moral conviction and compassion are inseparable.

The same conscientious moral commitment that prevents participation in life-ending procedures such as abortion also compels faith-based professionals and institutions to especially reach out in compassion to care for patients who do not adhere to the faith or follow faith-based moral commitments. This is why one finds so many faith-based professionals and institutions working with marginalized patients and in medically underserved areas.

In my practice as a faith-based medical professional, I and every faith-based medical colleague and institution I know of have compassionately and without discrimination cared for patients whose choices, including moral choices, have caused disease and damage.

We routinely and deliberately treat patients regardless of their faith and moral choices--choices which themselves often cause the need for treatment, such chronic smoking, alcohol abuse or

illicit drug use. Because I do not base the medical treatment I provide on the moral choices of my patients, I have personally treated--with an unwavering commitment to medical care quality--thieves, rapists, child molesters, murderers on death row and even those involved in genocide in Africa.

Conscience rights only would have impacted any of these instances if I had been asked to *facilitate or participate in* the patients' actions.

Because of my conscience convictions and medical ethics, I wouldn't hand out cigarettes to smokers or help an alcoholic find a bar. I wouldn't help a rapist avoid conviction by destroying DNA evidence or falsify a jailed murderer's symptoms to transfer him to a hospital to escape. I wouldn't give a drug addict a prescription for Oxycontin, and I wouldn't give a machete to a man involved in genocide in Kigali. If I did, I would be morally complicit in actions that I either consider morally wrong or medically ill-advised. My conscience and commitment to medical ethics standards prevents me from participating in such actions.

Additional comments

Despite my personal opposition to abortion, I have treated many women who have had an abortion. I have and will counsel women concerning abortion when asked telling them about the procedure, the complication rates, psychological effects and other alternatives--just as I do with any procedure.

But if I refer the patient for an abortion procedure, I become morally complicit. I facilitate and become a participant in the death of another human being. I endorse the morality and methods of the doctor I refer her to and enter into a professional relationship with that physician. That is something I cannot do.

In the same way, certain misclassified "contraceptives" work by causing the destruction of a developing human being by preventing the embryo's implantation in the womb ("Plan B") or by destroying its vital blood supply after implantation (Ella). I will not recommend, pay for or prescribe such an abortifacient.

Healthcare professionals are not claiming some new right. They simply want to exercise their right guaranteed for over 200 years under the First Amendment in the Bill of Rights. Its meaning is clear. Before it was made more concise in committee, James Madison worded it explicitly:

> "The Civil Rights of none shall be abridged on account of religious belief or worship, nor shall any national religion be established, nor shall the full and equal rights of conscience be in any manner, nor on any pretext infringed."

The new contraceptive insurance mandate infringes the constitutional right of conscience of millions of Americans, on the pretext that every woman has a "right" to contraceptives at no charge. Such a "right" is nowhere found in the Constitution.

Meanwhile, the constitutional rights of free exercise of religion, speech and association remain clear. Conscientious health care professionals only ask that these rights be clearly reflected in law.

Questions from the U.S. House of Representatives
Energy and Commerce Committee, Subcommittee on Health
December 13, 2011

Chairman Joseph R. Pitts
US House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515-6115

1. **Throughout your testimony you indicated that the mandate will help women of low income. You shared an anecdote about one of your patients, "Sarah." You indicated that Sarah is uninsured. Given that Sarah is uninsured, what benefit would the Interim Final Rule on Women's Preventive Services, as it relates to contraceptives, have for her?**

The Affordable Care Act provides a method for every uninsured American to gain access to health insurance coverage. All health plans, both publicly and privately sponsored, that will be made available to uninsured women, will be required to cover a comprehensive set of preventive health services including all FDA-approved contraceptives, the family planning visit, and the contraceptive counseling required to ensure women have the method that most effectively meets their health care needs.

The woman I identified in my testimony, Sarah, is a 22 year-old mother of two who currently lacks health insurance coverage. She is working two jobs to support her family and is struggling to make ends meet. As I testified, she could not afford the $300 intrauterine device she needed to help her prevent an unintended pregnancy. As a working mother, Sarah is likely to gain access to subsidized health insurance coverage under the ACA. However, because of her limited income she would still face difficulty accessing the contraception she needs because of the burdensome cost-sharing requirements currently required in health insurance plans.

Several studies show that even nominal cost-sharing can be a barrier to contraceptive access for many women. A 2004 national survey of women 18-44 who were using reversible contraception found that one-third of them would switch methods if cost was not a factor in their decision-making.[1]

[1] Jennifer Frost and Jacqueline Darroch, "Factors associated with contraceptive choice and inconsistent method use, United States, 2004," *Perspectives on Sexual and Reproductive Health*, 40 no. 2, (2008): 94-104.

The interim final rule implements the women's health preventive services requirement which will mean that Sarah can obtain the contraceptive services she needs without any additional cost to her and her family. This will allow her to prepare and plan for her future by accessing preventive health services that are important to her health.

2. **Was Sarah a recipient of Title X Services? Could you please clarify how much the US Government (USG) paid for Title X family planning services in the last year for which this data is available? Could you also provide the amount in total that the USG paid for family planning services in the latest year for which information is available? Should these funding levels change once the new contraceptive mandate goes into effect?**

Sarah received family planning services from Unity Health Care, a federally qualified health center in the District of Columbia and the Title X grantee for the Washington, DC metropolitan area. The Title X program provides resources to public health providers that allow them to offer free and reduced family planning services to uninsured and underinsured women and men. From its inception, Title X was designed to subsidize but not cover the full costs associated with family planning care -- in no case does Title X pay for the full cost of a patient visit or a clinician's time, for example. Sarah received family planning services at Unity Health Care which were supported in part by Title X funds. Patients do not receive Title X funds, the funds are provided to community health providers who can deliver the care.

(a) The Title X family planning program is an important public health program that over five million women and men rely on each year to access health services at more than 4,500 service delivery sites. For forty years, the Title X family planning program has provided quality confidential family planning services to millions of poor and low-income individuals who frequently lack access to any additional health care. Despite the fact that the program has been so successful, the Title X program sustained a 5.5% cut and was funded at $299.4 million in fiscal year 2011. In 2009 service delivery sites experienced an increase of more than 130,000 patients over 2008. ***This is the largest number of patients in the last 10 years,***[2] and stems from the worst recession the United States has seen in 70 years.

(b) In FY 2006, public expenditures for family planning services including Title X, the Medicaid program and revenue from other public health programs totaled $1.85 billion.[3] From FY 1980 through FY 2006 public funding for family planning services rose 18% (adjusted for inflation).[4] This figure represents a very small increase in expenditures.

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[2]RTI International, *Family Planning Annual Report: 2010 National Summary*, Office of Family Planning, Office of Population Affairs, September 2011.

[3] Adam Sonfield, Casey Alright and Rachel Benson Gold, *Public Funding for Family Planning Sterilization and Abortion Services FY 1980-2006*, Guttmacher Institute, January 2008.

[4] *Ibid.*

Incidentally, the **US taxpayer spends $11.1 billion annually on unintended pregnancy.**[5] This figure represents what the nation spends in Medicaid expenditures for pregnancy and infant care. The figure does not account for other medical and societal costs associated with unintended pregnancy. It should be noted that but for the investment the US government makes in family planning the cost to the taxpayer would be much higher. For every $1 spent on family planning saves almost $4 in Medicaid expenditures.[6] Study after study shows that investment in family planning services benefits millions of women. More than nine million low-income women rely on publicly funded family planning services enabling them to avoid almost two million unintended pregnancies.[7] In addition to reducing unintended pregnancy, publicly supported family planning has shown to benefit low-income women and their families by reducing interbirth intervals which are known to adversely impact birth outcomes.[8] For these reasons and many others not identified, the US government should be expanding not shrinking its investment in family planning.

3. **Following up on the line of questioning by Rep. Burgess regarding cost-analysis of different contraceptive methods, could you please provide the range of costs for FDA-approved contraceptives along with citations?**

Contraceptives can range in cost from as low as $1-$3 for condoms to as high as over $500 for the more effective long-acting reversible contraceptive methods such as the intrauterine device. Please find below the price estimates for Food and Drug Administration approved contraceptive methods.[9] The prices represent estimates based on surveys of Planned Parenthoods service delivery sites, family planning clinics, and various retailers, and are the cost of the method to patients without insurance coverage. The cost of each method may vary greatly depending on the specific brand of contraceptive, the insurance coverage and income of the patient, and the retailer, service provider, or pharmacy from which the method is purchased.

- Birth control patch - $45-50 (per month)
- Cervical cap - $55 plus fee for fitting (lasts up to a year)
- Depo-Provera - $75 (lasts three months)

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[5] Adam Sonfield, *The Public Costs of Births Resulting from Unintended Pregnancies: National and State-Level Estimates*, Guttmacher Institute.

[6] Jennifer Frost, Lawrence Finer and Athena Tapales, "The Impact of Publicly Funded Family Planning Clinic Services on Unintended Pregnancies and Government Cost Savings" *Journal of Health Care for the Poor and Underserved,* 19 no. 3 (July 2008).

[7] Rachel Gold, "Wise Investment: Reducing the Steep Cost to Medicaid of Unintended Pregnancy in the United States," *Guttmacher Policy Review,* 14 no. 3 (Summer 2011).

[8] *Ibid.*

[9] "Bedsider," National Campaign to Prevent Teen and Unplanned Pregnancy, accessed December 9, 2011.

- Diaphragm - $15-75 plus fee for fitting (lasts up to 10 years)
- Emergency contraception - $30-$55 (per use)
- Female condom - $3.50 from CVS (per condom)
- Implanon - $481 plus insertion fee (lasts up to three years)
- IUD - $450 to $550 plus insertion fee (lasts up to 10 years)
- Male condom - $0.18 - 1.83 (per condom)
- NuvaRing - $55 (per month)
- Oral contraceptive - $10-90 (per month)
- Sponge - $5-6 (per use)

In addition, please find attached two articles that outline the barrier that contraceptive costs can present to patients.

1. Mark Hathaway, "On the 50th Birthday of the Birth Control Pill, Looking Ahead to What's Next," *The Women's Health Activist*, (November/December 2010).
2. "Contraceptive Methods Available to Office-Based Physicians and Title X Clinics, United States 2009-2010," *Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention, (January 2011).

Thank you for the opportunity to respond to the Committee's questions. Please feel free to contact me for any further information that you may need.

Sincerely,

Dr. Mark Hathaway

Published on *National Women's Health Network* (http://nwhn.org)

On the 50th Birthday of the Birth Control Pill, Looking Ahead to What's Next

Women's Health Activist Newsletter
November/December 2010

By Mark Hathaway, MD, MPH

Happy 50th, Pills! You have really arrived in the world. Not only are you 50 years old, but many, many versions of you have come about in the last half century, and you've gotten better with age. Your accomplishments are impressive, and your unexpected benefits are equally notable. We salute and celebrate you, Birth Control Pills, but also hope you'll share the limelight in future years with some up-and-coming stars in the family planning world. These other players have great potential for women's health — if we can get them out into the public more broadly.

The ability to control fertility was a tremendous breakthrough. The impact for reproductive health in general, and for women's health and lives in particular, has been felt worldwide. The history of the birth control pill (or oral contraceptive pills [OCPs]) reaches back to the early part of the 20th century when Margaret Sanger, Planned Parenthood's founder, dreamed of a pill that would prevent pregnancy and be as easy to take as aspirin. Birth control pills were developed in the 1950s by scientist Gregory Pincus and physician John Rock, aided by advocacy and donations from Sanger and Katharine McCormick, one of the first women graduates of M.I.T. and heiress to a large fortune. The Food and Drug Administration (FDA) approved OCPs in 1960.

Today there are over 60 formulations of the Pill, containing varying amounts of estrogen and progesterone, and taken on varying cycles. In the last 50 years OCPs have become the number-one contraceptive for women in the U.S. The numbers vary slightly from year to year, but the top three birth control methods used in the U.S. today are OCPs (17.9%), female sterilization (16.7%), and condoms (13.9%).[1]

To be sure, oral contraceptives have many benefits even beyond contraception. The American College of Obstetricians and Gynecologists lists several in their evidence-based guidelines:

- Menstrual cycle regularity
- Decreased amount of menstrual bleeding
- Decrease in pain and mood swings with menses
- Decrease risk of several cancers (uterine, ovarian, colorectal)
- Improved acne symptoms.[2]

Make no mistake about it, the Pill works well for many women. If patients can get to a clinician, get a prescription, have the insurance or means to pay for OCPs, take them every day, get prescription refills, and keep paying for them, OCPs will be about 92 percent effective in preventing pregnancy. But for many women, that's a few too many ifs, hitches, barriers, and obstacles to overcome, and discontinuation rates and gaps in consistent daily use of OCPs are common, putting women at great risk for unintended pregnancy.

In the urban clinic system and hospital where I work, my colleagues and I see far too many unintended pregnancies. That's not unusual for this country. The percentage of U.S. pregnancies each year that are unintended, mistimed, or unwanted is a staggering 50 percent. That's three million unplanned pregnancies annually, an astonishingly high number in a country that has the knowledge and the means to prevent unintended pregnancies. One result is approximately 1.3 million abortions — almost half of the unplanned pregnancies end in abortion — and too many unwanted births. Some of our most vulnerable women — adolescents, young women in their 20s, and underinsured and/or uninsured women — have the highest rates of unintended pregnancy. Oral contraceptives (and condoms) are the most commonly used methods in this huge sector of our society; I think we're failing them by not providing them with a birth control method that is simpler, more effective, and doesn't require daily pill popping, and visits to clinics or pharmacies. In other words, we can and should do better.

This past week, a typical week in my practice, I saw three patients who asked for help with an unwanted pregnancy. One woman's story is particularly illustrative of the challenges women face around OCPs. At her appointment, "Molly" described to me that she had recently given birth. At her postpartum appointment, she was given a free package of brand-name birth control pills (we'll call them YAZ), and a prescription for six more months of pills. But, her insurance was deactivated because she had stopped working in order to stay at home with her newborn; she quickly discovered that YAZ cost $65 per cycle. She couldn't get through by phone to her doctor to find something cheaper, couldn't get into another clinic for a visit, and couldn't afford the $65 cost to refill her prescription. Five weeks later she was pregnant and in our clinic in tears.

What's distressing about this story is that Molly was clear, at least with me, that she had wanted to avoid pregnancy for at least three to four years. That's a lot of pills to take and a lot of hurdles to jump through for 3-4 years to prevent an unintended pregnancy! She wasn't aware of other methods and her provider failed to discuss them with her. As Molly found, birth control pills can be prohibitively expensive. They are also not the right answer for everyone. Some women want to avoid exposure to hormones in the Pill, while others worry about its side effects, such as blood clots in certain populations. (It should be noted, pregnancy has many more risks than almost any birth control method.)

For the past 30-50 years relying on OCPs as a birth control method for women like Molly who do not want to get pregnant in the near-future may have been acceptable because we didn't have other options for highly effective and reversible methods. But not now. Today, there are many simpler and more effective methods that can better meet Molly's needs and reproductive life plans than OCPs do. Specifically, long-acting reversible contraception (LARC), a category of birth control that includes two types of intrauterine devices (IUDs), and the single rod hormonal implant (SRHI).

The advantages of LARC methods are that they:

- Do not interrupt the sexual encounter and there's nothing to remember every day.
- Are highly effective (99.2% efficacy or greater) [3]
- Offer the highest rates of both continuation and user satisfaction
- Do not require "resupply" prescriptions or frequent office visits
- Are reversible, with a rapid return to fertility after their removal
- Are suitable for long-term usage (up to7-12 years for the IUD and up to 3 years for the implant)
- Are safe for almost all women, even those who cannot take the Pill because of other medical conditions

Although IUDs and the implant have high up-front costs and necessitate the need for office visits for insertion and removal, their cost effectiveness surpasses all other reversible methods, even over relatively short-term use of 12-24 months. [4] Despite these benefits, IUDs get little attention in the U.S., although they are popular in most other parts of the world. And the implant, first introduced in the U.S. in 2006, is still relatively unknown and underutilized.

So, although LARC methods are safe, more effective, longer lasting, simpler, and more cost-effective when compared to OCPs, they represent only 2-4% of contraceptive methods used in the U.S.[4] Underuse can be attributed to multiple factors, including negative myths about these methods, limited advertising, a dearth of trained clinicians, and poor reimbursement from government funding sources and insurers.

In addition, medical providers are much at fault for the slow uptake of LARC methods, partly due to overly restrictive criteria they place on IUD use. A recent patient told us that she had called three ob-gyn offices seeking a gynecologist who would provide her with an IUD. "Maggie" is 28 years old and has never been pregnant. She was told that she could not use an IUD because she had never been pregnant. The myth here is that IUDs might cause infertility, but current evidence indicates there is no increased risk of pelvic inflammatory disease or infertility among IUD users. This myth lingers, but the fact is that modern IUDs may be safely used by almost all women of reproductive age. We saw Maggie and, in one visit, inserted her IUD through a procedure that is only a touch more uncomfortable than a Pap smear and takes just 30-60 seconds longer. Maggie now has one of the most effective, reversible contraceptive methods in place.

Little by little, we're improving the use of LARC methods; I imagine much the same process occurred 50 years ago when birth control pills were so novel. But, the potential health benefits of

LARC methods for women are far too important to wait on. They could make a large dent in the astoundingly high rates of unintended pregnancy in our country, if only they were better promoted and utilized. Let's not wait another 50 years to celebrate such effective birth control methods.

Mark Hathaway, MD, MPH, is the Director of Community Programs for Washington Hospital Center's Obstetrics and Gynecology Department. This work involves directing Obstetrics and Gynecology services at Unity Health Care, Inc., a system of 14 community health centers throughout Washington, DC. The Washington Hospital Center was recently awarded a Family Planning Fellowship, which Dr. Hathaway will co-direct. He has recently been elected to the Board of Directors of the Association of Reproductive Health professionals (ARHP).

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Centers for Disease Control and Prevention

MMWR

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Contraceptive Methods Available to Patients of Office-Based Physicians and Title X Clinics — United States, 2009–2010

Unintended pregnancies, which accounted for an estimated 49% of all pregnancies in the United States in 2001, more often are associated with adverse outcomes for both mother and child than are intended pregnancies (*1*). In 2008, an estimated 36 million U.S. women of reproductive age were in need of family planning services because they were sexually active, able to get pregnant, and not trying to get pregnant; this represented a 6% increase from year 2000 estimates (*2*). To assess the provision of various reversible contraceptive methods by U.S family planning providers, CDC mailed a survey on contraceptive provision to random samples of 2,000 office-based physicians and 2,000 federally funded Title X clinics. This report summarizes those results, which indicated that a greater proportion of Title X clinic providers than office-based physicians offered on-site availability of a number of methods, including injectable depot medroxyprogesterone acetate (DMPA) (96.6% versus 60.9%) and combined oral contraceptive pills (92.1% versus 48.8%). However, a greater proportion of office-based physicians than Title X clinic providers reported on-site availability of the levonorgestrel-releasing intrauterine device (LNG-IUD) (56.4% versus 46.6%). Less than maximal use of long-acting, reversible contraceptive methods (LARCs), including IUDs and contraceptive implants, might be a contributing factor to high unintended pregnancy rates in the United States (*3*). Improving contraceptive delivery by increasing on-site availability in physicians' offices and clinics of a range of contraceptive methods, including LARCs, might increase contraceptive use and reduce rates of unintended pregnancy.

From December 2009 to March 2010, CDC conducted a mailed survey on contraceptive provision to random samples of 2,000 office-based physicians and 2,000 federally funded Title X clinics. Office-based physicians were sampled from the American Medical Association (AMA) Physician Masterfile, which includes information on AMA member and nonmember physicians residing in the United States and select territories. Three primary specialties were included: obstetrics/gynecology, family medicine, and adolescent medicine. Title X clinics, which can represent a range of provider agencies (e.g., public health departments, Planned Parenthood affiliates, hospitals, and community health centers), were sampled randomly from a current directory of Title X clinics maintained by the U.S. Department of Health and Human Services' Office of Population Affairs. Office-based physicians and one provider from each Title X clinic were eligible to participate if they provided family planning services* to women of reproductive age at least twice per week.

The survey included questions on contraceptive method availability and determined whether specific reversible contraceptive methods were 1) directly available to clients on-site, 2) available by prescription (or recommendation, for condoms), 3) available by referral, or 4) not available. For providers reporting multiple categories of availability for a single method (e.g., on-site and by prescription), availability

* A family planning service was defined as any service related to postponing or preventing conception and could include a medical examination related to provision of a method, contraceptive counseling, or method prescription or supply visits. A patient could receive a family planning service even if the primary purpose of her visit was not contraception.

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was classified according to the most accessible availability category (i.e., on-site, by prescription, or by referral to other providers, respectively). Surveys were pilot tested with physicians representing each targeted specialty, nurse practitioners, certified nurse midwives, and epidemiologists. Survey packets included a cover letter with signatures of support from key partner agencies and organizations. The initial survey mailing was followed by a reminder post card and a second survey mailing to nonresponders. Additional, systematic efforts to contact nonresponders were made by telephone.

Of the 2,000 office-based physicians sampled, 628 were excluded because they did not meet the eligibility criteria or could not be located. Of the 2,000 Title X clinics sampled, 334 were excluded because their providers did not meet the eligibility criteria, the clinic was closed, or it could not be located. After accounting for ineligibility, the response rate was 47.0% for office-based physicians and 78.5% for Title X clinic providers. The final sample included 635 office-based physicians and 1,368 Title X clinic providers.

A significantly higher proportion of Title X clinic providers than office-based physicians reported on-site availability of all methods ($p<0.05$), except the LNG-IUD, for which on-site availability was reported by 56.4% of office-based physicians and 46.6% of Title X clinic providers (Table). In contrast, a higher proportion of office-based physicians than Title X clinic providers reported prescribing or recommending each contraceptive method rather than having it available on-site, especially combined oral contraceptives (50.4% versus 6.9%), progestin-only oral contraceptives (70.9% versus 17.4%), DMPA (36.4% versus 2.6%), the contraceptive patch (60.5% versus 29.0%), and male condoms (60.8% versus 2.9%). The proportion of Title X clinic providers and office-based physicians who reported referring patients to other providers for contraceptive methods was low (≤8.0%), except for LARCs (including the copper IUD, 29.6% and 25.2%, respectively; LNG-IUD, 37.9% and 24.6%, respectively; and contraceptive implants, 44.5% and 40.0%, respectively. Few family planning providers indicated that specific contraceptive methods were unavailable to their patients; female condoms and implants most frequently were reported as unavailable by office-based physicians (17.8% and 8.0%, respectively) and Title X clinic providers (9.9% and 9.2%, respectively).

Reported by

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Editorial Note

Despite advances in contraceptive technology, the proportion of U.S. pregnancies that are unintended has remained relatively stable at approximately 50% (*1*). High unintended pregnancy rates in the United States are thought to result, in part, from lesser use of LARCs, which are highly effective (<1% typical use failure rates), compared with more commonly used methods, such as male condoms (15% typical use failure rate) and oral contraceptives (8% typical use failure rate) (*3*). LARCs are more effective at preventing unintended pregnancies during

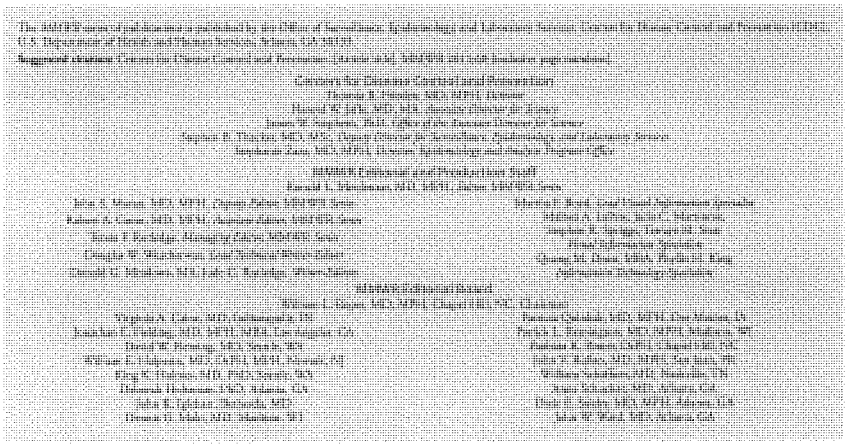


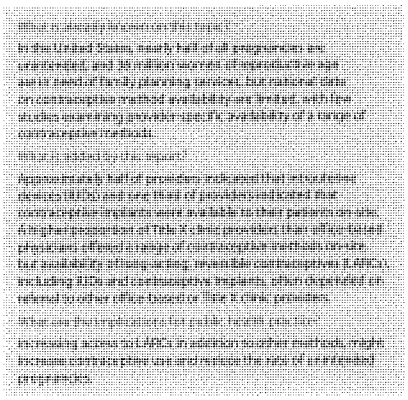
TABLE. Availability of reversible contraceptive methods to patients of office-based physicians and Title X clinic providers* — United States, 2009–2010†

Contraceptive method§	Directly available on-site	Available by prescription¶	Available by referral to other providers	Not available
	%	%	%	%
Levonorgestrel-releasing intrauterine device (LNG-IUD; Mirena)				
Office-based physicians	56.4	16.2	24.6	1.9
Title X clinics	46.6	9.6	37.9	3.8
Copper intrauterine device (ParaGard)				
Office-based physicians	53.5	15.8	25.2	2.8
Title X clinics	59.7	7.4	29.6	2.0
Implant (Implanon)				
Office-based physicians	32.0	13.2	40.0	8.0
Title X clinics	35.7	6.7	44.5	9.2
Depot medroxyprogesterone acetate (DMPA; Depo-Provera)				
Office-based physicians	60.9	36.4	1.6	0.2
Title X clinics	96.6	2.6	0.2	0.2
Combined oral contraceptives				
Office-based physicians	48.8	50.4	0.0	0.2
Title X clinics	92.1	6.9	0.2	0.2
Progestin-only oral contraceptives				
Office-based physicians	24.9	70.9	1.4	1.1
Title X clinics	78.3	17.4	1.1	1.4
Patch (Ortho Evra)				
Office-based physicians	29.1	60.5	1.7	4.9
Title X clinics	56.9	29.0	7.5	4.8
Vaginal ring (NuvaRing)				
Office-based physicians	43.0	52.3	3.3	0.5
Title X clinics	58.1	28.9	8.0	3.5
Male condom				
Office-based physicians	26.3	60.8	2.4	5.5
Title X clinics	95.6	2.9	0.3	0.4
Female condom				
Office-based physicians	7.1	47.9	6.5	17.8
Title X clinics	49.4	24.9	6.7	9.9

* Total = 2,003; office-based physicians = 635; Title X clinic providers = 1,368.
† Percentages might not sum to 100% because of missing or "not applicable" responses.
§ Classifications of contraceptive method availability were mutually exclusive.
¶ Male and female condoms were available by recommendation.

typical use than user-dependent methods (e.g., condoms and oral contraceptives) because they require only a single act of insertion for long-term use and eliminate the influence of adherence on effectiveness. Access to a range of contraceptive methods, including LARCs, might increase contraceptive use but might be impeded by cost, provider knowledge and training, or other factors (*4*).

Results of this national survey indicate variation in the availability of specific contraceptive methods by method type and by clinical setting, with a higher proportion of Title X clinic providers than office-based physicians offering a range of contraceptive methods on-site. Oral contraceptives, the most commonly used reversible contraceptive method among U.S. women (*5*), were available on-site from nearly all Title X clinic providers, whereas approximately half of office-based physicians had them available on-site and half had them available by prescription. Male condoms, which provide protection against both unintended pregnancy and sexually transmitted infections, were available on-site in nearly all Title X clinics but only in one quarter of physicians' offices. Availability of LARCs, which require insertion by a trained health-care provider, often depended on referral to other providers. Approximately one quarter of office-based physicians and nearly one third of Title X clinic providers referred clients to other providers for IUDs, and both often referred clients seeking implants to other providers, which could impede use of these contraceptive methods.



This is believed to be the only national survey to report on-site availability of specific contraceptive methods apart from availability though prescription or provider recommendation. Other studies on contraceptive method availability examined on-site availability in combination with prescription or provider recommendation (*6,7*), or examined on-site availability but combined all hormonal methods into one category (*8*). The findings are comparable to those of previous studies that found that contraceptive method availability either from on-site provision or through prescription or provider recommendation was highest for oral contraceptives and lower for the patch, IUD, and vaginal ring (*6–8*).

Differences in the availability of specific contraceptive methods might reflect variation in factors such as the reimbursable cost for each method (e.g., LARCs) (*7*), clinic or practice type and associated mandates (e.g., health department versus Planned Parenthood clinic) (*7,9*), federal and state policies (*9*), provider training in contraceptive implant or IUD insertion (*8*), health insurance coverage, and patient characteristics (*8*). For example, on-site availability for a range of contraceptive methods might be greater through Title X clinic providers than through office-based physicians because of 1) the federal Title X mandate to provide a broad range of contraceptive methods to all women, and 2) the larger proportion of patients seen at Title X clinics who are in need of contraceptive services (*10*). Additionally, social and demographic differences in patient population or a broad practice scope for office-based physicians could translate to fewer women seeking family planning services in these settings and might have led to lower on-site availability.

The findings in this report are subject to at least three limitations. First, although the 47.0% response rate for office-based physicians was similar to that of another physician provider survey (*6*), the rate was considerably lower than the response rate for Title X clinic providers (78.5%). Potential differences between respondents and nonrespondents in contraceptive method availability could not be determined. Second, the survey did not ascertain reasons for certain contraceptive methods being unavailable. Finally, although Title X providers might indicate that specific methods are available on-site, certain methods (e.g., LNG-IUD) are not available consistently to all clients because of high costs. Clinics or practices might opt to offer less expensive methods to some persons to have funds to serve a greater number of clients (*7*).

Descriptions of reversible contraceptive method availability among office-based physicians and Title X clinic providers can help guide practice, financing, and policy efforts aimed at improving contraceptive delivery. Reducing barriers to accessing a range of contraceptive methods, including LARCs, might reduce rates of unintended pregnancy in the United States.

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Local Health Department Costs Associated with Response to a School-Based Pertussis Outbreak — Omaha, Nebraska, September–November 2008

Pertussis is a highly infectious, vaccine-preventable respiratory illness. With the advent of a vaccine, case numbers fell in the United States from a high of 265,269 in 1934 (*1*) to a low of 1,010 cases in 1976, but then resurged to 25,827 in 2004. During 2004–2008, the average was 18,161 cases per year (*2,3*). Close contacts of persons with pertussis are at increased risk for developing infection and are recommended to receive preventive antibiotics (*4*) for two reasons: 1) the illness can be debilitating, with cough lasting several weeks and sometimes being severe enough to cause urinary incontinence, rib fracture, or other complications; and 2) the illness can be fatal in infants; it caused an average of 17 deaths each year during 2002–2006 (*3*). During pertussis outbreaks, the resources needed to identify and treat contacts can strain local public health resources (*5*). The Douglas County Health Department (DCHD) in Omaha, Nebraska, responded to a school-based pertussis outbreak with 26 cases occurring in late 2008. To assess the costs incurred by a local health department responding to such an outbreak, DCHD and CDC evaluated the total resources used by DCHD. This report describes the results of that analysis, which indicated that 1) staff members reported 1,032 person-hours spent responding to the outbreak, and 2) the total cost of outbreak response, including overhead, labor, travel, and other costs, was $52,131 (measured in 2008 U.S. dollars). The majority of costs (59%) occurred during an intensive 10-day period, when most of the contact tracing and prophylaxis recommendations were made. The elevated incidence of pertussis and the burden of response placed on health departments warrants exploring the impact of alternative response and chemoprophylaxis strategies.

On September 26, 2008, DCHD was notified of a student, aged 5 years, with a diagnosis of pertussis. The student attended a private school with approximately 600 other students in kindergarten through 12th grade. DCHD followed pertussis response protocols in which close contacts were identified and contacted. In keeping with CDC pertussis response guidelines, DCHD recommended chemoprophylaxis for close contacts, defined as persons who had direct face-to-face contact with an ill person, or shared a confined space with an ill person for more than 1 hour, or had direct contact with respiratory, oral, or nasal secretions from a symptomatic person (*4*). DCHD also recommended that the school exclude persons with a cough from school until they were evaluated by a doctor. After four additional cases were reported in the school on October 28, DCHD further recommended that students with cough be excluded from school until evaluated by a physician and either treated or determined not to have pertussis.

On November 17, CDC investigators were deployed at the request of DCHD to assist with the response and data analysis and assess the cost to the health department for its response. Cost data were obtained in a three-step process. First, DCHD management personnel were interviewed to determine the temporal course of the outbreak and response, the number of staff members involved in the response, and the health department's operating costs, including labor and overhead. Second, a survey instrument was created and distributed to DCHD personnel to assess time spent performing various activities during the outbreak response. The survey was voluntary and de-identified. Each survey was confidentially matched with the corresponding salary and fringe benefit rate obtained from accounting staff. Third, cost figures were calculated by multiplying hours worked by salary plus the fringe benefit rate, then adding travel and overhead expenses.* Cost was summed by operating division and compared with the division budget to determine the proportion of the total operating budget required for this outbreak response.

To assess the cost to DCHD during different phases of the response, data were split into three periods: 1) the initial period, from the first case notification to the declaration of the outbreak (September 26–October 26); 2) the outbreak period, when most of the cases were reported and DCHD worked to update control measures (October 27–November 5); and 3) the follow-up and reporting period, when DCHD implemented new control measures and observed reduced incidence of disease (November 6–21). Also, cost was separated by four DCHD divisions involved in the outbreak: Administration, Epidemiology, Data, and Media Relations.† Finally, labor cost was calculated by period and division as a percentage of the total DCHD labor budget. Labor cost as a proportion of labor budget was used to determine how many personnel in each division worked on the outbreak during that period. For example, a percentage of 100% would mean that the division spent all available personnel resources on the outbreak.

* Amortized from an annual rate per full-time employee by the number of hours worked on the outbreak in the following categories: information technology, telephone, and facilities rental expenses.

† DCHD had 113 employees, with seven administrators, eight members of the Epidemiology Division, three employees in the Data Division, and two media relations officers. Other divisions not involved in the outbreak (that incurred no cost) were the Community Health and Nutrition (40 employees), Environmental Health (33 employees), and Administration and Business Finance divisions (four employees).

To classify staff time, the survey captured several time categories, including investigation, communication, decisions and implementation, and "other." The categories were derived from interviews with health department staff members before conducting the survey. Investigation included all activities related to identifying contacts (contact tracing), following up with potential close contacts, analysis of epidemiologic data, other investigation, and record keeping. Communication time was divided among physicians, parents, school, and the media. Decisions and implementation were activities related to coordination of control measures during the outbreak. Specifically, these involved meetings to discuss how to identify close contacts, whether or not to exclude anyone with a cough from school, and "other." The "other" category included meetings with parents of school children and travel time.

In total, 26 laboratory-confirmed pertussis cases occurred (in 24 students and two staff members) (Figure). Two of the 26 cases were identified after the survey was conducted, and the costs associated with them were not included in the analysis. DCHD recommended chemoprophylaxis for 148 close contacts. DCHD staff members contributed 1,031 person-hours to control the outbreak during the period observed (Table 1). Outbreak cost totaled $52,131, or approximately $2,172 per case, which was nearly 1% of DCHD's annual program budget, excluding grants and external funding sources. Each case of pertussis required nearly 42 regular person-hours and approximately 1 hour of overtime. The time spent investigating a pertussis case included tracing of all close contacts, and each pertussis case led to an average of 21 telephone calls and chemoprophylaxis recommendations for six close contacts (range: zero to 70). DCHD did not pay for antibiotics or laboratory testing.

Of the total cost, the largest components were investigations (37.2%) and decisions and implementation (22.9%). Resource use was most intensive during the outbreak period for all divisions (Table 2). The most heavily affected divisions were Epidemiology (156% of budgeted hours), Administration (46%), and Media Relations (41%).[§] The Epidemiology Division's 156% resource use reflected overtime and compensation hours worked during the outbreak period. In total, staff members reported 28 hours of overtime with the largest component of overtime allocated to investigation-related activities.

Reported by

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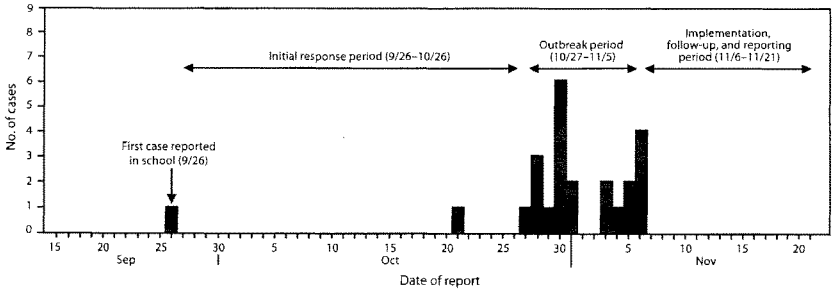
Editorial Note

This pertussis outbreak in Omaha in 2008 was resource-intensive and expensive for the local health department, with total costs estimated at $52,000 and 1,000 hours of staff time committed to the outbreak. Beyond the direct costs measured by the survey, the outbreak affected other projects and public health priorities of DCHD. Many staff members stopped working on their previous projects to work on the outbreak; although most staff members were able to return and complete

[§] Whereas some health departments split epidemiology and disease control functions, the DCHD Epidemiology Division is responsible for both, which might increase their resource use relative to other health departments that separate these functions.

FIGURE. Number of pertussis cases (N = 26*), by date reported — Omaha, Nebraska, September–November 2008



* Two cases identified after November 21 were excluded from the cost analysis because they were reported after the survey completion date.

TABLE 1. Costs* associated with a pertussis outbreak, by type of cost — Douglas County Health Department, Omaha, Nebraska, September–December 2008

Type of cost	Hours worked		Cost ($) by activity†		Mean cost ($) per hour		Total	
	Regular	Overtime	Regular	Overtime	Regular	Overtime	Cost ($)	% of total cost
Investigation								
Identifying contacts	128.6	3.0	4,324	133	34	44	4,458	8.6
Follow-up with contacts	57.9	1.0	1,950	44	34	44	1,994	3.8
Analysis of data	155.0	3.0	8,024	165	52	55	8,189	15.7
Other investigation	18.0	4.0	557	203	31	51	761	1.5
Record keeping	111.8	1.7	3,882	87	35	52	3,968	7.6
Subtotal	471.3	12.7	18,737	633			19,370	37.2
Communication								
Communications with school	80.1	0.5	2,635	39	33	78	2,674	5.1
Communications with physicians	41.8		1,459		35		1,459	2.8
Communications with laboratory	15.5	3.0	512	222	33	74	734	1.4
Media relations and public inquires	85.5	4.8	3,150	221	37	46	3,372	6.5
Subtotal	222.8	8.3	7,756	482			8,238	15.8
Decisions and implementation								
Making decisions	103.7		4,375		42		4,375	8.4
Developing recommendations	88.5	1.5	3,584	111	41	74	3,695	7.1
Writing letters, press releases, and reports	96.2		3,860		40		3,860	7.4
Subtotal	288.4	1.5	11,819	111			11,930	22.9
Other								
Meeting with parents at school	15.5	5.0	611	377	39	75	988	1.9
Travel	5.5	0.5	229	39	42	78	268	0.5
Subtotal	21.0	5.5	840	416			1,256	2.4
Total labor costs	1,003.5	28.0	39,152	1,642			40,794	78.3
Non-labor costs								
Travel (97 miles)							54	0.1
Telephone, information technology, and rent§							1,905	3.7
Department and county overhead							9,379	18.0
Total non-labor costs							11,337	21.7
Total cost							52,131	100.0

* All costs measured in 2008 U.S. dollars.

† Labor cost is measured by each individual employee's hours worked multiplied by their salary plus fringe benefit rate and then summed over all individuals for each activity. Overtime hours include nonpaid extra hours worked and are valued at 1.5 times the regular salary.

§ Amortized from an annual rate per full-time employee by the number of hours worked on the outbreak in the following categories: information technology, telephone, and facilities rental expenses.

their projects, DCHD staff members reported a total delay of 83 days on those projects. Staff members reported greater than usual stress resulting from balancing or delaying competing priorities. For example, staff members worked extra hours to respond to a tuberculosis case identified during the outbreak. Had the pertussis outbreak not occurred, staff members would have handled the tuberculosis case during regular working hours.

Such evaluations of public response costs to disease are rare in the literature. One other report evaluated the cost to a state health department responding to a measles outbreak in 2004 (*6*). Using a similar cost evaluation method, the authors found a very high cost of response (approximately $60,000 for one case).

When responding to the outbreak, the major costs to this health department were investigation of cases and decisions and implementation of updated chemoprophylaxis guidelines.

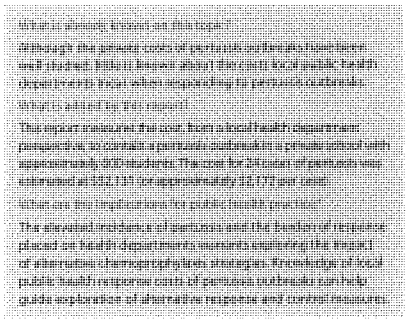


TABLE 2. Labor costs* associated with a pertussis outbreak, by division and response period — Douglas County Health Department, Omaha, Nebraska, September–December 2008

Division	Initial response period (9/26–10/26)	Outbreak response period (10/27–11/5)	Implementation, follow-up, and reporting period (11/6–11/21)	Total response period (9/26–11/21)
Administration (three employees)				
Labor hours	1.9	50.9	17.3	**70.0**
Labor cost ($)	126	3,916	954	**4,997**
Available labor budget ($)	22,159	8,441	12,662	**43,263**
% available labor budget	1	46	8	**12**
Epidemiology (four employees)†				
Labor hours	95.4	513.3	279.1	**887.8**
Labor cost ($)	2,960	24,931	15,441	**43,332**
Available labor budget ($)	63,533	16,011	36,304	**115,848**
% available labor budget	5	156	43	**37**
Data (three employees)				
Labor hours	6.2	6.3	6.2	**18.7**
Labor cost ($)	334	334	344	**1,012**
Available labor budget ($)	17,152	6,534	9,801	**33,488**
% available labor budget	2	5	4	**3**
Media relations and health advisor (two employees)				
Labor hours	12.4	30.3	12.4	**55.0**
Labor cost ($)	345	879	345	**1,568**
Available labor budget ($)	5,678	2,163	3,245	**11,086**
% available labor budget	6	41	11	**14**
Total health department				
Labor hours	115.8	600.8	314.9	**1031.5**
Labor cost ($)	3,764	30,060	17,084	**50,909**
Available labor budget ($)	108,523	33,150	62,013	**203,686**
% available labor budget	3.5	90.7	27.5	**25.0**

* All costs measured in 2008 U.S. dollars.
† Eight staff members worked in the Epidemiology Division. However, four members were absent during the outbreak phase for a training program. Therefore, only the hours for four staff members were used in this analysis.

Within these two components, data analysis, tracing contacts, and determining the appropriate close contact definition required the most time of health department personnel. Other health departments have employed guidelines that target tracing and chemoprophylaxis of contacts (*7*). Adoption of such targeted chemoprophylaxis strategies might streamline notification procedures and result in more efficient and complete notification of contacts at risk for severe or fatal disease, including infants (*7*). However, the effectiveness of targeted versus wider chemoprophylaxis remains to be determined.

The findings in this report are subject to at least three limitations. First, this report focused on the direct public cost incurred by a local health department in response to a pertussis outbreak. The private costs of pertussis, including those costs borne by patients, persons recommended chemoprophylaxis, health-care providers, or institutions, were not analyzed in this study. However, private costs of pertussis are well studied elsewhere and can be substantial (*8,9*). Second, although this report measured the total delay in projects resulting from the outbreak, it did not measure the type or number of projects delayed. Future cost analyses also should measure the "opportunity cost" of outbreaks in more detail. Finally, although these data offer a picture of public health cost when responding to an outbreak, they only reflect the resource use of one health department and might differ for other health departments. For example, health departments that pay for laboratory testing and antibiotic courses for patients would incur additional costs.

Costs of response to pertussis outbreaks can be substantial. Investigations and developing recommendations were the most resource-intensive aspects of this outbreak for the local health department. The elevated incidence of pertussis and the burden of response placed on health departments warrants exploring the impact of alternative response and chemoprophylaxis strategies.

Acknowledgments

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Progress in Immunization Information Systems — United States, 2009

An immunization information system (IIS) is a confidential, computerized, population-based system that collects and consolidates vaccination data from vaccine providers and provides tools for designing and sustaining effective immunization strategies at the provider and program levels. Among the capabilities of an IIS are the capacity to inform vaccine providers of upcoming patient vaccination needs; generate vaccination coverage reports, patient reminders, or recalls for past due vaccinations; and interoperate with electronic health record (EHR) systems. In 2010, the Task Force on Community Preventive Services recommended that immunization information systems be used to increase vaccination coverage after showing strong evidence of their effectiveness (*1*). A *Healthy People 2020* objective is to increase to 95% the percentage of children aged <6 years whose immunization records are housed in a fully operational IIS (*2*). To assess IIS progress toward meeting the *Healthy People* objective, CDC analyzed data from the 2009 Immunization Information Systems Annual Report (IISAR) survey (completed by 53 of 56 federal grantees with IIS sites), which indicated that 77% of all U.S. children aged <6 years participated in an IIS, an increase from 75% in 2008 (*3*). In addition, 59% of grantees reported being able to send and receive vaccination data using Health Level Seven (HL7) messaging standards, and 73% reported that some vaccine providers with EHR systems in their geographic area were providing vaccination data directly to an IIS from EHRs. Enhancing IIS and EHR with standards such as HL7 will provide greater consistency in data exchange and likely help to improve the quality and timeliness of IIS data.

To monitor progress toward IIS program objectives, CDC annually surveys 56 IIS grantees (50 states, five cities,* and the District of Columbia) via IISAR. In 2009, 53 (95%) of the 56 grantees completed the IISAR survey (Kentucky and Massachusetts were implementing a new IIS and did not have data to report; New Hampshire elected not to implement an IIS). The self-administered survey asks about vaccination coverage for all age groups, provider participation in IIS, and IIS functionality (e.g., managing vaccine inventory in the vaccine provider office, EHR communication with IIS, and conducting vaccine provider assessments using IIS).

Participation in an IIS

The percentage of children aged <6 years whose immunization records were housed in a fully operational IIS was calculated for each of the 56 grantees. The calculations were made by dividing the number of children participating in an IIS by the 2009 midyear U.S. Census projection of the population of children aged <6 years for that grantee geographic area.

In 2009, of the 53 responding grantees, 23 (43%) reported that >95% of children aged <6 years in their geographic area were participating in an IIS. Ten (19%) of the 53 reported participation ranging from 80% to 94% (Figure) (*3*). Overall in the United States, approximately 77% of children aged <6 years (18.4 million) participated in an IIS in 2009 (a small but statistically significant increase from 75% in 2008 [*3*]).

IIS Adherence to Standards

In 2001, the Technical Working Group of the National Immunization Program established 12 standards regarding the minimum technical functions an IIS should implement (*4,5*). Three of these standards were considered for this report: 1) electronically store data on all 17 core data elements recommended by the National Vaccine Advisory Committee (NVAC), 2) receive and process immunization information within 1 month of vaccine administration, and 3) exchange immunization records using HL7 standards, which allow for efficient transfer of records and data de-duplication within systems (*6*). To assess adherence to these three standards, data were analyzed from 51 of the 56 grantees (Chicago, Houston, Kentucky, Massachusetts, and New Hampshire were excluded) in 2009 and compared with data from 52 grantees in 2008.

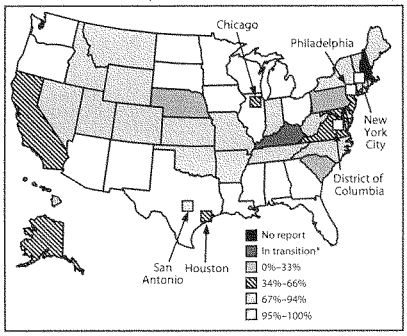
In 2009, six of the 17 NVAC-recommended core data elements (i.e., first name, last name, birth date, sex, vaccine type, and vaccination date) had completion rates of ≥97% for children aged <6 years, a result similar to findings in 2008 (Table). In addition, nine of the remaining 11 core data elements showed increases in completion rates from 2008 to 2009.

Regarding the other standards, 70% of IIS data were received and processed within 1 month of vaccine administration, an increase from 67% in 2008 (*3*). Also, 30 (59%) of the 51 grantees reported the ability to send and receive HL7 messages, four (8%) grantees reported partial ability to meet HL7 capability by either sending or receiving messages, and 17 (33%) grantees reported having no HL7 functionality.

In 2009, 37 (73%) of 51 grantees reported that at least some vaccine provider–site EHR systems were providing immunization data directly to an IIS. A total of 3,618 provider-site EHR systems provided immunization data directly to a grantee IIS, compared with 1,848 in 2008. Of these 3,618 systems, 2,797 (77%) were among the 33 grantees with >80% child participation.

* Chicago, Illinois; Houston and San Antonio, Texas; New York, New York; and Philadelphia, Pennsylvania.

FIGURE. Percentage of children aged <6 years participating in a grantee immunization information system — 50 states, five cities, and District of Columbia, 2009



* Grantee is implementing a new IIS project.

Reported by

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Editorial Note

Despite some progress in increasing the proportion of children aged <6 years whose immunization records are housed in an IIS, challenges remain to successful IIS implementation, such as resource costs to vaccine providers, and quality of data. Some challenges are being addressed through efforts to enhance interoperability of EHR and IIS, increase use of HL7 messaging, and offer vaccine provider incentives. These interventions can help 1) reduce the time from vaccine administration to inclusion of data in an IIS record, 2) reduce dual data entry by vaccine providers because vaccination data will only be entered into the EHR and then exchanged with the IIS using HL7 messaging, and 3) increase completeness of immunization information (core data elements and vaccination data) by adding data not collected previously by an IIS.

Provisions of the Health Information Technology for Clinical and Economic Health (HITECH) Act (*7*) are intended to accelerate adoption of nationally certified EHR systems, standardize EHR products, support growth in the health information technology workforce, and facilitate secure exchange of health data between disparate partners. A centerpiece of the HITECH Act is the EHR Incentive Program (*8*), administered by the Centers for Medicare and Medicaid Services (CMS). CMS provides financial incentives to eligible health-care providers, and hospitals must acquire certified products that support standards-based electronic reporting to IIS, including use of the HL7 table of vaccines administered. To receive their incentive payments, eligible professionals (outpatient vaccine providers) have to satisfy at least one of the following public health reporting requirements. They must conduct an HL7 messaging test, IIS reporting (and fulfill reporting requirements as per locality), laboratory reporting, or syndromic surveillance reporting. States can specify as mandatory any of the public health requirements for the Medicaid "meaningful use" program.

In 2010, CDC received HITECH funding for 20 IIS grantees to measurably enhance EHR-IIS interoperability. Over a 24-month project period, the 20 IIS grantees will be developing or enhancing HL7 messaging capacity and increasing the number of interfaces with EHRs. The grantees also will need to ensure adequate programmatic and technical capacity for increased electronic data submission testing, ensuring that electronic files submitted to EHR are complete and accurate. Finally, the grantees will coordinate with state health information technology coordinators and health information exchange organizations to ensure coordination with overall statewide plans, policies, and protocols for secure exchange of data using standards such as HL7 (*9*).

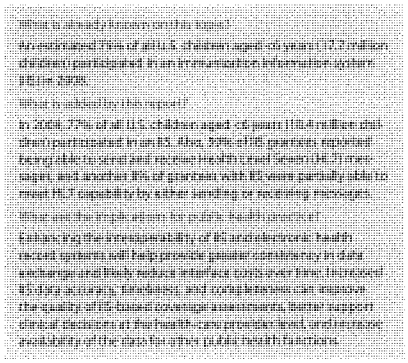
TABLE. Percentage of core data elements* that were complete† in immunization information system (IIS) records for children aged <6 years — United States, 2008 and 2009

Core data element	2008 (52 grantees) (%)	2009 (51 grantees) (%)	Change (%)
First name	100	100	0
Middle name	68	69	+1
Last name	100	100	0
Birth date	100	100	0
Sex	97	97	0
Birth state	44	46	+2
Birth country	28	28	0
Mother's first name	67	71	+4
Mother's maiden name	50	55	+5
Mother's last name	59	63	+4
Vaccine type	98	100	+2
Vaccine manufacture	40	50	+10
Vaccination date	98	100	+2
Vaccine lot number	38	45	+7
Race§	59	63	+4
Ethnicity§	39	43	+4
Patient birth order	63	61	-2

* Recommended by the National Vaccine Advisory Committee. Additional information available at http://www.cdc.gov/vaccines/programs/iis/stds/coredata.htm.

† Calculated using the number of data field completions in IIS records and the overall number of IIS records.

§ Additional core data element recommended by the National Vaccine Advisory Committee in 2007.



The findings in this report are subject to at least two limitations. First, although guidance on algorithms to validate their data are provided to IIS grantees by CDC, the data from the 2009 IISAR were self-reported and self-validated. Second, because some of the 56 grantees did not report data during the period studied, the nationwide IIS participation rates for children aged <6 years might be underestimated or overestimated.

Findings from the Taskforce on Community Preventive Services systematic review of the literature have highlighted how the IIS can be effective in increasing vaccination coverage (*1*). IIS offers capabilities such as patient reminder and recall systems, vaccine provider assessment and feedback, use of data for public health responses to outbreaks of vaccine-preventable disease, facilitation of vaccine management and accountability, and assessment of client vaccination status for decisions made by health-care providers (*1*). Enhancing IIS and EHR to adopt national standards and interoperability specifications will help provide greater consistency in data exchange and likely reduce interface costs over time. Increased IIS data accuracy, timeliness, and completeness can improve the quality of IIS-based vaccination coverage assessments, better support clinical decisions at the health-care provider level, and improve the data available for other public health functions.

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Updated Recommendations for Use of Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis (Tdap) Vaccine from the Advisory Committee on Immunization Practices, 2010

Despite sustained high coverage for childhood pertussis vaccination, pertussis remains poorly controlled in the United States. A total of 16,858 pertussis cases and 12 infant deaths were reported in 2009 (*1*; CDC, unpublished data, 2009). Although 2005 recommendations by the Advisory Committee on Immunization Practices (ACIP) called for vaccination with tetanus toxoid, reduced diphtheria toxoid and acellular pertussis (Tdap) for adolescents and adults to improve immunity against pertussis, Tdap coverage is 56% among adolescents and <6% among adults (*2,3*). In October 2010, ACIP recommended expanded use of Tdap. This report provides the updated recommendations, summarizes the safety and effectiveness data considered by ACIP, and provides guidance for implementing the recommendations.

ACIP recommends a single Tdap dose for persons aged 11 through18 years who have completed the recommended childhood diphtheria and tetanus toxoids and pertussis/diphtheria and tetanus toxoids and acellular pertussis (DTP/DTaP) vaccination series and for adults aged 19 through 64 years (*4,5*). Two Tdap vaccines are available in the United States. Boostrix (GlaxoSmithKline Biologicals, Rixensart, Belgium) is licensed for use in persons aged 10 through 64 years, and Adacel (Sanofi Pasteur, Toronto, Canada) is licensed for use in persons aged 11 through 64 years. Both Tdap products are licensed for use at an interval of at least 5 years between the tetanus and diphtheria toxoids (Td) and Tdap dose. On October 27, 2010, ACIP approved the following additional recommendations: 1) use of Tdap regardless of interval since the last tetanus- or diphtheria-toxoid containing vaccine, 2) use of Tdap in certain adults aged 65 years and older, and 3) use of Tdap in undervaccinated children aged 7 through 10 years.

The Pertussis Vaccines Working Group of ACIP reviewed published and unpublished Tdap immunogenicity and safety data from clinical trials and observational studies on use of Tdap. The Working Group also considered the epidemiology of pertussis, provider and program feedback, and data on the barriers to receipt of Tdap. The Working Group then presented policy options for consideration to the full ACIP. These additional recommendations are intended to remove identified barriers and programmatic gaps that contribute to suboptimal vaccination coverage. An important barrier that limited vaccination of persons with Tdap was unknown history of Td booster. Programmatic gaps included lack of a licensed Tdap vaccine for children aged 7 through 10 years and adults aged 65 years and older. In light of the recent increase of pertussis in the United States, the additional recommendations are made to facilitate use of Tdap to reduce the burden of disease and risk for transmission to infants (Box).

Timing of Tdap Following Td

Safety. When Tdap was licensed in 2005, the safety of administering a booster dose of Tdap at intervals <5 years after Td or pediatric DTP/DTaP had not been studied in adults. However, evaluations in children and adolescents suggested that the safety of intervals as short as 18 months was acceptable (*6*). Rates of local and systemic reactions after Tdap vaccination in adults were lower than or comparable to rates in adolescents during U.S. prelicensure trials; therefore, the safety of using intervals as short as 2 years between Td and Tdap in adults was inferred (*4*).

Additional data on the safety of administering Tdap <5 years after Td are now available. Two studies were conducted with 387 persons aged 18 through 76 years who received a Tdap or combined Tdap-inactivated polio vaccine (Tdap-IPV) vaccination either within 21 days, or <2 years following a previous Td-containing vaccine (*7,8*). Tdap-IPV vaccine is not licensed in the United States. In both studies, immediate or short-term adverse events (e.g., 30 minutes to 2 weeks) after receipt of Tdap or Tdap-IPV were examined. The majority of these events were limited to local reactions, including pain (68%–83%), erythema (20%–25%), and swelling (19%–38%) (*7,8*). Serious adverse events related to the receipt of Tdap or Tdap-IPV shortly after Td or Td-IPV vaccinations did not occur. However, the number of subjects in these studies was small and does not exclude the potential for rare, but serious, adverse events.

Guidance for use. ACIP recommends that pertussis vaccination, when indicated, should not be delayed and that Tdap should be administered regardless of interval since the last tetanus or diphtheria toxoid-containing vaccine. ACIP concluded that while longer intervals between Td and Tdap vaccination could decrease the occurrence of local reactions, the benefits of protection against pertussis outweigh the potential risk for adverse events.

Adults Aged 65 Years and Older

Unpublished data from trials for Adacel (N = 1,170) and Boostrix (N = 1,104) on the safety and immunogenicity of Tdap in adults aged 65 years and older who received vaccine were provided to ACIP by Sanofi Pasteur and GlaxoSmithKline.

BOX. Summary of updated recommendations for use of tetanus toxoid, reduced diphtheria toxoid and acellular pertussis (Tdap) vaccine — Advisory Committee on Immunization Practices, 2010

General Recommendations

For routine use, adolescents aged 11 through 18 years who have completed the recommended childhood diphtheria and tetanus toxoids and pertussis/diphtheria and tetanus toxoids and acellular pertussis (DTP/DTaP) vaccination series and adults aged 19 through 64 years should receive a single dose of Tdap. Adolescents should preferably receive Tdap at the 11 to 12 year-old preventive health-care visit.

Timing of Tdap

- Can be administered regardless of interval since the last tetanus- or diphtheria-toxoid containing vaccine.

Adults Aged 65 years and Older

- Those who have or anticipate having close contact with an infant aged less than 12 months should receive a single dose of Tdap.
- Other adults ages 65 years and older may be given a single dose of Tdap.

Children Aged 7 Through 10 Years

- Those not fully vaccinated against pertussis* and for whom no contraindication to pertussis vaccine exists should receive a single dose of Tdap.
- Those never vaccinated against tetanus, diphtheria, or pertussis or who have unknown vaccination status should receive a series of three vaccinations containing tetanus and diphtheria toxoids. The first of these three doses should be Tdap.

*Fully vaccinated is defined as 5 doses of DTaP or 4 doses of DTaP if the fourth dose was administered on or after the fourth birthday.

Safety. For both Tdap vaccines, the frequency and severity of adverse events in persons aged 65 years and older were comparable to those in persons aged less than 65 years. No increase in local or generalized reactions in Tdap recipients was observed, compared with persons who received Td. No serious adverse events were considered related to vaccination.

ACIP reviewed data on vaccine-related adverse events from the Vaccine Adverse Event Reporting System (VAERS). VAERS is a passive surveillance system jointly administered by CDC and the Food and Drug Administration that accepts reports from vaccine manufacturers, health-care providers, and vaccine recipients for vaccine safety. VAERS can be prone to overreporting or underreporting and inconsistency in the quality and completeness of reports. During September 2005–September 2010, a total of 243 VAERS reports were received regarding adults aged 65 years and older administered Tdap, out of 10,981 total VAERS reports on Tdap among recipients of all ages (CDC, unpublished data, 2010). Of the 243 reports regarding adults aged 65 years and older, 232 (96%) were nonserious. The most frequent adverse events after Tdap were local reactions, comprising 37% of all events. Eleven serious events were reported, including two deaths among persons with multiple underlying conditions. Although VAERS cannot assess causality, after review of data, it is unlikely the deaths were related to vaccine receipt. Postmarketing VAERS data also suggest that Tdap vaccine safety in adults aged 65 years and older is comparable to that of Td vaccine. Because Tdap is not licensed for use in this age group, comparisons between these reports and other reports need to be interpreted with caution.

Immunogenicity. Both Tdap vaccines showed that immune responses to diphtheria and tetanus toxoids were noninferior to responses produced by Td. In both Tdap vaccines, immune responses were observed to the pertussis antigens. For Boostrix, immune responses to pertussis antigens (pertussis toxin [PT], filamentous hemagglutinin [FHA], and pertactin [PRN]) were noninferior to those observed following a 3-dose primary pertussis vaccination series, as defined by the Vaccines and Related Biological Products Advisory Committee (VRBPAC) (*9*). For Adacel, immune responses to all pertussis antigens (PT, FHA, PRN, and fimbriae [FIM]) occurred (4.1 to 15.1-fold geometric mean concentration increases). ACIP concluded that both Tdap vaccines would provide pertussis protection in persons aged 65 years and older.

Guidance for use. ACIP recommends that adults aged 65 years and older (e.g., grandparents, child-care providers, and health-care practitioners) who have or who anticipate having close contact with an infant less than 12 months of age and who previously have not received Tdap should receive a single dose of Tdap to protect against pertussis and reduce the likelihood of transmission. For other adults aged 65 years and older, a single dose of Tdap vaccine may be given instead of Td vaccine, in persons who have not previously received Tdap. Tdap can be administered regardless of interval since the last tetanus- or diphtheria-toxoid containing vaccine. After receipt of Tdap, persons should continue to receive Td for routine booster immunization against tetanus and diphtheria, according to previously published guidelines (*4*). Either Tdap vaccine product may be used. Further recommendations on the use of both Tdap vaccines in adults aged 65 years and older will be forthcoming should one or more Tdap products be licensed for use in this age group.

Undervaccinated Children Aged 7 through 10 Years

No data have been published regarding the safety or immunogenicity of Tdap in children aged 7 through 10 years who

have never received pertussis-containing vaccines. One published study assessed the use of Tdap-IPV vaccine as the fifth dose of acellular pertussis vaccine in children aged 4 through 8 years (*10*). A subanalysis of the study data comparing safety and immunogenicity results among children aged 4 through 6 years (n = 703) and 7 through 8 years (n = 118) was provided to ACIP by GlaxoSmithKline. Three additional published studies have assessed use of Tdap in lieu of the fifth DTaP dose in children aged 4 through 6 years who had received 4 previous doses of DTaP (*11–13*). These three studies enrolled 609 subjects who received either Tdap or Tdap-IPV in lieu of the fifth DTaP dose.

Safety. In each study, no increase in risk of severe local reactions or systemic adverse events was observed. The most commonly reported adverse events within 15 days after receipt of Tdap were pain (40%–56%), erythema (34%–53%), and swelling (24%–45%). Fewer local reactions were observed or reported among Tdap or Tdap-IPV recipients compared with those who received DTaP or DTaP-IPV, but the differences were not statistically significant. No differences were noted when children aged 4 through 6 and 7 through 8 years were compared with respect to solicited or unsolicited adverse reactions following vaccination with Tdap-IPV. ACIP concluded that the overall safety of Tdap and frequency of local reactions in undervaccinated children likely would be similar to those observed in children who received 4 doses of DTaP.

Immunogenicity. Immune response to Tdap-IPV was comparable between children aged 4 through 6 and those aged 7 through 8 years, according to the GlaxoSmithKline subanalysis. In both age groups, at least 99.9% of Tdap-IPV recipients had seroprotective levels of antibodies for diphtheria and tetanus, and responses to pertussis antigens were comparable to those observed following a 3-dose primary pertussis vaccination series as defined by VRBPAC.

In children aged 4 through 6 years, the immune response following receipt of Tdap (Boostrix or Adacel) was comparable to DTaP or DTaP-IPV (*11,12*). All subjects had seroprotective antibody levels for diphtheria and tetanus 4 to 6 weeks after vaccination. For pertussis antigens, one study observed no significant difference between Boostrix and DTaP recipients in response rates to any of three pertussis antigens in the vaccines, with similar effects on cell-mediated immune responses 3.5 years after vaccination (*12*). Another study demonstrated a fourfold increase in four pertussis antibodies in the majority of children receiving Adacel or DTaP-IPV (*11*).

Guidance for use. ACIP recommends that children aged 7 through 10 years who are not fully vaccinated* against pertussis and for whom no contraindication to pertussis vaccine exists should receive a single dose of Tdap to provide protection against pertussis. If additional doses of tetanus and diphtheria toxoid–containing vaccines are needed, then children aged 7 through 10 years should be vaccinated according to catch-up guidance, with Tdap preferred as the first dose (*5*). Tdap is recommended in this age group because of its reduced antigen content compared with DTaP, resulting in reduced reactogenicity. Currently, Tdap is recommended only for a single dose across all age groups. Further guidance will be forthcoming on timing of revaccination in persons who have received Tdap previously.

* Fully vaccinated is defined as 5 doses of DTaP or 4 doses of DTaP if the fourth dose was administered on or after the fourth birthday.

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Notes from the Field

Congenital Lymphocytic Choriomeningitis — New York

Lymphocytic choriomeningitis virus (LCMV) is an arenavirus carried by rodents, most notably domestic house mice (*Mus musculus*), but also laboratory and pet rodents (*1*). Manifestations of infections in humans are protean, from inapparent or mild febrile illness to choriomeningitis, encephalitis, or severe multi-organ disease. Mother-to-child transmission of LCMV during pregnancy can cause abortion, chorioretinitis, hydrocephalus, or microencephaly, and can result in life-long vision deficits or neurologic impairment (*2,3*). Clinically, congenital LCMV infection closely resemhles perinatal infections caused by the pathogens grouped under the TORCH acronym: toxoplasmosis, ruhella, cytomegalovirus, and herpes simplex virus.

Reports of congenital LCMV cases are extremely rare in the United States. In January 2010, an infant in upstate New York with hydrocephalus and chorioretinitis was confirmed to have congenital LCMV infection by the Viral Special Pathogens Branch at CDC. A review of records by the Onondaga County Health Department (Syracuse, New York) and the New York State Department of Health found that 7 years earlier, two cases of congenital LCMV infection were diagnosed in infants residing within a 1.5-mile radius of the infant in the 2010 case.

LCMV infection is not a nationally notifiable disease in the United States, the extent of LCMV-associated morbidity is currently unknown, and most LCMV infections are believed to go undiagnosed. Health-care practitioners are encouraged to contact their local or state health department if they have ohserved cases of suspected LCMV infection. When LCMV-associated disease is suspected, the Viral Special Pathogens Branch at CDC asks that state health departments contact the hranch via e-mail (dvd-1spath@cdc.gov) or telephone (404-639-1510) for consultation and diagnostic assistance and to better identify and characterize LCMV-associated morhidity in the United States.

Reported by

Onondaga County Health Dept, Syracuse; New York State Dept of Health. Viral Special Pathogens Br, National Center for Emerging and Zoonotic Infectious Diseases, CDC.

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Notices to Readers

Celebrating the 50th Anniversary of *MMWR* at CDC

January 13, 2011, marks the 50th anniversary of the first publication of *MMWR* by CDC. *MMWR* was not new 50 years ago, but it was new to CDC, which itself had only been organized in 1946. The first ancestor of *MMWR* was the *Bulletin of the Public Health*, which began publication on July 13, 1878, under the National Quarantine Act. In the years between 1878 and 1961, *MMWR* and its antecedents went through several changes in name and format, and were housed in several different federal agencies. By 1960, the publication had assumed its current name, the *Morbidity and Mortality Weekly Report*, and was being published by the National Office of Vital Statistics (NOVS) in Washington, an agency of the U.S. Public Health Service (*1*). NOVS later became the National Center for Health Statistics.

In the late 1950s, Alexander D. Langmuir, CDC's chief epidemiologist, became determined to move the disease surveillance functions of NOVS to CDC, along with *MMWR*. Langmuir worked hard to accomplish this, securing the transfer in 1960 (*2*). CDC published its first issue of *MMWR* on January 13, 1961. On the cover of that issue, Langmuir wrote, "The Center welcomes the addition of this important function. We believe the closer current contact with those reporting morbidity and mortality data will better permit us more rapidly and successfully to carry out our primary role of providing consultation and assistance to the States when communicable disease problems occur" (*3*).

Since 1961, *MMWR* has broadened into a series of six different products: the *MMWR* Weekly, the Surveillance Summary series, Recommendations and Reports, the annual Summary of Notifiable Diseases, the weekly *MMWR* podcasts, and Supplements. Since 1961, *MMWR* has published reports about all of the major infectious diseases affecting the United States and the world. Through the decades, these have included smallpox (1960s), Legionnaire's disease (1970s), the first cases of acquired immunodeficiency disease (AIDS) (1980s), the first iatrogenic transmission of human immunodeficiency virus (HIV) and hantavirus pulmonary syndrome (1990s), and the first reports of severe acute respiratory syndrome (SARS) and 2009 influenza A (H1N1) (2000s) (*4*). By the 1970s, *MMWR* was publishing many reports on noninfectious diseases and injuries, and today, approximately 55% of all reports in the *MMWR* Weekly are on noninfectious disease topics.

In 1961, and for decades afterward, *MMWR* was the primary route by which CDC rapidly disseminated scientific information about public health events. Today, many channels exist for this purpose, and the Internet has revolutionized medical publishing. While recognizing that it must continue to serve as "the voice of CDC" and provide timely, authoritative, and useful public health information and recommendations, *MMWR* also recognizes it must adapt to rapid changes in the public health world. This will be one of the great challenges for *MMWR* in its next 50 years.

To celebrate the 50th anniversary, *MMWR* will publish a special supplement containing a history of *MMWR*, and an anthology of reports depicting the main events, developments, and innovations in public health from 1961 to the present. The supplement will be available later this year to all subscribers and on the *MMWR* website.

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Changes to the National Notifiable Infectious Disease List and Data Presentation — January 2011

This issue of *MMWR* incorporates changes to Table I (Provisional cases of infrequently reported notifiable diseases, United States) and Table II (Provisional cases of selected notifiable diseases, United States). In addition, changes are being made regarding the presentation of data on human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). This year, the Table I and Table II modifications add conditions designated as nationally notifiable by the Council of State and Territorial Epidemiologists (CSTE) in conjunction with CDC (*1–3*).

Modifications to Table I and Table II

Two new conditions have been added to the list of nationally notifiable infectious diseases: babesiosis and coccidioidomycosis. Incidence data for babesiosis will appear in Table I, and incidence data for coccidioidomycosis will appear in Table II. The surveillance case definitions adopted for these conditions

are listed in their respective CSTE position statements (*1,2*) and are posted in the case definitions section of the National Notifiable Diseases Surveillance System (NNDSS) website (*3*).

Elimination of HIV/AIDS Data Display

The Division of HIV/AIDS Prevention has decided to eliminate display of diagnoses of HIV infection in children aged <13 years, formerly displayed in Table I, and display of cases of AIDS and HIV/AIDS, formerly displayed in the quarterly Table IV. The rationales for these decisions are as follows: data on diagnoses of HIV infection in children aged <13 years are not transmitted to CDC on a weekly basis, and displaying data on HIV and AIDS diagnoses resulted in extended time requirements for producing the quarterly data sets. Data on HIV and AIDS diagnoses, including in children aged <13 years, are included in the annual HIV Surveillance Report published online by the Division of HIV/AIDS Prevention and available at http://www.cdc.gov/hiv/topics/surveillance/resources/reports.

2010 State Reportable Conditions Assessment

CSTE is collecting data for the 2010 State Reportable Conditions Assessment (2010 SRCA) from 56 reporting jurisdictions (50 U.S. states, the District of Columbia, New York City, and four U.S. territories) to determine which of the nationally notifiable conditions were reportable in each reporting jurisdiction during 2010. Data collection and validation for 2010 SRCA will conclude in 2011; results will be used to populate the "N" indicators for 2010 and 2011 NNDSS data displayed in the 2011 *MMWR* data tables. The 2010 and 2011 NNDSS data displayed in the 2011 *MMWR* weekly provisional tables will reflect reporting requirements gathered from the 2009 SRCA until 2010 SRCA official results are available.

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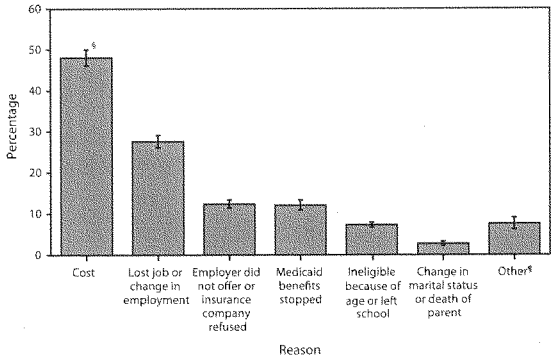
Errata: Vol. 60, No. RR-12

In the Recommendations and Reports, "Sexually Transmitted Diseases Treatment Guidelines, 2010," three errors occurred. In the "Recommended Regimens" boxes on pages 50 and 51, the recommendation for doxycycline should read "**100 mg orally twice a day for 7 days.**" In the "Alternative Regimens" box on page 57, the first recommendation for tinidazole should read "**2 g orally once daily for 2 days.**"

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Reasons for No Health Insurance Coverage* Among Uninsured Persons Aged <65 Years — National Health Interview Survey (NHIS), United States, 2009†



* Based on response to a survey question regarding the reasons a household member stopped being covered by health insurance or did not have health insurance. Persons could provide more than one reason.
† Estimates are age adjusted using the projected 2000 U.S. population as the standard population and using four age groups: 0–11 years, 12–17 years, 18–44 years, and 45–64 years. Estimates are based on household interviews of a sample of the civilian noninstitutionalized U.S. population and are derived from the NHIS Family Core component.
§ 95% confidence interval.
¶ Including moved, self-employed, never had coverage, did not want or need coverage, and other unspecified reasons.

Overall, in 2009, approximately 18% (46 million) of persons aged <65 years in the United States had no health insurance coverage at the time of interview. Of these uninsured persons, 48.1% cited cost as the reason they did not have coverage, and 27.6% cited loss of a job or a change in employment; 12.4% said they did not have coverage because an employer did not offer it or the insurance company refused coverage, and 12.1% said they did not have coverage because of cessation of Medicaid benefits.

Source: Adams PF, Martinez ME, Vickerie, JL. Summary health statistics for the U.S. population: National Health Inteview Survey, 2009. Vital Health Stat 2010;10(248).Available at http://www.cdc.gov/nchs/data/series/sr_10/sr10_248.pdf.

Notifiable Diseases and Mortality Tables

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending January 8, 2011 (1st week)*

Disease	Current week	Cum 2011	5-year weekly average†	Total cases reported for previous years 2010	2009	2008	2007	2006	States reporting cases during current week (No.)
Anthrax	—	—	—	—	1	—	1	1	
Arboviral diseases§,¶:									
California serogroup virus disease	—	—	—	72	55	62	55	67	
Eastern equine encephalitis virus disease	—	—	—	10	4	4	4	8	
Powassan virus disease	—	—	0	5	6	2	7	1	
St. Louis encephalitis virus disease	—	—	0	8	12	13	9	10	
Western equine encephalitis virus disease	—	—	—	—	—	—	—	—	
Babesiosis	—	—	—	NN	NN	NN	NN	NN	
Botulism, total	1	1	3	103	118	145	144	165	
foodborne	—	—	0	7	10	17	32	20	
infant	1	1	2	70	83	109	85	97	PA (1)
other (wound and unspecified)	—	—	1	26	25	19	27	48	
Brucellosis	1	1	2	126	115	80	131	121	FL (1)
Chancroid	1	1	0	37	28	25	23	33	VA (1)
Cholera	—	—	0	8	10	5	7	9	
Cyclosporiasis**	1	1	4	169	141	139	93	137	FL (1)
Diphtheria	—	—	—	—	—	—	—	—	
Haemophilus influenzae,†† invasive disease (age <5 yrs):									
serotype b	—	—	1	16	35	30	22	29	
nonserotype b	—	—	5	149	236	244	199	175	
unknown serotype	5	5	6	260	178	163	180	179	PA (2), OH (1), TN (1), NM (1)
Hansen disease**	—	—	1	57	103	80	101	66	
Hantavirus pulmonary syndrome**	—	—	0	17	20	18	32	40	
Hemolytic uremic syndrome, postdiarrheal**	2	2	5	218	242	330	292	288	AL (1), OR (1)
Influenza-associated pediatric mortality§,††	4	4	2	61	358	90	77	43	FL (1), NC (1), NYC (1), PA (1)
Listeriosis	4	4	18	753	851	759	808	884	VA (1), FL (2), CO (1)
Measles§§	—	—	1	57	71	140	43	55	
Meningococcal disease, invasive¶¶:									
A, C, Y, and W-135	1	1	6	232	301	330	325	318	ID (1)
serogroup B	—	—	4	108	174	188	167	193	
other serogroup	—	—	1	9	23	38	35	32	
unknown serogroup	9	9	13	412	482	616	550	651	CT (1), NYC (1), PA (2), OH (2), MO (1), FL (1), OR (1)
Novel influenza A virus infections***	—	—	0	4	43,774	2	4	NN	
Plague	—	—	0	2	8	3	7	17	
Poliomyelitis, paralytic	—	—	0	—	1	—	—	—	
Polio virus infection, nonparalytic**	—	—	—	—	—	—	—	NN	
Psittacosis**	—	—	0	4	9	8	12	21	
Q fever, total**	1	1	3	117	113	120	171	169	
acute	1	1	1	89	93	106	—	—	GA (1)
chronic	—	—	0	28	20	14	—	—	
Rabies, human	—	—	0	1	4	2	1	3	
Rubella†††	—	—	0	6	3	16	12	11	
Rubella, congenital syndrome	—	—	—	—	2	—	—	1	
SARS-CoV**	—	—	—	—	—	—	—	—	
Smallpox**	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome**	—	—	4	156	161	157	132	125	
Syphilis, congenital (age <1 yr)§§§	—	—	7	221	423	431	430	349	
Tetanus	—	—	0	8	18	19	28	41	
Toxic-shock syndrome (staphylococcal)**	—	—	2	73	74	71	92	101	
Trichinellosis	1	1	0	4	13	39	5	15	CA (1)
Tularemia	—	—	1	110	93	123	137	95	
Typhoid fever	1	1	9	409	397	449	434	353	CA (1)
Vancomycin-intermediate *Staphylococcus aureus***	1	1	1	89	78	63	37	6	FL (1)
Vancomycin-resistant *Staphylococcus aureus***	—	—	0	1	1	—	2	1	
Vibriosis (noncholera *Vibrio* species infections)**	—	—	9	766	789	588	549	NN	
Viral hemorrhagic fever¶¶¶	—	—	0	1	NN	NN	NN	NN	
Yellow fever	—	—	—	—	—	—	—	—	

See Table 1 footnotes on next page.

TABLE I. (*Continued*) Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending January 8, 2011 (1st week)*

—: No reported cases. N: Not reportable. NN: Not Nationally Notifiable Cum: Cumulative year-to-date counts.

* Case counts for reporting years 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf.

† Calculated by summing the incidence counts for the current week, the 2 weeks preceding the current week, and the 2 weeks following the current week, for a total of 5 preceding years. Additional information is available at http://www.cdc.gov/ncphi/disss/nndss/phs/files/5yearweeklyaverage.pdf.

§ Not reportable in all states. Data from states where the condition is not reportable are excluded from this table except starting in 2007 for the arboviral diseases, STD data, TB data, and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/ncphi/disss/nndss/phs/infdis.htm.

¶ Includes both neuroinvasive and nonneuroinvasive. Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for West Nile virus are available in Table II.

** Data for H. influenzae (all ages, all serotypes) are available in Table II.

†† Updated weekly from reports to the Influenza Division, National Center for Immunization and Respiratory Diseases. Since October 3, 2010, eight influenza-associated pediatric death occurred during the 2010-11 influenza season. Since August 30, 2009, a total of 282 influenza-associated pediatric deaths occurring during the 2009-10 influenza season have been reported.

§§ No measles cases were reported for the current week.

¶¶ Data for meningococcal disease (all serogroups) are available in Table II.

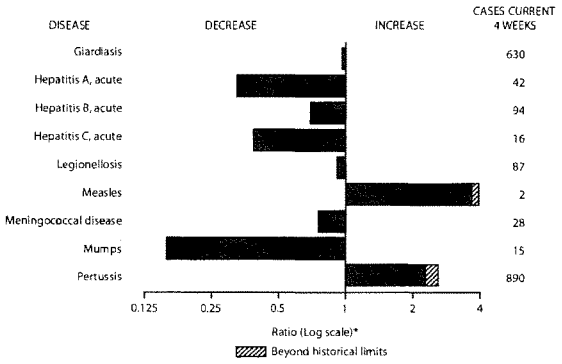
*** CDC discontinued reporting of individual confirmed and probable cases of 2009 pandemic influenza A (H1N1) virus infections on July 24, 2009. During 2009, four cases of human infection with novel influenza A viruses, different from the 2009 pandemic influenza A (H1N1) strain, were reported to CDC. The four cases of novel influenza A virus infection reported to CDC during 2010 were identified as swine influenza A (H3N2) virus and are unrelated to the 2009 pandemic influenza A (H1N1) virus. Total case counts for 2009 were provided by the Influenza Division, National Center for Immunization and Respiratory Diseases (NCIRD).

††† No rubella cases were reported for the current week.

§§§ Updated weekly from reports to the Division of STD Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.

¶¶¶ There was one case of viral hemorrhagic fever reported during week 12 of 2010. The one case report was confirmed as lassa fever. See Table II for dengue hemorrhagic fever.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals January 8, 2011, with historical data



* Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

Notifiable Disease Data Team and 122 Cities Mortality Data Team

Patsy A. Hall-Baker

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TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2011, and January 9, 2010 (1st week)*

Reporting area	*Chlamydia trachomatis* infection					Coccidioidomycosis					Cryptosporidiosis				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	9,393	23,907	26,312	9,393	21,625	165	—	165	165	NN	43	120	343	43	155
New England	510	781	1,211	510	499	—	0	0	—	NN	—	7	77	—	77
Connecticut	—	177	402	—	20	—	0	0	—	NN	—	0	71	—	71
Maine[§]	—	50	100	—	45	—	0	0	—	NN	—	1	7	—	2
Massachusetts	432	401	693	432	327	—	0	0	—	NN	—	3	8	—	2
New Hampshire	1	49	114	1	41	—	0	0	—	NN	—	1	5	—	1
Rhode Island[§]	47	66	120	47	53	—	0	0	—	NN	—	0	2	—	—
Vermont[§]	30	23	51	30	13	—	0	0	—	NN	—	1	5	—	1
Mid. Atlantic	1,069	3,364	5,073	1,069	2,772	—	0	0	—	NN	4	15	38	4	9
New Jersey	331	512	680	331	427	—	0	0	—	NN	—	0	4	—	1
New York (Upstate)	290	697	1,036	290	187	—	0	0	—	NN	—	4	14	—	1
New York City	—	1,217	2,766	—	1,440	—	0	0	—	NN	—	2	6	—	1
Pennsylvania	448	945	1,092	448	718	—	0	0	—	NN	4	8	26	4	6
E.N. Central	981	3,498	3,975	981	3,379	—	0	0	—	NN	17	30	122	17	31
Illinois	20	762	1,025	20	1,000	—	0	0	—	NN	—	4	21	—	7
Indiana	—	364	797	—	160	—	0	0	—	NN	—	3	10	—	3
Michigan	575	946	1,419	575	888	—	0	0	—	NN	3	5	18	3	8
Ohio	247	992	1,109	247	1,028	—	0	0	—	NN	14	7	24	14	7
Wisconsin	139	426	513	139	303	—	0	0	—	NN	—	9	57	—	6
W.N. Central	263	1,377	1,556	263	1,337	—	0	0	—	NN	6	21	83	6	7
Iowa	15	205	270	15	270	—	0	0	—	NN	—	4	24	—	4
Kansas	53	189	235	53	185	—	0	0	—	NN	—	2	9	—	—
Minnesota	—	283	348	—	321	—	0	0	—	NN	—	0	16	—	—
Missouri	112	505	621	112	409	—	0	0	—	NN	2	4	30	2	3
Nebraska[§]	56	97	173	56	78	—	0	0	—	NN	4	3	26	4	—
North Dakota	—	28	79	—	11	—	0	0	—	NN	—	0	9	—	—
South Dakota	27	62	78	27	63	—	0	0	—	NN	—	1	6	—	—
S. Atlantic	3,300	4,737	5,653	3,300	3,839	—	0	0	—	NN	9	18	51	9	6
Delaware	83	85	220	83	65	—	0	0	—	NN	—	0	1	—	—
District of Columbia	76	91	177	76	49	—	0	0	—	NN	—	0	1	—	—
Florida	633	1,460	1,712	633	1,316	—	0	0	—	NN	6	7	19	6	4
Georgia	—	610	1,217	—	156	—	0	0	—	NN	1	5	31	1	2
Maryland[§]	319	469	718	319	164	—	0	0	—	NN	—	1	3	—	—
North Carolina	1,210	756	1,563	1,210	686	—	0	0	—	NN	—	0	12	—	—
South Carolina[§]	—	535	845	—	458	—	0	0	—	NN	—	1	8	—	—
Virginia[§]	857	599	902	857	902	—	0	0	—	NN	2	2	8	2	—
West Virginia	122	72	117	122	43	—	0	0	—	NN	—	0	3	—	—
E.S. Central	230	1,741	2,415	230	1,412	—	0	0	—	NN	—	4	19	—	6
Alabama[§]	—	524	758	—	449	—	0	0	—	NN	—	2	13	—	—
Kentucky	—	269	614	—	49	—	0	0	—	NN	—	1	6	—	1
Mississippi	230	384	780	230	422	—	0	0	—	NN	—	0	3	—	3
Tennessee[§]	—	555	790	—	492	—	0	0	—	NN	—	1	5	—	2
W.S. Central	715	3,013	4,310	715	4,222	—	0	0	—	NN	—	7	28	—	1
Arkansas[§]	336	273	391	336	225	—	0	0	—	NN	—	0	3	—	—
Louisiana	378	310	1,073	378	1,073	—	0	0	—	NN	—	1	6	—	—
Oklahoma	1	254	1,374	1	1,339	—	0	0	—	NN	—	1	8	—	—
Texas[§]	—	2,240	3,183	—	1,585	—	0	0	—	NN	—	4	21	—	1
Mountain	466	1,438	1,913	466	950	111	0	111	111	NN	3	10	30	3	7
Arizona	87	509	706	87	3	110	0	110	110	NN	—	1	3	—	1
Colorado	185	338	560	185	427	—	0	0	—	NN	1	2	8	1	—
Idaho[§]	—	69	200	—	39	—	0	0	—	NN	2	2	7	2	2
Montana[§]	—	60	82	—	51	—	0	0	—	NN	—	1	4	—	2
Nevada[§]	—	172	329	—	158	—	0	0	—	NN	—	0	7	—	1
New Mexico[§]	122	150	274	122	35	—	0	0	—	NN	—	2	12	—	—
Utah	72	121	175	72	169	1	0	1	1	NN	—	1	5	—	1
Wyoming[§]	—	41	90	—	68	—	0	0	—	NN	—	0	2	—	—
Pacific	1,859	3,658	4,552	1,859	3,215	54	0	54	54	NN	4	12	28	4	11
Alaska	—	113	148	—	129	—	0	0	—	NN	—	0	1	—	—
California	1,426	2,771	3,563	1,426	2,469	54	0	54	54	NN	2	7	18	2	10
Hawaii	—	112	158	—	128	—	0	0	—	NN	—	0	1	—	—
Oregon	136	212	496	136	127	—	0	0	—	NN	2	3	13	2	1
Washington	297	406	661	297	362	—	0	0	—	NN	—	1	6	—	—
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	NN	N	0	0	N	NN
C.N.M.I.	—	—	—	—	—	—	—	—	—	NN	—	—	—	—	—
Guam	—	8	31	—	—	—	0	0	—	NN	—	0	0	—	—
Puerto Rico	116	92	265	116	76	—	0	0	—	NN	N	0	0	N	NN
U.S. Virgin Islands	—	11	29	—	6	—	0	0	—	NN	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2011, and January 9, 2010 (1st week)*

Reporting area	Dengue Virus Infection									
	Dengue Fever†					Dengue Hemorrhagic Fever§				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max		
United States	—	0	0	—	—	—	0	0	—	—
New England	—	0	0	—	—	—	0	0	—	—
Connecticut	—	0	0	—	—	—	0	0	—	—
Maine¶	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	0	0	—	—	—	0	0	—	—
New Hampshire	—	0	0	—	—	—	0	0	—	—
Rhode Island¶	—	0	0	—	—	—	0	0	—	—
Vermont¶	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	—	0	0	—	—	—	0	0	—	—
New Jersey	—	0	0	—	—	—	0	0	—	—
New York (Upstate)	—	0	0	—	—	—	0	0	—	—
New York City	—	0	0	—	—	—	0	0	—	—
Pennsylvania	—	0	0	—	—	—	0	0	—	—
E.N. Central	—	0	0	—	—	—	0	0	—	—
Illinois	—	0	0	—	—	—	0	0	—	—
Indiana	—	0	0	—	—	—	0	0	—	—
Michigan	—	0	0	—	—	—	0	0	—	—
Ohio	—	0	0	—	—	—	0	0	—	—
Wisconsin	—	0	0	—	—	—	0	0	—	—
W.N. Central	—	0	0	—	—	—	0	0	—	—
Iowa	—	0	0	—	—	—	0	0	—	—
Kansas	—	0	0	—	—	—	0	0	—	—
Minnesota	—	0	0	—	—	—	0	0	—	—
Missouri	—	0	0	—	—	—	0	0	—	—
Nebraska¶	—	0	0	—	—	—	0	0	—	—
North Dakota	—	0	0	—	—	—	0	0	—	—
South Dakota	—	0	0	—	—	—	0	0	—	—
S. Atlantic	—	0	0	—	—	—	0	0	—	—
Delaware	—	0	0	—	—	—	0	0	—	—
District of Columbia	—	0	0	—	—	—	0	0	—	—
Florida	—	0	0	—	—	—	0	0	—	—
Georgia	—	0	0	—	—	—	0	0	—	—
Maryland¶	—	0	0	—	—	—	0	0	—	—
North Carolina	—	0	0	—	—	—	0	0	—	—
South Carolina¶	—	0	0	—	—	—	0	0	—	—
Virginia¶	—	0	0	—	—	—	0	0	—	—
West Virginia	—	0	0	—	—	—	0	0	—	—
E.S. Central	—	0	0	—	—	—	0	0	—	—
Alabama¶	—	0	0	—	—	—	0	0	—	—
Kentucky	—	0	0	—	—	—	0	0	—	—
Mississippi	—	0	0	—	—	—	0	0	—	—
Tennessee¶	—	0	0	—	—	—	0	0	—	—
W.S. Central	—	0	0	—	—	—	0	0	—	—
Arkansas¶	—	0	0	—	—	—	0	0	—	—
Louisiana	—	0	0	—	—	—	0	0	—	—
Oklahoma	—	0	0	—	—	—	0	0	—	—
Texas¶	—	0	0	—	—	—	0	0	—	—
Mountain	—	0	0	—	—	—	0	0	—	—
Arizona	—	0	0	—	—	—	0	0	—	—
Colorado	—	0	0	—	—	—	0	0	—	—
Idaho¶	—	0	0	—	—	—	0	0	—	—
Montana¶	—	0	0	—	—	—	0	0	—	—
Nevada¶	—	0	0	—	—	—	0	0	—	—
New Mexico¶	—	0	0	—	—	—	0	0	—	—
Utah	—	0	0	—	—	—	0	0	—	—
Wyoming¶	—	0	0	—	—	—	0	0	—	—
Pacific	—	0	0	—	—	—	0	0	—	—
Alaska	—	0	0	—	—	—	0	0	—	—
California	—	0	0	—	—	—	0	0	—	—
Hawaii	—	0	0	—	—	—	0	0	—	—
Oregon	—	0	0	—	—	—	0	0	—	—
Washington	—	0	0	—	—	—	0	0	—	—
Territories										
American Samoa	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

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† Dengue Fever includes cases that meet criteria for Dengue Fever with hemorrhage, other clinical and unknown case classifications.
§ DHF includes cases that meet criteria for dengue shock syndrome (DSS), a more severe form of DHF.
¶ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2011, and January 9, 2010 (1st week)*

Reporting area	Ehrlichiosis/Anaplasmosis†													
	Ehrlichia chaffeensis					*Anaplasma phagocytophilum*					Undetermined			
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	1	8	47	1	2	—	11	56	—	—	—	1	10	—	—
New England	—	0	1	—	—	—	1	8	—	—	—	0	2	—	—
Connecticut	—	0	0	—	—	—	0	5	—	—	—	0	2	—	—
Maine§	—	0	1	—	—	—	0	2	—	—	—	0	0	—	—
Massachusetts	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
New Hampshire	—	0	1	—	—	—	0	3	—	—	—	0	1	—	—
Rhode Island§	—	0	0	—	—	—	0	5	—	—	—	0	0	—	—
Vermont§	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	—	1	5	—	—	—	4	12	—	—	—	0	1	—	—
New Jersey	—	0	0	—	—	—	0	1	—	—	—	0	0	—	—
New York (Upstate)	—	0	4	—	—	—	4	12	—	—	—	0	1	—	—
New York City	—	0	3	—	—	—	0	1	—	—	—	0	0	—	—
Pennsylvania	—	0	1	—	—	—	0	0	—	—	—	0	0	—	—
E.N. Central	—	0	4	—	—	—	4	39	—	—	—	0	7	—	—
Illinois	—	0	2	—	—	—	0	2	—	—	—	0	2	—	—
Indiana	—	0	0	—	—	—	0	0	—	—	—	0	3	—	—
Michigan	—	0	1	—	—	—	0	0	—	—	—	0	1	—	—
Ohio	—	0	3	—	—	—	0	1	—	—	—	0	0	—	—
Wisconsin	—	0	1	—	—	—	4	39	—	—	—	0	4	—	—
W.N. Central	—	1	13	—	—	—	0	3	—	—	—	0	3	—	—
Iowa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Kansas	—	0	1	—	—	—	0	0	—	—	—	0	0	—	—
Minnesota	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Missouri	—	1	13	—	—	—	0	3	—	—	—	0	3	—	—
Nebraska§	—	0	1	—	—	—	0	0	—	—	—	0	0	—	—
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
South Dakota	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
S. Atlantic	1	3	19	1	2	—	1	7	—	—	—	0	2	—	—
Delaware	—	0	3	—	—	—	0	1	—	—	—	0	0	—	—
District of Columbia	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Florida	—	0	2	—	1	—	0	1	—	—	—	0	0	—	—
Georgia	1	0	4	1	1	—	0	1	—	—	—	0	1	—	—
Maryland§	—	0	3	—	—	—	0	2	—	—	—	0	2	—	—
North Carolina	—	1	13	—	—	—	0	4	—	—	—	0	0	—	—
South Carolina§	—	0	2	—	—	—	0	1	—	—	—	0	0	—	—
Virginia§	—	1	8	—	—	—	0	2	—	—	—	0	1	—	—
West Virginia	—	0	1	—	—	—	0	0	—	—	—	0	0	—	—
E.S. Central	—	0	10	—	—	—	0	2	—	—	—	0	1	—	—
Alabama§	—	0	3	—	—	—	0	2	—	—	—	0	0	—	—
Kentucky	—	0	2	—	—	—	0	0	—	—	—	0	0	—	—
Mississippi	—	0	1	—	—	—	0	1	—	—	—	0	0	—	—
Tennessee§	—	0	6	—	—	—	0	2	—	—	—	0	1	—	—
W.S. Central	—	0	5	—	—	—	0	2	—	—	—	0	1	—	—
Arkansas§	—	0	5	—	—	—	0	2	—	—	—	0	0	—	—
Louisiana	—	0	1	—	—	—	0	0	—	—	—	0	0	—	—
Oklahoma	—	0	5	—	—	—	0	1	—	—	—	0	0	—	—
Texas§	—	0	1	—	—	—	0	1	—	—	—	0	1	—	—
Mountain	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Arizona	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Colorado	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Idaho§	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Montana§	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Nevada§	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
New Mexico§	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Utah	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Wyoming§	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Pacific	—	0	1	—	—	—	0	0	—	—	—	0	1	—	—
Alaska	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
California	—	0	1	—	—	—	0	0	—	—	—	0	1	—	—
Hawaii	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Oregon	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Washington	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† Cumulative total *E. ewingii* cases reported for year 2010 = 10 and 0 case reports for 2011.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2011, and January 9, 2010 (1st week)*

Reporting area	Giardiasis					Gonorrhea					*Haemophilus influenzae*, invasive† All ages, all serotypes				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	132	329	479	132	252	2,253	5,581	6,382	2,253	5,584	30	58	81	30	81
New England	1	32	54	1	32	46	100	196	46	61	—	3	8	—	5
Connecticut	—	5	13	—	8	—	39	169	—	2	—	0	6	—	—
Maine§	—	4	12	—	3	—	3	11	—	6	—	0	1	—	—
Massachusetts	—	13	24	—	16	42	47	80	42	42	—	2	5	—	3
New Hampshire	1	3	8	1	—	2	3	7	2	5	—	0	2	—	2
Rhode Island§	—	1	7	—	—	—	5	15	—	6	—	0	2	—	—
Vermont§	—	4	10	—	5	2	0	17	2	—	—	0	3	—	—
Mid. Atlantic	14	61	106	14	29	245	690	1,167	245	600	8	11	19	8	18
New Jersey	—	6	18	—	4	96	111	175	96	96	—	2	5	—	3
New York (Upstate)	2	22	54	2	5	36	108	203	36	35	—	3	7	—	1
New York City	2	17	33	2	10	—	238	531	—	274	—	2	6	—	5
Pennsylvania	10	15	27	10	10	113	255	366	113	195	8	4	9	8	9
E.N. Central	25	55	84	25	48	256	947	1,232	256	943	6	10	20	6	13
Illinois	—	11	26	—	12	7	189	278	7	248	—	3	7	—	4
Indiana	—	5	14	—	3	—	99	222	—	59	—	1	6	—	3
Michigan	1	13	25	1	13	159	254	471	159	249	—	0	3	—	—
Ohio	22	17	29	22	16	66	315	381	66	333	6	2	6	6	2
Wisconsin	2	8	32	2	4	24	94	155	24	54	—	2	5	—	4
W.N. Central	13	24	101	13	25	92	286	348	92	271	—	3	14	—	7
Iowa	—	5	11	—	7	6	33	57	6	51	—	0	1	—	—
Kansas	1	4	10	1	7	7	40	62	7	36	—	0	2	—	1
Minnesota	—	0	75	—	—	—	37	62	—	42	—	0	9	—	—
Missouri	8	8	26	8	4	55	141	180	55	118	—	2	6	—	6
Nebraska§	4	4	9	4	4	23	22	48	23	16	—	0	3	—	—
North Dakota	—	0	5	—	—	—	1	8	—	—	—	0	2	—	—
South Dakota	—	1	7	—	3	1	7	20	1	8	—	0	0	—	—
S. Atlantic	38	69	101	38	35	939	1,345	1,790	939	1,348	7	14	26	7	22
Delaware	—	0	5	—	1	23	18	48	23	11	—	0	1	—	—
District of Columbia	—	1	5	—	—	30	34	66	30	26	—	0	1	—	—
Florida	28	41	75	28	21	216	391	490	216	454	5	3	9	5	3
Georgia	—	6	51	—	2	—	205	392	—	56	2	3	9	2	4
Maryland§	4	5	11	4	2	108	132	216	108	66	—	1	5	—	1
North Carolina	N	0	0	N	N	379	245	596	379	392	—	2	9	—	4
South Carolina§	—	2	9	—	2	—	153	262	—	144	—	1	7	—	7
Virginia§	6	9	19	6	7	163	150	223	163	192	—	2	4	—	3
West Virginia	—	0	6	—	—	20	10	26	20	7	—	0	3	—	—
E.S. Central	—	5	12	—	5	80	468	697	80	460	5	3	9	5	3
Alabama§	—	4	11	—	3	—	152	217	—	150	3	0	3	3	—
Kentucky	N	0	0	N	N	—	73	142	—	17	—	1	3	—	2
Mississippi	N	0	0	N	N	80	115	216	80	150	—	0	2	—	—
Tennessee§	—	0	6	—	2	—	137	195	—	143	2	2	9	2	1
W.S. Central	—	7	14	—	8	181	835	1,298	181	1,206	—	2	10	—	2
Arkansas§	—	2	7	—	1	105	80	133	105	73	—	0	3	—	—
Louisiana	—	3	8	—	4	75	90	351	75	351	—	0	4	—	2
Oklahoma	—	1	5	—	3	1	75	359	1	359	—	1	7	—	—
Texas§	N	0	0	N	N	—	599	959	—	423	—	0	1	—	—
Mountain	10	31	51	10	24	104	177	235	104	88	2	5	15	2	10
Arizona	—	3	8	—	5	18	60	100	18	—	—	2	10	—	4
Colorado	8	13	27	8	8	47	54	95	47	52	1	1	5	1	1
Idaho§	2	4	9	2	2	—	2	14	—	2	—	0	2	—	—
Montana§	—	2	7	—	1	—	2	6	—	2	—	0	1	—	—
Nevada§	—	1	11	—	—	—	29	94	—	27	—	0	2	—	—
New Mexico§	—	2	5	—	—	38	20	35	38	3	1	1	5	1	5
Utah	—	4	11	—	8	1	5	15	1	2	—	0	4	—	—
Wyoming§	—	1	7	—	—	—	0	4	—	—	—	0	2	—	—
Pacific	31	53	80	31	46	310	608	815	310	607	2	2	21	2	1
Alaska	—	2	6	—	2	—	24	37	—	22	—	0	2	—	1
California	24	33	57	24	37	263	496	691	263	511	1	0	18	1	—
Hawaii	—	0	4	—	—	—	14	26	—	18	—	0	2	—	—
Oregon	7	9	20	7	7	14	19	34	14	12	1	1	5	1	—
Washington	—	9	21	—	—	33	53	83	33	44	—	0	2	—	—
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	1	—	—	—	0	5	—	—	—	0	0	—	—
Puerto Rico	—	1	8	—	—	4	5	14	4	2	—	0	1	—	—
U.S. Virgin Islands	—	0	0	—	—	—	2	7	—	1	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNational%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† Data for H. influenzae (age <5 yrs for serotype b, nonserotype b, and unknown serotype) are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2011, and January 9, 2010 (1st week)*

Reporting area	Hepatitis (viral, acute), by type														
	A					B					C				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	6	30	43	6	29	17	60	90	17	39	6	14	25	6	14
New England	—	2	5	—	2	—	1	5	—	3	—	1	4	—	2
Connecticut	—	0	3	—	—	—	0	2	—	2	—	0	4	—	1
Maine†	—	0	1	—	—	—	0	2	—	—	—	0	0	—	—
Massachusetts	—	1	5	—	2	—	0	2	—	1	—	0	2	—	1
New Hampshire	—	0	1	—	—	—	0	2	—	—	N	0	0	N	N
Rhode Island†	—	0	4	—	—	U	0	0	U	U	U	0	0	U	U
Vermont†	—	0	0	—	—	—	0	1	—	—	—	0	1	—	—
Mid. Atlantic	—	4	10	—	5	1	5	10	1	3	—	2	6	—	1
New Jersey	—	0	2	—	1	—	1	5	—	—	—	0	2	—	—
New York (Upstate)	—	1	4	—	—	—	1	6	—	—	—	1	4	—	1
New York City	—	1	7	—	2	—	1	4	—	2	—	0	1	—	—
Pennsylvania	—	1	4	—	2	1	1	5	1	1	—	0	3	—	—
E.N. Central	1	4	9	1	4	—	9	17	—	6	—	2	7	—	2
Illinois	—	1	3	—	1	—	2	5	—	1	—	0	1	—	—
Indiana	—	0	2	—	—	—	1	5	—	1	—	0	2	—	—
Michigan	—	1	5	—	—	—	3	6	—	2	—	1	6	—	2
Ohio	1	1	5	1	1	—	2	6	—	—	—	0	1	—	—
Wisconsin	—	0	3	—	2	—	2	8	—	2	—	0	2	—	—
W.N. Central	1	1	13	1	3	1	2	7	1	—	—	0	8	—	—
Iowa	1	0	3	1	1	—	0	2	—	—	—	0	0	—	—
Kansas	—	0	2	—	—	—	0	2	—	—	—	0	1	—	—
Minnesota	—	0	12	—	—	—	0	4	—	—	—	0	6	—	—
Missouri	—	0	2	—	1	—	1	3	—	—	—	0	2	—	—
Nebraska†	—	0	4	—	1	1	0	2	1	—	—	0	1	—	—
North Dakota	—	0	3	—	—	—	0	0	—	—	—	0	0	—	—
South Dakota	—	0	1	—	—	—	0	1	—	—	—	0	0	—	—
S. Atlantic	2	6	14	2	6	6	16	32	6	11	2	2	6	2	4
Delaware	—	0	1	—	—	—	0	2	—	1	U	0	0	U	U
District of Columbia	—	0	1	—	—	—	0	1	—	—	—	0	1	—	—
Florida	1	3	7	1	1	5	5	11	5	5	—	0	0	—	—
Georgia	1	1	3	1	2	—	3	7	—	3	—	0	2	—	—
Maryland†	—	0	3	—	—	—	1	6	—	—	2	0	3	2	2
North Carolina	—	0	5	—	—	—	1	16	—	1	—	1	3	—	2
South Carolina†	—	0	3	—	3	—	1	4	—	—	—	0	1	—	—
Virginia†	—	1	6	—	—	1	1	6	1	1	—	0	2	—	—
West Virginia	—	0	5	—	—	—	0	12	—	—	—	0	5	—	—
E.S. Central	—	1	5	—	—	7	8	13	7	8	3	3	8	3	1
Alabama†	—	0	2	—	—	—	1	4	—	2	—	0	1	—	—
Kentucky	—	0	5	—	—	4	2	8	4	2	2	2	6	2	1
Mississippi	—	0	1	—	—	—	0	3	—	—	U	0	0	U	U
Tennessee†	—	0	2	—	—	3	2	8	3	4	1	1	4	1	—
W.S. Central	—	2	7	—	—	—	9	29	—	2	—	1	5	—	—
Arkansas†	—	0	1	—	—	—	0	4	—	—	—	0	0	—	—
Louisiana	—	0	2	—	—	—	1	3	—	2	—	0	1	—	—
Oklahoma	—	0	1	—	—	—	2	6	—	—	—	0	3	—	—
Texas†	—	2	7	—	—	—	5	25	—	—	—	0	3	—	—
Mountain	—	3	8	—	4	—	2	8	—	5	1	1	5	1	—
Arizona	—	1	4	—	3	—	0	2	—	1	U	0	0	U	U
Colorado	—	1	3	—	—	—	0	5	—	1	1	0	1	1	—
Idaho†	—	0	2	—	—	—	0	1	—	—	—	0	2	—	—
Montana†	—	0	1	—	—	—	0	1	—	—	—	0	1	—	—
Nevada†	—	0	2	—	—	—	0	3	—	3	—	0	1	—	—
New Mexico†	—	0	1	—	—	—	0	1	—	—	—	0	2	—	—
Utah	—	0	1	—	1	—	0	1	—	—	—	0	2	—	—
Wyoming†	—	0	3	—	—	—	0	1	—	—	—	0	0	—	—
Pacific	2	5	17	2	5	2	6	17	2	1	—	1	4	—	4
Alaska	—	0	1	—	—	—	0	1	—	—	U	0	0	U	U
California	2	4	16	2	5	—	4	16	—	1	—	0	4	—	4
Hawaii	—	0	1	—	—	—	0	1	—	—	U	0	0	U	U
Oregon	—	0	2	—	—	2	1	3	2	—	—	0	3	—	—
Washington	—	0	2	—	—	—	1	4	—	—	—	0	3	—	—
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	6	—	—	—	1	6	—	—	—	0	7	—	—
Puerto Rico	—	0	2	—	—	—	0	2	—	—	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2010 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for HIV/AIDS, AIDS and TB, when available, are displayed in Table IV, which appears quarterly.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2011, and January 9, 2010 (1st week)*

Reporting area	Legionellosis					Lyme disease					Malaria				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	20	56	114	20	36	35	383	1,655	35	267	7	26	80	7	17
New England	—	3	15	—	3	—	119	495	—	79	—	1	4	—	—
Connecticut	—	1	6	—	—	—	42	211	—	43	—	0	1	—	—
Maine†	—	0	4	—	—	—	11	65	—	—	—	0	1	—	—
Massachusetts	—	2	10	—	2	—	39	216	—	27	—	1	3	—	—
New Hampshire	—	0	5	—	—	—	24	68	—	7	—	0	2	—	—
Rhode Island†	—	0	4	—	1	—	1	40	—	—	—	0	1	—	—
Vermont†	—	0	2	—	—	—	4	27	—	2	—	0	1	—	—
Mid. Atlantic	2	14	47	2	8	16	171	737	16	120	—	7	17	—	6
New Jersey	—	1	11	—	3	—	49	220	—	35	—	0	1	—	—
New York (Upstate)	—	5	19	—	1	1	38	200	1	1	—	1	6	—	2
New York City	—	2	17	—	2	—	2	7	—	4	—	4	14	—	2
Pennsylvania	2	6	18	2	2	15	86	383	15	80	—	1	3	—	2
E.N. Central	3	12	44	3	8	—	24	323	—	12	1	2	9	1	2
Illinois	—	1	15	—	1	—	1	17	—	—	—	1	7	—	1
Indiana	—	2	6	—	—	—	1	7	—	—	—	0	2	—	—
Michigan	—	2	20	—	1	—	1	13	—	—	—	0	4	—	—
Ohio	3	4	15	3	5	—	0	9	—	—	1	1	5	1	1
Wisconsin	—	1	11	—	1	—	21	296	—	12	—	0	1	—	—
W.N. Central	1	2	9	1	1	—	1	11	—	—	—	1	4	—	1
Iowa	—	0	2	—	—	—	0	10	—	—	—	0	2	—	1
Kansas	—	0	2	—	—	—	0	1	—	—	—	0	2	—	—
Minnesota	—	0	8	—	—	—	0	0	—	—	—	0	3	—	—
Missouri	1	0	4	1	1	—	0	1	—	—	—	0	3	—	—
Nebraska†	—	0	2	—	—	—	0	2	—	—	—	0	2	—	—
North Dakota	—	0	1	—	—	—	0	5	—	—	—	0	1	—	—
South Dakota	—	0	2	—	—	—	0	1	—	—	—	0	2	—	—
S. Atlantic	4	10	27	4	7	16	56	174	16	53	6	7	44	6	6
Delaware	—	0	3	—	1	3	11	32	3	11	—	0	1	—	—
District of Columbia	—	0	4	—	—	—	0	4	—	—	—	0	2	—	—
Florida	2	3	9	2	1	1	2	10	1	2	2	3	7	2	—
Georgia	—	1	4	—	—	—	0	2	—	1	2	0	6	2	1
Maryland†	2	2	6	2	4	6	24	101	6	17	—	1	24	—	3
North Carolina	—	0	7	—	—	—	1	9	—	—	—	0	13	—	—
South Carolina†	—	0	2	—	—	—	0	3	—	—	—	0	1	—	—
Virginia†	—	1	10	—	1	6	17	76	6	21	2	1	5	2	2
West Virginia	—	0	3	—	—	—	0	29	—	1	—	0	1	—	—
E.S. Central	2	2	10	2	1	—	0	4	—	1	—	0	3	—	1
Alabama†	—	0	2	—	—	—	0	1	—	—	—	0	1	—	1
Kentucky	1	0	4	1	—	—	0	1	—	—	—	0	1	—	—
Mississippi	—	0	3	—	—	—	0	0	—	—	—	0	2	—	—
Tennessee†	1	1	6	1	1	—	0	4	—	1	—	0	2	—	—
W.S. Central	1	3	8	1	1	—	2	8	—	1	—	1	7	—	—
Arkansas†	—	0	2	—	—	—	0	0	—	—	—	0	1	—	—
Louisiana	—	0	2	—	1	—	0	1	—	—	—	0	1	—	—
Oklahoma	—	0	3	—	—	—	0	0	—	—	—	0	1	—	—
Texas†	1	2	7	1	—	—	2	7	—	1	—	1	7	—	—
Mountain	—	3	10	—	3	—	0	3	—	—	—	1	4	—	1
Arizona	—	1	6	—	1	—	0	1	—	—	—	0	2	—	—
Colorado	—	0	5	—	1	—	0	1	—	—	—	0	3	—	—
Idaho†	—	0	1	—	—	—	0	2	—	—	—	0	1	—	—
Montana†	—	0	1	—	—	—	0	1	—	—	—	0	1	—	—
Nevada†	—	0	2	—	1	—	0	1	—	—	—	0	1	—	—
New Mexico†	—	0	2	—	—	—	0	2	—	—	—	0	1	—	—
Utah	—	0	2	—	—	—	0	1	—	—	—	0	1	—	1
Wyoming†	—	0	2	—	—	—	0	0	—	—	—	0	0	—	—
Pacific	7	4	19	7	4	3	4	10	3	1	—	3	10	—	—
Alaska	—	0	2	—	—	—	0	1	—	—	—	0	1	—	—
California	7	4	19	7	4	3	3	7	3	—	—	2	9	—	—
Hawaii	—	0	1	—	—	N	0	0	N	N	—	0	1	—	—
Oregon	—	0	3	—	—	—	1	4	—	1	—	0	3	—	—
Washington	—	0	4	—	—	—	0	3	—	—	—	0	5	—	—
Territories															
American Samoa	—	0	0	—	—	N	0	0	N	N	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	1	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	N	0	0	N	N	—	0	2	—	1
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2011, and January 9, 2010 (1st week)*

Reporting area	Meningococcal disease, invasive† All serogroups					Mumps					Pertussis				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	10	15	26	10	18	3	30	221	3	29	136	449	780	136	129
New England	1	0	3	1	—	—	0	4	—	—	—	8	22	—	2
Connecticut	1	0	1	1	—	—	0	2	—	—	—	1	8	—	—
Maine§	—	0	1	—	—	—	0	1	—	—	—	1	5	—	—
Massachusetts	—	0	2	—	—	—	0	2	—	—	—	5	13	—	1
New Hampshire	—	0	0	—	—	—	0	1	—	—	—	0	2	—	—
Rhode Island§	—	0	0	—	—	—	0	0	—	—	—	0	9	—	—
Vermont§	—	0	1	—	—	—	0	0	—	—	—	0	4	—	1
Mid. Atlantic	3	1	4	3	2	—	22	209	—	26	10	37	142	10	8
New Jersey	—	0	2	—	—	—	4	24	—	19	—	3	9	—	2
New York (Upstate)	—	0	2	—	—	—	3	99	—	7	2	11	77	2	—
New York City	1	0	2	1	1	—	1	201	—	—	—	0	9	—	—
Pennsylvania	2	0	2	2	1	—	0	16	—	—	8	14	69	8	6
E.N. Central	2	2	9	2	8	2	1	6	2	3	51	108	180	51	60
Illinois	—	0	3	—	2	—	0	2	—	1	1	20	49	1	9
Indiana	—	0	3	—	3	—	0	1	—	—	—	12	26	—	8
Michigan	—	0	4	—	2	—	0	2	—	2	11	28	57	11	13
Ohio	2	0	2	2	1	2	0	5	2	—	37	33	80	37	19
Wisconsin	—	0	3	—	—	—	0	2	—	—	2	9	21	2	11
W.N. Central	1	1	5	1	—	1	1	14	1	—	16	33	193	16	13
Iowa	—	0	3	—	—	—	0	7	—	—	—	12	34	—	2
Kansas	—	0	2	—	—	—	0	1	—	—	—	3	9	—	2
Minnesota	—	0	1	—	—	—	0	1	—	—	—	0	143	—	—
Missouri	1	0	4	1	—	—	0	2	—	—	10	8	44	10	4
Nebraska§	—	0	2	—	—	1	0	10	1	—	6	4	13	6	3
North Dakota	—	0	1	—	—	—	0	1	—	—	—	0	30	—	—
South Dakota	—	0	0	—	—	—	0	1	—	—	—	0	5	—	2
S. Atlantic	1	2	7	1	4	—	1	4	—	—	15	30	79	15	15
Delaware	—	0	1	—	—	—	0	0	—	—	—	0	4	—	—
District of Columbia	—	0	0	—	—	—	0	1	—	—	—	0	2	—	—
Florida	1	1	5	1	3	—	0	3	—	—	3	6	28	3	6
Georgia	—	0	2	—	1	—	0	1	—	—	—	4	18	—	1
Maryland§	—	0	1	—	—	—	0	1	—	—	1	3	8	1	2
North Carolina	—	0	2	—	—	—	0	0	—	—	—	0	32	—	3
South Carolina§	—	0	1	—	—	—	0	2	—	—	8	6	22	8	1
Virginia§	—	0	2	—	—	—	0	2	—	—	3	5	34	3	1
West Virginia	—	0	1	—	—	—	0	1	—	—	—	1	21	—	1
E.S. Central	—	1	3	—	2	—	0	2	—	—	10	16	34	10	9
Alabama§	—	0	1	—	1	—	0	2	—	—	—	4	8	—	—
Kentucky	—	0	2	—	1	—	0	1	—	—	9	6	16	9	5
Mississippi	—	0	1	—	—	—	0	0	—	—	—	1	8	—	1
Tennessee§	—	0	2	—	—	—	0	1	—	—	1	4	11	1	3
W.S. Central	—	1	9	—	1	—	1	11	—	—	—	54	113	—	3
Arkansas§	—	0	1	—	1	—	0	1	—	—	—	3	14	—	—
Louisiana	—	0	4	—	—	—	0	2	—	—	—	1	3	—	2
Oklahoma	—	0	7	—	—	—	0	0	—	—	—	0	23	—	—
Texas§	—	1	4	—	—	—	1	11	—	—	—	49	108	—	1
Mountain	1	1	6	1	1	—	0	4	—	—	25	29	123	25	15
Arizona	—	0	2	—	1	—	0	1	—	—	—	7	16	—	8
Colorado	—	0	4	—	—	—	0	1	—	—	25	5	108	25	1
Idaho§	1	0	1	1	—	—	0	1	—	—	—	2	15	—	3
Montana§	—	0	1	—	—	—	0	0	—	—	—	1	16	—	—
Nevada§	—	0	1	—	—	—	0	1	—	—	—	0	7	—	—
New Mexico§	—	0	1	—	—	—	0	2	—	—	—	2	11	—	2
Utah	—	0	1	—	—	—	0	1	—	—	—	4	13	—	1
Wyoming§	—	0	1	—	—	—	0	1	—	—	—	0	2	—	—
Pacific	1	3	9	1	—	—	0	18	—	—	9	66	222	9	4
Alaska	—	0	1	—	—	—	0	1	—	—	—	0	6	—	1
California	—	2	9	—	—	—	0	18	—	—	9	41	194	9	—
Hawaii	—	0	1	—	—	—	0	1	—	—	—	0	6	—	—
Oregon	1	1	2	1	—	—	0	1	—	—	—	6	15	—	3
Washington	—	0	4	—	—	—	0	2	—	—	—	6	38	—	—
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	1	15	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	1	—	—	—	0	1	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
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† Data for meningococcal disease, invasive caused by serogroups A, C, Y, and W-135; serogroup B; other serogroup; and unknown serogroup are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2011, and January 9, 2010 (1st week)*

Reporting area	Rabies, animal					Salmonellosis					Shiga toxin-producing *E. coli* (STEC)†				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	10	62	143	10	36	238	876	1,736	238	990	38	87	212	38	90
New England	1	4	13	1	5	3	31	496	3	496	—	2	57	—	57
Connecticut	—	0	9	—	—	—	0	480	—	480	—	0	57	—	57
Maine§	1	1	4	1	1	2	2	7	2	—	—	0	3	—	—
Massachusetts	—	0	0	—	—	—	22	52	—	11	—	1	9	—	—
New Hampshire	—	0	5	—	1	—	3	12	—	3	—	0	2	—	—
Rhode Island§	—	0	4	—	—	—	2	17	—	2	—	0	1	—	—
Vermont§	—	1	3	—	3	1	1	5	1	—	—	0	2	—	—
Mid. Atlantic	8	19	41	8	11	17	95	218	17	68	—	9	32	—	4
New Jersey	—	0	0	—	—	—	17	57	—	19	—	1	9	—	1
New York (Upstate)	8	9	19	8	5	3	25	63	3	—	—	3	13	—	—
New York City	—	1	12	—	—	1	25	56	1	26	—	1	7	—	1
Pennsylvania	—	8	24	—	6	13	31	81	13	23	—	2	13	—	2
E.N. Central	1	2	27	1	1	22	86	244	22	74	1	10	43	1	13
Illinois	1	1	11	1	—	—	28	114	—	23	—	1	9	—	4
Indiana	—	0	0	—	—	—	11	62	—	12	—	1	10	—	1
Michigan	—	1	5	—	—	4	15	49	4	11	—	2	16	—	1
Ohio	—	0	12	—	1	18	24	47	18	22	1	2	11	1	2
Wisconsin	—	0	0	—	—	—	9	45	—	6	—	3	17	—	5
W.N. Central	—	4	14	—	—	17	46	97	17	15	3	11	39	3	3
Iowa	—	0	3	—	—	3	9	34	3	2	—	2	16	—	—
Kansas	—	1	4	—	—	2	7	18	2	3	—	1	5	—	2
Minnesota	—	0	4	—	—	—	0	32	—	—	—	0	7	—	—
Missouri	—	1	6	—	—	9	13	44	9	9	—	4	27	—	1
Nebraska§	—	1	4	—	—	3	4	13	3	1	3	1	6	3	—
North Dakota	—	0	3	—	—	—	0	13	—	—	—	0	10	—	—
South Dakota	—	0	0	—	—	—	3	17	—	—	—	0	4	—	—
S. Atlantic	—	20	104	—	13	91	258	611	91	169	15	13	30	15	4
Delaware	—	0	0	—	—	1	3	11	1	2	—	0	2	—	—
District of Columbia	—	0	0	—	—	—	1	6	—	—	—	0	1	—	—
Florida	—	0	96	—	—	48	108	226	48	87	8	4	23	8	1
Georgia	—	0	0	—	—	22	43	132	22	44	1	1	15	1	2
Maryland§	—	6	14	—	4	6	17	55	6	15	4	2	9	4	1
North Carolina	—	0	0	—	—	—	32	240	—	1	—	1	10	—	—
South Carolina§	—	0	0	—	—	—	24	99	—	9	—	0	2	—	—
Virginia§	—	10	25	—	8	14	19	57	14	11	2	2	9	2	—
West Virginia	—	1	7	—	1	—	2	13	—	—	—	0	3	—	—
E.S. Central	—	3	7	—	1	18	55	177	18	42	5	5	22	5	2
Alabama§	—	1	4	—	—	2	19	52	2	18	1	1	4	1	2
Kentucky	—	0	4	—	—	10	11	32	10	5	1	1	6	1	—
Mississippi	—	0	1	—	—	1	18	67	1	9	—	0	12	—	—
Tennessee§	—	1	4	—	1	5	15	53	5	10	3	2	7	3	—
W.S. Central	—	0	30	—	—	4	105	261	4	24	—	5	15	—	1
Arkansas§	—	0	7	—	—	2	12	43	2	—	—	1	5	—	—
Louisiana	—	0	0	—	—	2	20	49	2	15	—	0	2	—	1
Oklahoma	—	0	30	—	—	—	12	39	—	1	—	0	8	—	—
Texas§	—	0	0	—	—	—	63	170	—	8	—	3	14	—	—
Mountain	—	1	7	—	2	16	49	108	16	49	1	11	34	1	3
Arizona	—	0	0	—	—	—	16	42	—	21	—	1	13	—	1
Colorado	—	0	0	—	—	14	10	24	14	8	—	3	21	—	2
Idaho§	—	0	2	—	—	2	3	9	2	5	1	2	7	1	—
Montana§	—	0	3	—	—	—	1	7	—	7	—	1	5	—	—
Nevada§	—	0	2	—	—	—	4	22	—	3	—	0	5	—	—
New Mexico§	—	0	2	—	—	—	6	19	—	4	—	1	6	—	—
Utah	—	0	2	—	—	—	6	17	—	1	—	1	7	—	—
Wyoming§	—	0	4	—	2	—	1	8	—	—	—	0	3	—	—
Pacific	—	2	12	—	3	50	114	253	50	53	13	11	36	13	3
Alaska	—	0	2	—	2	—	1	5	—	1	—	0	1	—	—
California	—	1	12	—	1	50	79	217	50	50	13	6	20	13	3
Hawaii	—	0	0	—	—	—	3	14	—	—	—	0	4	—	—
Oregon	—	0	2	—	—	—	8	48	—	2	—	2	14	—	—
Washington	—	0	0	—	—	—	15	33	—	—	—	3	19	—	—
Territories															
American Samoa	N	0	0	N	N	—	0	1	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	2	—	—	—	0	0	—	—
Puerto Rico	—	1	3	—	—	—	10	21	—	8	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
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† Includes E. coli O157:H7; Shiga toxin-positive, serogroup non-O157; and Shiga toxin-positive, not serogrouped.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2011, and January 9, 2010 (1st week)*

Reporting area	Shigellosis					Spotted Fever Rickettsiosis (including RMSF)†									
						Confirmed					Probable				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	87	267	452	87	252	—	2	11	—	2	—	23	91	—	1
New England	—	4	68	—	68	—	0	0	—	—	—	0	1	—	—
Connecticut	—	0	63	—	63	—	0	0	—	—	—	0	0	—	—
Maine§	—	0	1	—	—	—	0	0	—	—	—	0	1	—	—
Massachusetts	—	4	16	—	5	—	0	0	—	—	—	0	0	—	—
New Hampshire	—	0	2	—	—	—	0	0	—	—	—	0	1	—	—
Rhode Island§	—	0	2	—	—	—	0	0	—	—	—	0	0	—	—
Vermont§	—	0	1	—	—	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	1	33	62	1	39	—	0	1	—	—	—	1	4	—	—
New Jersey	—	6	16	—	6	—	0	0	—	—	—	0	0	—	—
New York (Upstate)	—	3	15	—	1	—	0	1	—	—	—	0	3	—	—
New York City	1	5	14	1	9	—	0	1	—	—	—	0	4	—	—
Pennsylvania	—	12	55	—	23	—	0	1	—	—	—	0	3	—	—
E.N. Central	4	26	238	4	24	—	0	1	—	—	—	1	10	—	—
Illinois	—	9	228	—	12	—	0	1	—	—	—	0	5	—	—
Indiana§	—	1	4	—	—	—	0	1	—	—	—	0	5	—	—
Michigan	—	5	10	—	1	—	0	0	—	—	—	0	1	—	—
Ohio	4	5	18	4	6	—	0	0	—	—	—	0	2	—	—
Wisconsin	—	4	21	—	5	—	0	0	—	—	—	0	1	—	—
W.N. Central	12	39	81	12	59	—	0	4	—	—	—	4	21	—	—
Iowa	—	1	5	—	5	—	0	0	—	—	—	0	1	—	—
Kansas§	2	5	13	2	1	—	0	1	—	—	—	0	0	—	—
Minnesota	—	0	3	—	—	—	0	0	—	—	—	0	0	—	—
Missouri	10	31	66	10	53	—	0	4	—	—	—	4	20	—	—
Nebraska§	—	1	10	—	—	—	0	1	—	—	—	0	1	—	—
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	1	—	—
South Dakota	—	0	2	—	—	—	0	0	—	—	—	0	0	—	—
S. Atlantic	39	51	134	39	25	—	1	9	—	1	—	8	60	—	1
Delaware§	—	0	4	—	2	—	0	1	—	—	—	0	3	—	—
District of Columbia	—	0	4	—	—	—	0	1	—	—	—	0	0	—	—
Florida§	31	22	53	31	3	—	0	1	—	—	—	0	2	—	—
Georgia	6	14	39	6	15	—	1	6	—	1	—	0	0	—	—
Maryland§	1	2	8	1	—	—	0	1	—	—	—	0	5	—	—
North Carolina	—	3	36	—	2	—	0	3	—	—	—	2	48	—	—
South Carolina§	—	1	5	—	3	—	0	1	—	—	—	0	2	—	1
Virginia§	1	3	8	1	—	—	0	2	—	—	—	2	12	—	—
West Virginia	—	0	66	—	—	—	0	0	—	—	—	0	0	—	—
E.S. Central	4	13	40	4	6	—	0	3	—	—	—	5	29	—	—
Alabama§	1	4	14	1	1	—	0	1	—	—	—	1	8	—	—
Kentucky	2	3	28	2	—	—	0	2	—	—	—	0	0	—	—
Mississippi	—	1	4	—	1	—	0	0	—	—	—	0	3	—	—
Tennessee§	1	5	14	1	4	—	0	2	—	—	—	4	20	—	—
W.S. Central	1	51	108	1	5	—	0	3	—	—	—	1	18	—	—
Arkansas§	—	1	6	—	1	—	0	2	—	—	—	0	17	—	—
Louisiana	—	5	13	—	3	—	0	0	—	—	—	0	1	—	—
Oklahoma	—	5	13	—	—	—	0	3	—	—	—	0	6	—	—
Texas§	1	38	87	1	1	—	0	1	—	—	—	0	3	—	—
Mountain	13	15	32	13	10	—	0	5	—	—	—	0	4	—	—
Arizona	4	8	18	4	3	—	0	4	—	—	—	0	4	—	—
Colorado§	8	2	6	8	3	—	0	1	—	—	—	0	1	—	—
Idaho§	1	0	3	1	—	—	0	0	—	—	—	0	1	—	—
Montana§	—	0	1	—	—	—	0	1	—	—	—	0	1	—	—
Nevada§	—	0	6	—	—	—	0	0	—	—	—	0	0	—	—
New Mexico§	—	2	10	—	2	—	0	0	—	—	—	0	1	—	—
Utah	—	1	4	—	2	—	0	0	—	—	—	0	1	—	—
Wyoming§	—	0	0	—	—	—	0	0	—	—	—	0	1	—	—
Pacific	13	21	58	13	16	—	0	2	—	1	—	0	0	—	—
Alaska	—	0	1	—	—	N	0	0	N	N	N	0	0	N	N
California	13	17	50	13	16	—	0	2	—	1	—	0	0	—	—
Hawaii	—	0	3	—	—	N	0	0	N	N	N	0	0	N	N
Oregon	—	1	4	—	—	—	0	1	—	—	—	0	0	—	—
Washington	—	1	17	—	—	—	0	0	—	—	—	0	0	—	—
Territories															
American Samoa	—	1	1	—	—	N	0	0	N	N	N	0	0	N	N
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	1	—	—	N	0	0	N	N	N	0	0	N	N
Puerto Rico	—	0	1	—	—	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† Illnesses with similar clinical presentation that result from Spotted fever group rickettsia infections are reported as Spotted fever rickettsioses. Rocky Mountain spotted fever (RMSF) caused by Rickettsia rickettsii, is the most common and well-known spotted fever.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2011, and January 9, 2010 (1st week)*

Reporting area	*Streptococcus pneumoniae*,† invasive disease										Syphilis, primary and secondary				
	All ages					Age <5									
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	253	267	495	253	430	12	42	84	12	60	40	243	317	40	194
New England	3	9	99	3	11	—	1	14	—	1	4	9	20	4	2
Connecticut	—	0	91	—	—	—	0	12	—	—	—	1	8	—	—
Maine§	3	2	6	3	4	—	0	1	—	1	—	0	3	—	—
Massachusetts	—	1	5	—	—	—	0	4	—	—	3	5	15	3	2
New Hampshire	—	0	7	—	4	—	0	1	—	—	—	0	2	—	—
Rhode Island§	—	0	36	—	—	—	0	3	—	—	1	1	4	1	—
Vermont§	—	1	6	—	3	—	0	1	—	—	—	0	2	—	—
Mid. Atlantic	24	28	56	24	31	—	7	19	—	8	7	32	45	7	26
New Jersey	—	2	8	—	2	—	1	5	—	1	3	4	12	3	4
New York (Upstate)	1	3	7	1	4	—	2	7	—	1	3	2	8	3	—
New York City	6	11	32	6	6	—	2	14	—	1	—	19	31	—	20
Pennsylvania	17	10	22	17	19	—	1	5	—	5	1	7	16	1	2
E.N. Central	55	59	98	55	95	1	6	18	1	10	1	27	48	1	21
Illinois	—	2	7	—	2	—	2	5	—	2	—	8	26	—	12
Indiana	—	9	24	—	18	—	1	6	—	1	—	3	14	—	—
Michigan	7	13	27	7	26	—	1	6	—	4	—	4	12	—	4
Ohio	44	25	49	44	43	1	2	6	1	3	1	9	19	1	5
Wisconsin	4	7	22	4	6	—	0	4	—	—	—	1	3	—	—
W.N. Central	6	10	61	6	9	1	1	12	1	1	1	6	18	1	3
Iowa	—	0	0	—	—	—	0	0	—	—	—	0	3	—	—
Kansas	2	2	7	2	—	—	0	2	—	—	—	0	3	—	—
Minnesota	—	0	46	—	—	—	0	8	—	—	—	2	9	—	1
Missouri	2	2	10	2	3	—	1	4	—	—	1	3	9	1	2
Nebraska§	2	2	9	2	5	1	0	2	1	1	—	0	2	—	—
North Dakota	—	0	11	—	—	—	0	1	—	—	—	0	0	—	—
South Dakota	—	0	3	—	1	—	0	2	—	—	—	0	1	—	—
S. Atlantic	105	62	144	105	126	8	9	27	8	18	23	56	103	23	39
Delaware	2	1	3	2	1	—	0	0	—	—	—	0	4	—	—
District of Columbia	—	0	3	—	1	—	0	2	—	1	2	2	20	2	1
Florida	65	25	89	65	45	4	3	18	4	3	4	21	44	4	11
Georgia	16	9	28	16	28	2	2	9	2	7	—	9	29	—	2
Maryland§	22	9	31	22	25	2	1	6	2	2	5	6	14	5	2
North Carolina	—	0	0	—	—	—	0	0	—	—	8	6	22	8	8
South Carolina§	—	8	25	—	25	—	1	4	—	4	—	3	7	—	4
Virginia§	—	1	4	—	1	—	1	4	—	1	4	5	22	4	11
West Virginia	—	2	9	—	—	—	0	4	—	—	—	0	2	—	—
E.S. Central	18	24	50	18	50	2	2	7	2	6	—	16	39	—	10
Alabama§	—	0	0	—	—	—	0	0	—	—	—	5	11	—	6
Kentucky	5	3	16	5	2	1	0	2	1	—	—	2	12	—	—
Mississippi	—	1	8	—	4	—	0	2	—	1	—	4	16	—	—
Tennessee§	13	20	44	13	44	1	2	6	1	5	—	5	17	—	4
W.S. Central	6	35	109	6	17	—	5	21	—	4	1	37	63	1	33
Arkansas§	—	3	19	—	2	—	0	3	—	—	1	3	12	1	—
Louisiana	1	2	8	1	5	—	0	3	—	3	—	8	28	—	14
Oklahoma	—	1	5	—	1	—	1	5	—	1	—	1	7	—	—
Texas§	5	27	88	5	9	—	3	17	—	—	—	24	33	—	19
Mountain	30	34	82	30	82	—	4	12	—	9	2	10	25	2	1
Arizona	9	13	51	9	51	—	2	7	—	6	1	3	8	1	—
Colorado	20	11	22	20	20	—	1	4	—	1	—	2	8	—	—
Idaho§	—	0	2	—	—	—	0	2	—	—	—	0	2	—	—
Montana§	—	0	2	—	—	—	0	1	—	—	—	0	2	—	—
Nevada§	—	2	4	—	3	—	0	1	—	1	—	2	9	—	1
New Mexico§	—	3	10	—	3	—	0	4	—	—	1	1	4	1	—
Utah	—	4	9	—	5	—	0	3	—	1	—	1	4	—	—
Wyoming§	1	0	15	1	—	—	0	1	—	—	—	0	0	—	—
Pacific	6	5	15	6	9	—	0	7	—	3	1	44	63	1	59
Alaska	—	2	9	—	6	—	0	5	—	2	—	0	1	—	—
California	6	3	14	6	3	—	0	5	—	1	—	38	54	—	54
Hawaii	—	0	2	—	—	—	0	0	—	—	—	0	5	—	—
Oregon	—	0	0	—	—	—	0	0	—	—	—	1	7	—	—
Washington	—	0	0	—	—	—	0	0	—	—	1	4	11	1	5
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	0	—	—	2	3	15	2	2
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2010 and 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB are displayed in Table IV, which appears quarterly.
† Includes drug resistant and susceptible cases of invasive Streptococcus pneumoniae disease among children <5 years and among all ages. Case definition: Isolation of *S. pneumoniae* from a normally sterile body site (e.g., blood or cerebrospinal fluid).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 8, 2011, and January 9, 2010 (1st week)*

Reporting area	Varicella (chickenpox)§					West Nile virus disease†								
						Neuroinvasive					Nonneuroinvasive§			
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	62	282	550	62	225	—	0	71	—	—	—	1	53	—	—
New England	—	14	34	—	14	—	0	3	—	—	—	0	1	—	—
Connecticut	—	5	20	—	2	—	0	2	—	—	—	0	1	—	—
Maine¶	—	4	15	—	5	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	0	1	—	—	—	0	2	—	—	—	0	1	—	—
New Hampshire	—	2	8	—	5	—	0	1	—	—	—	0	0	—	—
Rhode Island¶	—	0	3	—	1	—	0	0	—	—	—	0	0	—	—
Vermont¶	—	0	10	—	1	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	11	32	62	11	30	—	0	19	—	—	—	0	13	—	—
New Jersey	—	8	30	—	16	—	0	3	—	—	—	0	6	—	—
New York (Upstate)	N	0	0	N	N	—	0	9	—	—	—	0	7	—	—
New York City	—	0	1	—	—	—	0	7	—	—	—	0	4	—	—
Pennsylvania	11	23	40	11	14	—	0	3	—	—	—	0	3	—	—
E.N. Central	41	98	176	41	101	—	0	14	—	—	—	0	8	—	—
Illinois	3	22	45	3	28	—	0	10	—	—	—	0	5	—	—
Indiana¶	—	5	35	—	6	—	0	2	—	—	—	0	2	—	—
Michigan	12	31	62	12	31	—	0	6	—	—	—	0	1	—	—
Ohio	26	28	56	26	34	—	0	1	—	—	—	0	1	—	—
Wisconsin	—	7	22	—	2	—	0	0	—	—	—	0	1	—	—
W.N. Central	10	15	32	10	13	—	0	7	—	—	—	0	11	—	—
Iowa	N	0	0	N	N	—	0	1	—	—	—	0	2	—	—
Kansas¶	—	4	22	—	8	—	0	1	—	—	—	0	3	—	—
Minnesota	—	0	0	—	—	—	0	1	—	—	—	0	3	—	—
Missouri	10	8	23	10	5	—	0	1	—	—	—	0	0	—	—
Nebraska¶	N	0	0	N	N	—	0	3	—	—	—	0	7	—	—
North Dakota	—	0	10	—	—	—	0	2	—	—	—	0	2	—	—
South Dakota	—	1	7	—	—	—	0	2	—	—	—	0	3	—	—
S. Atlantic	—	35	100	—	21	—	0	4	—	—	—	0	4	—	—
Delaware¶	—	0	3	—	—	—	0	0	—	—	—	0	0	—	—
District of Columbia	—	0	4	—	—	—	0	1	—	—	—	0	1	—	—
Florida¶	—	16	57	—	9	—	0	3	—	—	—	0	1	—	—
Georgia	N	0	0	N	N	—	0	1	—	—	—	0	3	—	—
Maryland¶	N	0	0	N	N	—	0	3	—	—	—	0	2	—	—
North Carolina	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
South Carolina¶	—	0	35	—	2	—	0	1	—	—	—	0	0	—	—
Virginia¶	—	10	29	—	2	—	0	1	—	—	—	0	1	—	—
West Virginia	—	8	26	—	8	—	0	0	—	—	—	0	0	—	—
E.S. Central	—	5	22	—	5	—	0	1	—	—	—	0	3	—	—
Alabama¶	—	5	22	—	5	—	0	1	—	—	—	0	1	—	—
Kentucky	N	0	0	N	N	—	0	1	—	—	—	0	1	—	—
Mississippi	—	0	2	—	—	—	0	1	—	—	—	0	2	—	—
Tennessee¶	N	0	0	N	N	—	0	1	—	—	—	0	2	—	—
W.S. Central	—	43	177	—	8	—	0	15	—	—	—	0	3	—	—
Arkansas¶	—	2	32	—	2	—	0	3	—	—	—	0	1	—	—
Louisiana	—	2	5	—	—	—	0	3	—	—	—	0	1	—	—
Oklahoma	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
Texas¶	—	40	171	—	6	—	0	15	—	—	—	0	2	—	—
Mountain	—	20	36	—	33	—	0	18	—	—	—	0	15	—	—
Arizona	—	0	0	—	—	—	0	13	—	—	—	0	9	—	—
Colorado¶	—	8	18	—	16	—	0	5	—	—	—	0	11	—	—
Idaho¶	N	0	0	N	N	—	0	0	—	—	—	0	1	—	—
Montana¶	—	3	17	—	5	—	0	0	—	—	—	0	0	—	—
Nevada¶	N	0	0	N	N	—	0	0	—	—	—	0	1	—	—
New Mexico¶	—	1	8	—	3	—	0	5	—	—	—	0	2	—	—
Utah	—	4	17	—	9	—	0	1	—	—	—	0	1	—	—
Wyoming¶	—	0	3	—	—	—	0	1	—	—	—	0	1	—	—
Pacific	—	1	6	—	—	—	0	7	—	—	—	0	6	—	—
Alaska	—	0	5	—	—	—	0	0	—	—	—	0	0	—	—
California	—	0	0	—	—	—	0	7	—	—	—	0	6	—	—
Hawaii	—	0	6	—	—	—	0	0	—	—	—	0	0	—	—
Oregon	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
Washington	N	0	0	N	N	—	0	1	—	—	—	0	1	—	—
Territories															
American Samoa	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	2	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	9	30	—	1	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for California serogroup, eastern equine, Powassan, St. Louis, and western equine diseases are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).
¶ Not reportable in all states. Data from states where the condition is not reportable are excluded from this table, except starting in 2007 for the domestic arboviral diseases and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/ncphi/disss/nndss/phs/infdis.htm.

TABLE III. Deaths in 122 U.S. cities,* week ending January 8, 2011 (1st week)

Reporting area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45–64	25–44	1–24	<1	
New England	682	479	149	38	10	6	64
Boston, MA	177	124	39	9	3	2	19
Bridgeport, CT	U	U	U	U	U	U	U
Cambridge, MA	23	17	6	—	—	—	4
Fall River, MA	44	39	3	2	—	—	5
Hartford, CT	57	37	14	4	2	—	6
Lowell, MA	32	24	7	—	1	—	4
Lynn, MA	9	5	2	2	—	—	—
New Bedford, MA	41	28	11	1	—	1	4
New Haven, CT	51	33	12	4	1	1	5
Providence, RI	108	71	26	6	3	2	5
Somerville, MA	3	3	—	—	—	—	—
Springfield, MA	38	27	10	1	—	—	2
Waterbury, CT	31	18	11	2	—	—	—
Worcester, MA	68	53	8	7	—	—	10
Mid. Atlantic	2,450	1,741	541	104	40	21	158
Albany, NY	51	33	13	3	1	1	6
Allentown, PA	40	32	6	2	—	—	3
Buffalo, NY	120	86	24	6	3	1	10
Camden, NJ	45	30	11	4	—	—	3
Elizabeth, NJ	21	13	6	2	—	—	2
Erie, PA	60	40	19	1	—	—	1
Jersey City, NJ	44	30	11	3	—	—	5
New York City, NY	1,444	1,042	317	49	23	10	82
Newark, NJ	39	24	5	5	3	2	—
Paterson, NJ	24	16	4	4	—	—	1
Philadelphia, PA	155	93	46	11	3	2	13
Pittsburgh, PA§	31	25	5	—	1	—	1
Reading, PA	46	36	9	—	—	1	5
Rochester, NY	91	58	23	5	3	2	6
Schenectady, NY	28	21	5	1	1	—	5
Scranton, PA	28	21	4	2	—	1	—
Syracuse, NY	90	75	13	2	—	—	7
Trenton, NJ	43	27	10	3	2	1	2
Utica, NY	16	14	2	—	—	—	2
Yonkers, NY	34	25	8	1	—	—	4
E.N. Central	2,269	1,557	503	136	44	29	159
Akron, OH	50	41	4	2	1	2	7
Canton, OH	38	30	7	1	—	—	5
Chicago, IL	250	174	43	26	7	—	16
Cincinnati, OH	87	64	15	6	1	1	3
Cleveland, OH	341	247	71	15	6	2	22
Columbus, OH	167	106	40	16	2	3	13
Dayton, OH	156	118	29	6	2	1	10
Detroit, MI	211	116	67	17	7	4	17
Evansville, IN	48	35	12	1	—	—	4
Fort Wayne, IN	73	49	17	6	1	—	1
Gary, IN	9	1	3	3	2	—	—
Grand Rapids, MI	47	32	11	2	—	2	4
Indianapolis, IN	215	132	57	15	5	6	12
Lansing, MI	110	82	17	4	4	3	13
Milwaukee, WI	118	68	39	9	2	—	9
Peoria, IL	52	40	8	3	—	1	6
Rockford, IL	84	57	23	2	1	1	3
South Bend, IN	39	31	5	1	1	1	3
Toledo, OH	103	76	22	1	2	2	4
Youngstown, OH	71	58	13	—	—	—	7
W.N. Central	837	577	188	47	15	10	56
Des Moines, IA	97	72	18	4	3	—	5
Duluth, MN	38	28	10	—	—	—	3
Kansas City, KS	31	17	12	—	1	1	—
Kansas City, MO	143	102	27	8	5	1	10
Lincoln, NE	61	51	7	2	—	1	7
Minneapolis, MN	79	49	21	8	—	1	3
Omaha, NE	103	74	19	7	1	2	11
St. Louis, MO	135	75	42	14	3	1	9
St. Paul, MN	70	48	18	1	1	2	4
Wichita, KS	80	61	14	3	1	1	4
S. Atlantic	1,386	928	319	85	31	23	95
Atlanta, GA	152	103	36	8	3	2	10
Baltimore, MD	113	69	26	12	4	2	10
Charlotte, NC	143	101	28	10	1	3	15
Jacksonville, FL	240	167	52	12	5	4	21
Miami, FL	117	72	29	10	4	2	6
Norfolk, VA	80	58	15	3	1	3	—
Richmond, VA	79	49	24	2	3	1	3
Savannah, GA	62	38	17	4	2	1	5
St. Petersburg, FL	71	46	17	4	3	1	5
Tampa, FL	204	144	42	11	5	2	14
Washington, D.C.	111	69	31	9	—	2	6
Wilmington, DE	14	12	2	—	—	—	—
E.S. Central	995	659	253	46	22	15	100
Birmingham, AL	165	117	34	6	3	5	23
Chattanooga, TN	84	61	20	3	—	—	8
Knoxville, TN	143	102	36	4	1	—	16
Lexington, KY	94	59	29	6	—	—	6
Memphis, TN	220	144	54	9	9	4	23
Mobile, AL	75	48	15	5	4	3	3
Montgomery, AL	38	20	13	4	—	1	6
Nashville, TN	176	108	52	9	5	2	15
W.S. Central	1,411	936	348	70	31	25	82
Austin, TX	107	64	30	10	1	2	10
Baton Rouge, LA	67	51	11	4	1	—	1
Corpus Christi, TX	71	50	14	4	2	1	6
Dallas, TX	335	198	95	23	11	7	22
El Paso, TX	133	99	29	4	1	—	8
Fort Worth, TX	U	U	U	U	U	U	U
Houston, TX	84	53	25	2	2	2	2
Little Rock, AR	68	49	14	3	—	2	—
New Orleans, LA	U	U	U	U	U	U	U
San Antonio, TX	321	226	71	11	6	7	19
Shreveport, LA	45	27	13	1	3	1	3
Tulsa, OK	180	119	46	8	4	3	11
Mountain	1,234	846	255	86	24	21	102
Albuquerque, NM	111	81	21	7	1	1	8
Boise, ID	84	61	17	4	1	1	6
Colorado Springs, CO	66	46	14	2	2	2	2
Denver, CO	79	54	14	5	4	2	6
Las Vegas, NV	267	172	65	24	3	3	27
Ogden, UT	38	31	6	—	1	—	8
Phoenix, AZ	184	113	39	17	5	8	13
Pueblo, CO	52	36	10	5	1	—	4
Salt Lake City, UT	167	109	34	15	5	4	15
Tucson, AZ	186	143	35	7	1	—	13
Pacific	2,077	1,434	446	121	43	33	209
Berkeley, CA	12	12	—	—	—	—	1
Fresno, CA	159	103	33	14	3	6	12
Glendale, CA	44	36	6	2	—	—	12
Honolulu, HI	74	49	10	9	5	1	11
Long Beach, CA	79	54	14	7	3	1	4
Los Angeles, CA	322	213	75	21	7	6	38
Pasadena, CA	25	18	5	2	—	—	2
Portland, OR	136	93	32	5	2	4	11
Sacramento, CA	254	164	69	12	6	3	36
San Diego, CA	216	169	35	10	1	1	28
San Francisco, CA	139	89	39	4	2	5	16
San Jose, CA	244	181	48	7	6	2	26
Santa Cruz, CA	41	28	10	1	1	1	1
Seattle, WA	140	82	39	15	4	—	1
Spokane, WA	71	51	8	9	1	2	3
Tacoma, WA	121	92	23	3	2	1	7
Total¶	13,341	9,157	3,002	733	260	183	1,025

U: Unavailable. —: No reported cases.

* Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of >100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

† Pneumonia and influenza.

§ Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶ Total includes unknown ages.

TABLE IV. Provisional cases of selected notifiable disease,* United States, fourth quarter ending January 1, 2011 (52nd week)

Reporting area	Tuberculosis†				
	Current quarter	Previous 4 quarters			
		Min	Max	Cum 2010	Cum 2009
United States	1,504	1,504	2,467	8,079	11,371
New England	65	65	95	322	390
Connecticut	17	16	23	76	95
Maine	3	0	4	8	9
Massachusetts	39	39	60	200	240
New Hampshire	1	1	4	9	16
Rhode Island	3	3	11	25	24
Vermont	2	0	2	4	6
Mid. Atlantic	312	312	406	1,361	1,616
New Jersey	106	47	124	370	405
New York (Upstate)	39	34	61	180	217
New York City	110	90	195	590	759
Pennsylvania	57	52	57	221	235
E.N. Central	92	92	237	696	912
Illinois	—	0	107	252	413
Indiana	32	13	32	92	119
Michigan	—	0	44	114	137
Ohio	49	32	51	183	178
Wisconsin	11	11	17	55	65
W.N. Central	44	44	61	219	354
Iowa	—	0	8	19	42
Kansas	—	0	1	1	64
Minnesota	32	25	40	128	161
Missouri	7	3	12	33	32
Nebraska	5	3	8	23	32
North Dakota	—	0	0	—	5
South Dakota	—	0	7	15	18
S. Atlantic	286	286	519	1,738	2,221
Delaware	—	0	7	15	19
District of Columbia	7	6	14	38	41
Florida	98	98	233	741	828
Georgia	33	33	122	356	414
Maryland	65	42	65	218	218
North Carolina	—	0	0	—	246
South Carolina	28	10	53	131	164
Virginia	53	44	77	224	272
West Virginia	2	2	7	15	19
E.S. Central	112	97	152	498	568
Alabama	27	27	42	145	168
Kentucky	9	0	28	53	75
Mississippi	26	18	34	106	122
Tennessee	50	37	55	194	203
W.S. Central	56	56	405	1,056	1,859
Arkansas	4	4	16	50	82
Louisiana	28	7	63	150	193
Oklahoma	13	13	21	63	101
Texas	11	11	312	793	1,483
Mountain	138	70	148	474	568
Arizona	59	37	72	225	233
Colorado	25	8	25	61	79
Idaho	3	0	8	13	18
Montana	—	0	4	5	8
Nevada	36	1	45	104	106
New Mexico	11	10	14	46	48
Utah	4	1	9	18	74
Wyoming	—	0	2	2	2
Pacific	399	399	446	1,715	2,883
Alaska	—	0	0	—	37
California	297	297	335	1,294	2,385
Hawaii	34	21	34	110	117
Oregon	22	19	24	85	88
Washington	46	46	65	226	256
Territories					
American Samoa	1	0	1	3	3
C.N.M.I.	—	0	8	20	32
Guam	—	0	0	—	100
Puerto Rico	16	16	22	74	63
U.S. Virgin Islands	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.

U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.

* CDC is in the process of upgrading the national surveillance data management system for human immunodeficiency virus/acquired immunodeficiency syndrome. As a result, the quarterly data scheduled for this issue of MMWR is not being published in Table IV.

† CDC is in the process of implementing Public Health Information Network tuberculosis (TB) case notification message standards, which will simplify reporting of TB cases. As a result, TB provisional incidence counts are now reported from the National Electronic Disease Surveillance System (NEDSS) and the Tuberculosis Information Management System (TIMS) data sources. Previously, provisional TB incidence counts were reported through the National Electronic Telecommunications System for Surveillance (NETSS). The TB provisional incidence counts are low in some reporting jurisdictions as these areas continue to catch up with data entry and transmission to CDC during this transition.

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House Energy and Commerce Committee
Subcommittee on Health
Hearing, "Do New Health Law Mandates Threaten Conscience Rights and Access to Care?"
November 2, 2011

Questions for the Record for Ms. Jane G. Belford, Esq.

Questions from the Honorable Joseph R. Pitts

1. **What kind of penalty would a Catholic college or university be subject to if it offered a health insurance plan to its employees that did not provide coverage for *ella* and other drugs and devices that the university believes operate in an abortifacient manner?**

   The interim final rule requires that non-grandfathered plans cover all FDA-approved contraceptives, including drugs that, though classified by the FDA as a contraceptive, can operate as an abortifacient. It is unlikely, as a practical matter, that a college or university would be able to offer a plan that excludes contraceptives because that would require securing the cooperation of an insurer (or, if self-insured, a plan administrator) to implement an exclusion that the interim final rule forbids. The only option would be either to comply with the mandate in violation of the institution's religious beliefs or to drop health plan coverage altogether, thereby placing the institution at an enormous competitive disadvantage in attracting and retaining employees, and subjecting it to those penalties PPACA imposes upon employers that do not offer compliant coverage.

2. **Can you please elaborate upon the concept that certain drugs and/or devices can act as abortifacients? In particular, can you please provide links/citations to research studies indicating mechanisms of action for *ella*?**

   Some drugs and devices approved by the FDA as contraceptives or "emergency contraceptives" may also act by interfering with the implantation and therefore survival of the new embryo, and this is openly acknowledged in the manufacturer's package insert for these products. This anti-implantation effect is seen as abortifacient in Catholic teaching and in the viewpoint of many others. One drug recently approved as an emergency contraceptive, known as ella (ulipristal acetate or HRP 2000) is a close analogue to the abortion drug RU-486 (mifepristone), and like that drug it is seen as being able to disrupt an already implanted pregnancy by blocking progesterone. This effect, confirmed in various animal studies, would be an abortion by anyone's definition. *See* A. Tarantal, *et al.*, "Effects of Two Antiprogestins on Early Pregnancy in the Long-Tailed Macaque (*Macaca fascicularis*)," 54 *Contraception* 107-115 (1996), at 114 ("studies with mifepristone and HRP 2000 have shown both antiprogestins to have roughly comparable activity in terminating pregnancy when administered during the early stages of gestation"); G. Bernagiano & H. von Hertzen, "Towards more effective emergency contraception?",

375 *The Lancet* 527-28 (Feb. 13, 2010), at 527 ("Ulipristal has similar biological effects to mifepristone, the antiprogestin used in medical abortion"); European Medicines Agency, *Evaluation of Medicines for Human Use: CHMP Assessment for Ellaone* (2009), at 8 ("Ulipristal acetate prevents progesterone from occupying its receptor, thus the gene transcription normally turned on by progesterone is blocked, and the proteins necessary to begin and maintain pregnancy are not synthesized") and 16 (in animal tests "ulipristal acetate is embryotoxic at low doses"). The European Medicines Agency report is available at: www.ema.europa.eu/docs/en_GB/document_library/EPAR_-_Public_assessment_report/human/001027/WC500023673.pdf .

3. Rep. Baldwin asked you several hypothetical questions and you expressed uncertainty about the answers. If you are now able, please address the following questions relating to H.R. 1179, the *Respect for Rights of Conscience Act of 2011*:

a. Could a plan exclude coverage for certain infertility services because the plan's sponsor has a religious objection to such a service?

Thank you for giving me the opportunity to answer these questions more fully after studying the legislation. The shortest answer to this and the questions which follow is: No more than it can at present. H.R. 1179 does not preempt, or create an exception to, any state or federal law except the Patient Protection and Affordable Care Act of 2010 (PPACA). In addition, a plan could exclude specific items only if the purchaser or sponsor of the plan finds an issuer willing to offer that kind of plan – the legislation allows such negotiations to take place without the federal government dictating one outcome, but does not require an issuer of a health plan to agree to the purchaser's or sponsor's request.

More specifically, the only list of mandated services issued thus far under PPACA is the new list of "preventive services," which includes no infertility services. Thus health plans are free now to include or exclude those services, for a religious reason or any reason, unless another state or federal law creates a requirement in this regard. H.R. 1179 will not change this. If the final "essential health benefits" list to be issued by the Department of Health and Human Services in the future includes infertility services that violate some religious teachings, a religious exemption could be claimed. I am advised that even the Clinton Administration's proposed health care reform plan in the early 1990s explicitly excluded IVF from essential services, possibly because it is an elective and very costly procedure.

b. Could a plan exclude coverage for alcohol and drug addiction services because a plan's sponsor believes that use of alcohol or drugs is sinful?

The first paragraph of my answer to (a) is valid here as well. In addition, H.R. 1179 allows an accommodation only for moral or religious objection to "specific items or services" themselves, not for an objection to the patient's past conduct.

c. Could a plan exclude coverage for HIV and AIDS patients because the plan's sponsor expresses moral objections to homosexuality?

My answer to (b) is valid here as well. In addition, H.R. 1179's rule of construction (creating sec. 1302 (b)(6)(D) of PPACA) references existing provisions of PPACA to ensure that health plans still may not "make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life," and that they must "ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life." The reference in these provisions to disability would seem to include HIV-positive status and AIDS. *See* U.S. Dep't of Justice, *Questions and Answers: The Americans With Disabilities Act and Persons With HIV/AIDS* (concluding that persons with HIV or AIDS have a disability), at http://www.ada.gov/pubs/hivqanda.txt.

d. Could a plan exclude coverage for blood transfusions because the plan's sponsor is religiously opposed to this medical service even in an emergency situation?

The first paragraph of my answer to (a) is valid here as well.

e. Could a plan exclude coverage for unmarried pregnant women because the plan's sponsor has a religious objection to premarital sex?

My answer to (b) is valid here as well. H.R. 1179 addresses moral or religious objections to "specific items or services," not refusals to provide any care at all for classes of people.

CATHOLICS
FOR
CHOICE

IN GOOD CONSCIENCE

December 13, 2011

US House of Representatives
Committee on Energy and Commerce
Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515-6115

Catholics for Choice was honored to be invited to provide testimony as the Subcommittee considered the provisions of the Affordable Care Act, and specifically the Preventive Services Rule, as it relates to people of faith, especially Catholics, and to religiously affiliated institutions. In response to the additional questions raised by Mr. Pitts in his letter of November 29, 2011, we provide the following information.

Questions from Representative Joseph R. Pitts:

1. Your organization advocates for individual choice. Under the terms of the Preventive Services Rule, what choice would an individual have to purchase a health insurance plan that does not cover services that the individual finds morally objectionable (e.g, *ella* and other drugs and devices that the individual believes operate in an abortifacient manner)?

Answer:
Catholics for Choice is not an organization expert in US law in general or the Affordable Care Act in particular. As such, we are not competent to predict what could happen under certain proposals to amend the Affordable Care Act, particularly proposals that have not yet been settled and that could still change.

Catholics for Choice's expertise lies in the widespread support of Catholics for access to the full range of reproductive healthcare services, as well as the need to ensure that these services are truly accessible and affordable, especially for people with limited economic means and in places where the choice of healthcare services are limited. Catholics for Choice advocates for the right of individuals to make moral decisions according to their conscience about issues like family planning that have a direct and dramatic impact on their lives and the lives of their families. Catholics for Choice does not believe that an institution, organization or individual has the right to make those decisions for another person, or to place additional obstacles in the way of individuals' ability to act upon their conscientious decisions that have such an impact on their lives.

It is our understanding that the Preventive Services Rule enhances individuals' ability to make more choices about the healthcare services they need and wish to use. At the same time, it is our understanding that the Preventive Services Rule makes no demand that that individuals use services or medications to which they object, for whatever reason.

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2. What kinds of penalty would a Catholic college or university be subject to if it offered a health insurance plan to its employees that did not provide coverage for *ella* and other drugs and devices that the university believes operate in an abortifacient manner)?

Answer:
Catholics for Choice is not an organization expert in US law in general or the Affordable Care Act in particular. As such, we are not competent to predict what could happen under certain proposals to amend the Affordable Care Act, particularly proposals that have not yet been settled and that could still change. However, Catholics for Choice is well-informed about Catholic teaching and tradition; the beliefs and opinions of the 68 million Catholics in the United States; and the realities of healthcare delivery and accessibility for people who work for or are served by Catholics-affiliated institutions and organizations.

Some argue that it is not possible for religiously affiliated institutions to comply with the law's requirement to include contraceptive coverage in health insurance plans, and that they require an unnecessarily broad exemption to allow the institution to deny essential preventive services without being subject to a penalty. This is a specious argument. It is a fact that in states with refusal clauses similar to the one proposed for the list of women's preventive healthcare services that must be covered under the Affordable Care Act, Catholic healthcare systems and universities have complied with the law by offering the full range of contraceptive coverage to their employees. As a result, employees of those institutions may choose to utilize or not utilize that coverage according to their own beliefs and their individual healthcare needs, whether for family planning reasons or to regulate other health conditions.

In California and New York, for example, where contraceptive coverage laws include refusal clauses similar to those proposed by the Department of Health and Human Services, Catholic institutions provide coverage for their employees and students. Catholic Healthcare West, a Catholic health system which operates 40 hospitals in California, Nevada and Arizona, has offered contraceptive coverage as part of its employee health insurance packages since 1997—two full years before California passed its contraceptive coverage law in 1999. In New York, Fordham University, another Catholic institution, includes contraceptive coverage in both its employee and student health insurance plans, in keeping with the requirements of a New York state contraceptive coverage law.

Recently, just as the Affordable Care Act promised to allow Americans to keep the coverage that they already have, a Fordham University spokesperson stated that the university would continue to cover birth control in its employee and student plans even if proposed refusal clauses were expanded to allow religiously affiliated universities to refuse its employees and students that coverage. We cannot be certain, however, that other institutions would keep that promise.

By providing contraceptive coverage to their employees, these institutions are respecting the moral agency of women and men and their ability to make their own moral healthcare decisions by leaving the door open for them to follow their own consciences, whether they decide to utilize contraception or not. This deference to the primacy of individuals' consciences, respect for all beliefs and commitment to affordable healthcare access for all is in keeping with our Catholic tradition and with the beliefs of the majority of the more than 68 million U.S. Catholics. Indeed, the overwhelming majority of sexually active Catholic women (98 percent) not only have used contraception, but the majority of Catholic voters (more than six in ten) support allowing all individuals to access affordable contraception by requiring health insurance plans—whether government or privately-run—to include contraceptive coverage.

December 12, 2011

The Honorable Joseph R. Pitts

1. **How does California's contraceptive mandate differ from the mandate contained in the Preventive Services Rule promulgated by the U.S. Department of Health and Human Services?**

   A. Like California's statute, HHS's interim final rule exempts a religious employer from its mandate if, and only if, the employer meets all of the following criteria: 1) its purpose is the inculcation of religious values; 2) it primarily hires people who share its religious tenets; 3) it primarily serves persons who share its religious tenets; and 4) it is a non-profit organization under Internal Revenue Code section 6033(a)(3)(A)(i) or (iii), (i.e., it is a "church" or "integrated auxiliary of a church").

   California was the first state to enact this crabbed definition of religious employer, but its mandate is more narrowly focused than is HHS's. California law requires health care and disability insurance plans to include coverage for prescription contraceptive methods *only if* they also provide coverage for outpatient prescription drug benefits.

   In contrast, HHS's mandate imposes an unprecedented requirement that **all** types of health plans – including *ERISA* plans* – not only include all FDA-approved contraceptive methods, it broadens the mandated services to include sterilization procedures, as well as patient education and counseling for all women with reproductive capacity. Moreover, at least one drug approved by the FDA for "contraceptive use," a close analogue to the abortion drug RU-486 (mifepristone), can cause an abortion when taken to interrupt pregnancy.

   Hence, the HHS mandate is more sweeping than California's law, or any other state's law, both in the scope of plans covered and in its mandated services.

2. **Do any state laws require contraceptive coverage in health insurance plans that do not provide coverage for prescription drugs?**

   A. Yes, Colorado and Maryland require contraceptive coverage in health insurance plans that do not provide coverage for prescription drugs

3. **Do any state laws require contraceptive coverage in self-insured and ERISA health insurance plans?**

   A. No.

4. **How many states require coverage of sterilization in health insurance plans?**

   A. One state, Vermont, requires coverage of sterilization.

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* The Employee Retirement Income Security Act of 1974 (ERISA) (Pub. L. 93-406, 88 Stat. 829, enacted September 2, 1974).

5. How would a conscientiously opposed entity get out from under California's contraceptive mandate? Can that entity get out from under this new federal mandate? What is the remedy for an entity or individual that objects to this federal mandate because of a religious or moral belief?

A. Until HHS promulgated its Preventive Services rule, there were two ways in which a conscientiously opposed entity could get out from under the California contraceptive mandate: The entity could either self-insure under *ERISA*, or it could stop providing prescription drug coverage altogether. As currently written, the HHS Preventive Services interim final rule forecloses both of these options.

Under HHS's Preventive Services interim final rule, as currently written, there is no remedy for an entity or individual that objects to this federal mandate because of a religious or moral belief.

○