

*Testimony of
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*On behalf of
The Becket Fund for Religious Liberty*

*Before the Judiciary Committee of the
United States House of Representatives*

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Mr. Chairman and distinguished members of the Committee, allow me to thank you for the invitation and opportunity to be with you today to offer testimony on the religious liberty issues related to the recent Department of Health and Human Services mandate on women's preventive services.

I am here today representing the Becket Fund for Religious Liberty, where I work as an attorney specializing in domestic and international religious freedom. I will summarize my remarks and ask that my full written testimony be entered into the record.

I. Introduction

Under the Affordable Care Act of 2010 (“the ACA”),¹ all employer health care plans must provide—at no cost to the employee—certain preventive services for women.² The inclusion of contraceptives—including abortion-causing contraceptives—in this mandated coverage has caused a public uproar, with religious groups opposed to contraception and/or abortion decriing the violation of their religious freedom. Supporters of the mandate, in contrast, see this as a civil rights issue—specifically, one involving women's rights—that should not be trumped by religious concerns. At the heart of this position, however, lies a profound misunderstanding about the nature of religion and the scope of constitutional protections for religious liberty.

A. Background

One provision of the ACA, signed into law by President Barack Obama on March 23, 2010, mandates that health plans “provide coverage for and shall not impose any cost sharing requirements for . . . with respect to women, such additional preventive care and screenings . . . as provided for in comprehensive guidelines supported by the Health Resources and Services Administration” (“Mandate”). However, when the Department of Health and Human Services (“HHS”) published an interim final rule on July 19, 2010, it had not yet defined “contraceptive preventative services for women”; instead, it delegated that decision to the Health Resources and Services Administration (“HRSA”), a division of HHS. HRSA, in turn, directed a private policy organization, the Institute of Medicine (“IOM”), to suggest a list of recommended guidelines describing which preventive drugs, procedures, and services should be covered by all health plans.³

¹ The Affordable Care Act is actually two laws: the Patient Protection and Affordable Care Act, Pub. L. 111-148 (March 23, 2010), and the Health Care and Education Reconciliation Act, Pub. L. 111-152 (March 30, 2010).

² 42 U.S.C. § 300gg-13(a)(4).

³ In developing its guidelines, IOM invited a select number of groups to make presentations on the preventive care that should be mandated by all health plans. These were the Institute, the American Congress of Obstetricians and Gynecologists (ACOG), John Santelli, the National Women's Law Center, National Women's Health Network, Planned Parenthood Federation of America, and Sara Rosenbaum. No religious groups or other groups that

Simultaneously, HHS also accepted public comments to the 2010 interim final rule until September 17, 2010. A number of groups filed comments warning of the potential conscience implications of requiring religious individuals and groups to pay for certain kinds of health care, including contraception, sterilization, and abortion.

Despite the stated concerns of these religious entities, on July 19, 2011—one year after the first interim final rule was published—the IOM issued its recommendation that preventive services include well-woman visits; screening for gestational diabetes; human papillomavirus (HPV) DNA testing for women 30 years and older; sexually-transmitted infection counseling; human immunodeficiency virus (HIV) screening and counseling; FDA-approved contraception methods and contraceptive counseling; breastfeeding support, supplies, and counseling; and domestic violence screening and counseling.⁴ FDA-approved contraceptive methods include birth-control pills; prescription contraceptive devices, including IUDs; Plan B, also known as the “morning-after pill”; and ulipristal, also known as “ella” or the “week-after pill”; and other drugs, devices, and procedures.

On August 1, 2011, thirteen days after the IOM issued its recommendations HRSA issued guidelines adopting the IOM recommendations.⁵ These guidelines make clear that the HHS Mandate includes not just FDA approved contraceptive methods and sterilization procedures, but also “patient education and counseling” concerning those methods. On the same day that HRSA adopted the IOM regulations, HHS issued an amended interim final rule, adding an exemption from the contraceptive Mandate for “religious employers.”

Separate from the issue of contraception, as mentioned above, included in “FDA-approved contraceptive methods” are the drugs Plan B and ella. Many religious individuals and organizations that have conscientious objections to abortion object to the use of Plan B and ella because they believe, and scientific evidence supports their belief, that these drugs constitute abortifacients. That is, Plan B and ella can prevent a human embryo, which these religious groups understand to include a fertilized egg before it implants in the uterus, from implanting in the wall of the uterus thereby causing the death of the embryo.

It was precisely these sorts of concerns that were repeatedly articulated by religious groups in the more than 200,000 public comments submitted in response to the amended interim rule. HHS created an exceedingly narrow religious exemption—one that is narrower than any other religious exemption in federal law.⁶ Under the regulations, the only organizations

oppose government-mandated coverage of contraception, sterilization, abortion, and related education and counseling were among the invited presenters.

⁴ Institute of Medicine, *Clinical Preventive Services for Women: Closing the Gaps* (July 19, 2011).

⁵ See <http://www.hrsa.gov/womensguidelines> (last visited February 11, 2012).

⁶ Until now, federal policy has generally protected the conscience rights of religious institutions and individuals in the health care sector. For example, for 25 years, Congress has protected religious institutions from discrimination (based on their adherence to natural family planning) in

religious enough to receive an exemption are those that are not already exempt from the ACA for having fewer than fifty employees and meet *all* of the following criteria:

- (1) its purpose is the inculcation of religious values,
- (2) it employs “primarily” persons who share its religious tenets;
- (3) it serves “primarily” persons who share its religious tenets; *and also*
- (4) it qualifies under the IRS code as a church or religious order.⁷

This exemption is of little solace to religious employers for two primary reasons. First, because the regulation merely states that HRSA “*may* establish exemptions,”⁸ it is possible that the federal government will decide not to provide any religious exemptions at all.

Second, HRSA has this discretion with respect to only a vanishingly small class of religious employers. Under this definition, most, if not all, religious colleges or universities would not qualify for any exemption, because these institutions exist not just to inculcate religious values, but also to teach students. The nature of many religious institutions is in fact to serve those outside their community, conditioning their help on a person’s need rather than their chosen faith. As many Christian objectors to the Mandate have made clear, not even Jesus’ ministry would qualify for the exemption as he served both Christians and non-Christians. No homeless shelter, soup kitchen, or adoption agency would qualify, because these organizations exist to serve anyone in need, not just those that profess a certain religious

foreign aid grant applications. For 12 years, Congress has both exempted religious health plans from the contraception mandate in the Federal Employees’ Health Benefit Program and protected individuals covered under other health plans from discrimination based on their refusal to dispense contraception due to religious belief.

The HHS mandate is not only unprecedented in federal law, but also broader in scope and narrower in its exemption than all of the 28 State’s comparable laws. Almost half the States do not have a state contraception mandate at all, so there is no need for an exemption. Of the States that have some sort of state contraception mandate (all less sweeping than the federal one here), 19 provide an exemption. Of those 19 States without an exemption, only three (California, New York, and Oregon) define the exemption nearly as narrowly as the federal one, although the federal exemption is still worse because of the regulation’s discretionary language that the government “*may*” grant an exemption. Moreover, religious organizations in States with a mandate—even those where there is no express exemption—may opt out by simply dropping prescription drug coverage or offering self-insured plans, which are governed by federal ERISA law rather than state law. The federal mandate permits none of these alternatives, and therefore is less protective of religious liberty than any of the States’ policies.

⁷ 76 Fed. Reg. 46623 (Aug. 3, 2011).

⁸ 76 Fed. Reg. 46626 (Aug. 3, 2011).

creed.⁹ And few, if any, of these organizations qualify as a church or religious order under the tax code.

The Obama Administration's "Accommodations"

Given the Mandate's lack of protection for religious liberty, religious organizations and individuals voiced their concerns vociferously. In an effort to respond to these concerns, on January 20, 2012, the Administration announced it would not expand the exemption to protect religious schools, colleges, hospitals, and charitable service organizations, but it would give them one extra year to comply with the Mandate. This, of course, was no accommodation at all, as it ignored the underlying religious liberty concerns. Also, the one year extension applied only to employee health plans, not student health plans. In essence, religious organizations still had no choice but to comply with the Mandate or drop their health insurance coverage altogether and pay the resulting hefty fines.

This "accommodation" was of course deemed insufficient by religious objectors to the Mandate, as it did nothing to address the substance of their concerns. Indeed, the blatant disregard for the First Amendment rights at issue created a firestorm of opposition from across the political and religious spectrum. Thus, within three weeks, on February 10, 2012, the President held a press conference to announce a *second* compromise. But this compromise also did not change any of the provisions of the August 2011 Mandate, nor did it make any changes to the Mandate's narrow religious exemptions.

Instead, for non-exempt religious organizations, the president made two promises. First, he reiterated that enforcement of the Mandate on employee health plans would be delayed by one extra year. Second, the president promised that the administration would work to develop—at some unspecified time in the future—a rule that would require insurers of *non-profit* organizations with religious objections to pay the costs of the mandated coverage for abortion-inducing drugs, sterilization, and contraception.

The problems with this proffered compromise are many. First, it is unlikely that insurance companies will offer these services for free; religious employers would still ultimately be paying for these services against their conscience, with the costs spread through higher insurance premiums for their employees. Although some argue that insurance companies would cover these services for free because it helps their bottom line, such an argument is tenuous at best—

⁹ The only other exemption available under the ACA is for "grandfathered" plans. However, here too the law is terribly misleading. Under the new regulations, any one of a number of changes, *even if immaterial*, will cause a plan to lose its grandfathered status. Thus, although President Obama promised throughout the health reform debate that "if you like your health plan, you can keep it," religious organizations will soon be forced to abandon health plans that reflect their deepest convictions unless they: (1) stopped modifying their health care plans nearly a year and a half *before* the HHS mandate was announced; *and* (2) henceforth avoid any triggering condition. These conditions, of course, may have already been violated, will become increasingly difficult to meet, and in any case are unacceptable.

after all, if that were the case, insurance companies would have arguably already provided contraception for free. Moreover, the provision of these so-called free contraceptives still depends on the religious employer purchasing insurance for its employees. While they might not be paying for the drugs, they are still facilitating their use by employees. Religious organizations should not be forced to turn a blind eye to the inclusion of something in their insurance plan that violates their conscience.

Second, hundreds if not thousands of religious organizations have self-insured plans, where the religious organization itself is the “insurance company.” Although the preamble to the final rule does state an intent to achieve the same “goals” for self-insured religious organizations, it is unclear how the proposed compromise would resolve the concerns of these entities,

Third, the new proposal does nothing to address the concerns of for-profit organizations and individuals with religious objections. Rather, the proposed compromise simply underscores how the government’s policy discriminates between various categories of religious groups and individuals, with churches receiving the greatest protection, non-profit religious organizations potentially receiving a lower level of protection, and individuals and for-profit entities receiving no protection at all. This picking and choosing of who is entitled to First Amendment protections is unconstitutional.

If an employer with moral objections to the HHS Mandate is not covered by the Administration’s compromise solution, the employers final alternative is to stop providing health care benefits altogether. But this too places religious employers in an unacceptable double bind: either they must pay for contraception, sterilization, and abortion-inducing drugs, or they must stop providing their employees with health care and pay a stiff civil penalty. The first option forces religious employers to violate their moral convictions. The second option forces them to pay steep fines for exercising their religion and creates enormous hardships for their employees, some of whom have limited means to purchase health insurance on their own. And the burden does not end there. Without employer health plans, many religious institutions would find themselves at a serious competitive disadvantage vis-à-vis other employers. Some religious institutions could find that without a group health plan, they could not attract sufficient staff and would be forced to close their operations altogether.

The fines imposed on religious employers that refuse to violate their consciences are significant. For example, a charitable organization with 100 employees will have to pay the federal government \$140,000 per year for the “privilege” of not underwriting medical services it believes are immoral.¹⁰

B. Legal Claims

Given these coercive burdens on the religious freedom of organizations and individuals that hold religious beliefs against contraception and/or abortion, the Becket Fund for Religious Liberty has brought several lawsuits. The lawsuits, each of which make the same claims, are

¹⁰ See Nat’l Fed’n of Indep. Business, *The Free Rider Provision: A One-Page Primer*, available at <http://www.nfib.com/Portals/0/PDF/AllUsers/Free%20Rider%20Provision.pdf>.

on behalf of (1) Belmont Abbey College (BAC), a Catholic liberal arts college founded by Benedictine monks; (2) Colorado Christian University (CCU), an interdenominational Christian college; (3) Eternal Word Television Network (EWTN), a television network that serves to spread Catholic teachings; and (4) Ave Maria University, a Catholic University dedicated to transmitting authentic Catholic values to students. For failing to comply by the Mandate, BAC would pay approximately \$340,000 annually, CCU would pay \$500,000; EWTN would pay \$620,000; and Ave Maria close to \$340,000.

These lawsuits challenge the government Mandate as a violation of the First Amendment of the U.S. Constitution, the Religious Freedom Restoration Act (RFRA), and the Administrative Procedures Act (APA). The religious freedom claims turn on the fact that the burden placed on these organizations is not justified, as is required by law, by a compelling government interest that is narrowly tailored to serve that interest. There is also a free exercise claim of intentional discrimination because the Mandate protects certain religions and religious groups, such as those that serve and employ members of their own faith, while penalizing other religions. This sort of discrimination also raises Establishment Clause issues as it prefers some denominations to others and places a selective burden on the plaintiffs.

The lawsuits seek a declaration from the court that the Mandate violates the First Amendment, RFRA, and the APA. They also seek an order prohibiting the government from enforcing the Mandate against our clients and any other religious group that cannot provide access to these drugs and services because of their religious convictions.

Thus far, the Administration has responded to only one of the four lawsuits, and fails to address in its brief any of our client's constitutional claims. Instead, it calls on the court to dismiss the case altogether in light of their "promise" to pass the costs onto insurance companies. As I've already articulated, this is not a valid solution for our clients' legitimate claims.

II. The Contraception Mandate and Women's Rights

Some have framed the controversy surrounding the Mandate as a women's rights issue. At the outset, the point must be made that our clients are acting because of what is being asked for (an act that violates their deeply held beliefs), rather than who is doing the asking. That is, religious organizations are not objecting to the Mandate because it is targeted toward preventive care for women; rather, they object to paying for, or providing access to, contraception, sterilization, and/or abortion-inducing drugs, regardless of gender. Indeed, the relevant employee might be male, with a female dependent.

Moreover, including a robust exemption protecting the deeply held religious beliefs of those who oppose contraception and abortion would not harm women or women's health. Access to these contraceptives is widespread: Nine out of ten employer-based insurance plans in the United States already cover contraception. The government admits these services are widely available in "community health centers, public clinics, and hospitals with income-based support."¹¹ In fact,

¹¹ See *A statement by U.S. Department of Health and Human Services Secretary Kathleen Sebelius*. <http://www.hhs.gov/news/press/2012pres/01/20120120a.html>.

the federal government already spends hundreds of millions of dollars each year funding free or nearly free family planning services under its Title X program. Therefore, the issue is not really about access to contraception but rather about who pays for it.

Finally, one of the issues that is consistently overlooked when the issue is framed as “women’s rights versus religious freedom” is that women, too, seek the freedom to live in accordance with their sincerely held religious beliefs. Not all women agree with the Mandate; in fact, 41% of Catholic women do not support the Mandate.¹² Religious freedom is a right enjoyed by everyone, men and women, and it is just as much in women’s interest to protect that right as it is in men’s. As a female member of religious minority, I hold this right to religious freedom particularly dear, as, for example, a Muslim woman’s right to dress as she pleases is restricted by many governments across the world.

IV. Conclusion: Looking Forward

As it turns out, this conflict is entirely unnecessary. A robust exemption from the HHS Mandate would be a workable way for the federal government to advance both its interest in women’s health and its commitment to respecting the legitimate autonomy and convictions of religious institutions.

In particular, expanding the existing “religious employer” exemption into a “religious conviction” exemption would eliminate the conflict entirely. Specifically, the exemption should be expanded to include all individuals and organizations—whether nonprofit or for-profit—that have a sincere religious conviction prohibiting them from purchasing or providing access to the mandated goods and services. In addition, any limitations over how, by whom, and for whom these individuals and organizations carry out their missions should be eliminated. And finally, the exemption should be expanded to include effected student health plans in addition to employee health plans.

These changes to the existing exemption would also help carry out the purposes of the Affordable Care Act by ensuring that employees and students can remain part of their existing healthcare plans.

¹² See Public Policy Polling,

http://www.coalitiontoprotectwomenshealth.org/wp-content/uploads/2012/02/catholics_and_birth_control_benefit.pdf