

June 19, 2012

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9968-ANPRM  
P.O. Box 8016  
Baltimore, MD 21244-185

Submitted electronically at [www.regulations.gov](http://www.regulations.gov)

Subject: ANPRM: Certain Preventive Services Under the Affordable Care Act, CMS-9968-ANPRM, Docket ID: CMS-2012-0031

The MergerWatch Project submits the following comments in response to the Advance Notice of Proposed Rulemaking (ANPRM) on “Certain Preventive Services Under the Affordable Care Act,” published in the Federal Register on March 21, 2012 by the Department of the Treasury, Department of Labor and the Department of Health and Human Services (Departments).<sup>1</sup>

MergerWatch is a non-profit nonpartisan organization whose mission is to protect patients’ rights and access to care from the impact of religiously-based health care restrictions and provider refusals. Our primary work is assisting community residents, hospital executives and public policymakers when non-sectarian (or non-religious) hospitals are considering business partnerships with religiously-sponsored hospitals, especially those affiliated with the Catholic Church, which prohibits the provision of some reproductive health services.<sup>2</sup> Since our founding 15 years ago, MergerWatch staff have worked on more than 90 proposed religious/non-sectarian hospital mergers in 34 states. We have helped bring about a number of creative approaches to ensuring continued community access to reproductive health services threatened by the introduction of religious health care restrictions. We have also assisted state-based reproductive health advocates in securing policies that a) require all hospitals to offer emergency contraception to rape victims; b) require contraceptive coverage with no religious employer exemption or a very narrow one; and c) ensure that women can fill contraceptive prescriptions at local pharmacies when individual pharmacists raise religious or moral objections. Our comments to the Departments are based on our 15 years of experience in these areas of health care policy.

**First, we strongly urge that the religious employer exemption as defined by the Departments not be expanded beyond the current definition adopted in the final regulations on February 15, 2012.**<sup>3</sup> That

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<sup>1</sup> Certain Preventive Services Under the Affordable Care Act, 77 Fed. Reg. 16,501 (proposed Mar. 21, 2012) (to be codified at 45 C.F.R. pt. 147).

<sup>2</sup> “Ethical and Religious Directives for Catholic Health Care Services,” United States Conference of Catholic Bishops (Nov. 2009), *also available at*, <http://www.usccb.org/bishops/directives.shtml>.

<sup>3</sup> A “religious employer” is defined as an employer 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

definition follows the religious exemption model established by contraceptive coverage laws in both California and New York.<sup>4</sup> Those exemptions were upheld by the highest courts in each state, which rejected challenges by the same types of religiously-affiliated employers (hospitals, charities and the like) that are now requesting a broader exemption from the federal contraceptive coverage requirement.<sup>5</sup> Their arguments did not prevail in those courts, and should not prevail in federal rule-making.

There are sound public policy reasons for requiring employers to provide contraceptive coverage for their employees. As the Institute of Medicine report on this subject explained, contraception is a key women's preventive service that allows for the planning and spacing of pregnancies, with attendant benefits for the health of women and infants.<sup>6</sup> Planning of pregnancies has been shown to produce reductions in rates of maternal mortality and morbidity and of pre-term births that lead to infant mortality and morbidity. For some women, contraception is also a medically-indicated treatment for certain conditions like severe menstrual pain and excessive menstrual bleeding, which can lead to anemia. Other non-contraceptive uses include prevention of menstrual-related migraines and treatment of pelvic pain that accompanies endometriosis and of bleeding due to uterine fibroids.<sup>7</sup> For some women with conditions such as diabetes or hypertension, pregnancy can be a serious threat to their health and even their lives, and often leads to a recommendation from their physicians that they undergo a tubal ligation.<sup>8</sup> For all of these reasons, there is a compelling public purpose in ensuring that as many employees as possible benefit from the affordable coverage for contraceptive services that has been made possible through the Women's Preventive Services Amendment to the Affordable Care Act.

Expanding the religious exemption to religiously-affiliated institutions such as hospitals, as requested by the Catholic Health Association (CHA) in its June 15 comments to your Departments,<sup>9</sup> would deprive their employees and dependents of the benefits of affordable contraceptive coverage. CHA member hospitals employ over 765,000 full and part-time workers, many of whom do not share their employers'

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(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. Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, Interim Final Rules, 76 Fed. Reg. 46,621, 46,623 (Aug. 3, 2011). This definition was finalized without change. Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8,727 (Feb. 15, 2012) (to be codified at 45 C.F.R. pt. 147).

<sup>4</sup> Cal. Health & Safety Code § 1367.25(b); N.Y. Insurance Law § 4303.

<sup>5</sup> *Catholic Charities of Sacramento, Inc. v. Superior Court of Sacramento*, 32 Cal. 4<sup>th</sup> 527 (2004); *Catholic Charities of Diocese of Albany v. Serio*, 808 N.Y.S. 2d 447 (2006).

<sup>6</sup> "Clinical Preventive Services For Women," Committee on the Preventive Services for Women., (July 2011).

<sup>7</sup> "Beyond Birth Control: The Overlooked Benefits of Oral Contraceptive Pills," The Guttmacher Institute, (November 2011), *also available at*, <http://www.guttmacher.org/pubs/Beyond-Birth-Control.pdf>.

<sup>8</sup> "Benefits and Risks of Sterilization," American College of Obstetricians and Gynecologists Practice Bulletin., No. 46 (2003), p. 339, 340-49, 350.

<sup>9</sup> "Certain Preventive Services Under the Affordable Care Act: Advanced Notice of Proposed Rulemaking," Catholic Health Association, *Letter*, (June 2012).

beliefs about contraception.<sup>10</sup> They and their dependents should not be excluded from the contraceptive coverage benefits made possible by the ACA's Women's Health Amendment.

What about the argument made by CHA in its June 15 comments to you that failure to expand the Department's definition of a religious employer so as to allow an exemption for Catholic hospitals and similar religiously-affiliated entities would "create a false dichotomy between the Catholic Church and the ministries through which the Church lives out the teachings of Jesus Christ"?

First, it is perfectly within the purview of public policymakers to draw such a definitional distinction, as demonstrated by the New York and California religious employer exemptions that were found constitutional by the highest courts in both states. Moreover, we believe your Department drew this distinction correctly in adopting the models from the New York and California laws.

**Catholic hospitals, while affiliated with the Catholic Church, do not occupy the same private religious space as do seminaries or diocesan offices. Instead, Catholic hospitals have affirmatively chosen to enter the public sphere and assume a role unlike those church entities that have as their primary purpose the inculcation of religious values.**

Catholic hospitals have sought and received state licenses to provide health care to the general public in their catchment regions. Such licenses require adherence to state hospital regulatory requirements. Moreover, Catholic hospitals operate with little or no church money, instead relying primarily on third party reimbursements, including from the Medicare and Medicaid public insurance programs, as well as public programs funding indigent care and medical research. In data analysis conducted for MergerWatch in 2002,<sup>11</sup> an independent health care consulting firm concluded that religiously-sponsored hospitals in the United States (of which the majority are Catholic hospitals) received more than \$44 billion a year in Medicare and Medicaid reimbursements. In order to receive Medicare and Medicaid funding, Catholic hospitals have agreed to follow the "conditions of participation" for these programs<sup>12</sup> thus subjecting themselves to federal oversight of the care they deliver.

The emergence of Catholic hospitals into the public sphere over the last 100 years, and their evolving relationship with government, is traced in a new book by nursing historian Barbra Mann Wall entitled *American Catholic Hospitals: A Century of Changing Markets and Missions*.<sup>13</sup> "That Catholic hospitals ideologically preferred to keep the government at bay did not diminish their participation in government programs when it helped their own hospitals to grow," Wall writes. As her book recounts, participation in the Medicare and Medicaid programs after they were created in 1965 required Catholic hospitals to

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<sup>10</sup> "Catholic Health Care in the United States," Catholic Health Association of the United States, (Jan. 2012).

<sup>11</sup> Lois Uttley et al., "No Strings Attached: Public Funding of Religiously Sponsored Hospitals in the United States," The MergerWatch Project, (2002), p. 11-19.

<sup>12</sup> 42 C.F.R. 485.601.

<sup>13</sup> Barbra Mann Wall, *American Catholic Hospitals: A Century of Changing Markets and Missions*, Rutgers University Press, (2011).

accept government prohibitions on racial discrimination. Up until that point, Wall reports, Catholic hospitals in some parts of the country still did not admit black patients or kept them in segregated wards, and had no black physicians or nurses. A comparison might be drawn with the Affordable Care Act, which is expected to significantly increase the number of insured, or paying, patients seeking care at all hospitals, including Catholic facilities. While benefitting financially from this advancement in health policy, Catholic hospitals should be expected to accept the ACA's prohibition on gender discrimination in health coverage and the provisions of the Women's Health Amendment that have led to your Departments' rule requiring contraceptive coverage.

It is worth noting, as well, that religiously-sponsored hospitals, nursing homes and homes for abused children have on numerous occasions been rebuffed in their requests for religious exemptions from the jurisdiction of the National Labor Relations Board. Courts have repeatedly noted the reliance of religious hospitals on public funding as a factor in their determinations that a religiously-affiliated institution must comply with generally applicable laws and regulations, even when the institution claims such requirements infringe on its religious liberty.<sup>14</sup>

In recent years, Catholic hospitals in a number of states have managed to comply with new laws requiring all hospitals to offer emergency contraception for rape victims, after first insisting that to do so would violate their religious beliefs. In New York State in 2003, for example, the state Catholic Conference contested a proposed law requiring provision of emergency contraception for rape victims, saying such a law would "strike a serious blow to religious freedom in this state."<sup>15</sup> But a survey conducted by the New York State Coalition Against Sexual Assault and Family Planning Advocates of NYS found that many Catholic hospitals already were offering the medication to rape victims voluntarily, and all complied with the law when it was enacted. This type of mandate is currently in place in 12 states and Washington, DC.<sup>16</sup>

**We believe that providing an accommodation for objecting religiously-affiliated employers is not necessary.** The ANPRM announces the Departments' intention to provide an "accommodation" to "religious organizations" that object to coverage of contraceptive services for religious reasons, but do not qualify for the religious employer exemption. We do not believe that there is a need for this type of accommodation, since states like California and New York have adopted contraceptive coverage mandates and many religiously-affiliated employers have willingly complied without special accommodations.

**If the Departments *do* move forward with offering an accommodation, it must be structured in a seamless way that does not unfairly disadvantage those individuals subject to it or harm their health.**

Employees and dependents of religiously-affiliated employers that choose an accommodation, such as the use of a third-party administrator, must not be impeded in their ability to learn about and use the

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<sup>14</sup> Uttley, at 52-53; *See e.g., St. Elizabeth Community Hospital v. NLRB*, 708 F.2d 1436 (9<sup>th</sup> Cir. 1983); *Tressler Lutheran Home v. NLRB*, 677 F.2d 302 (3<sup>rd</sup> Cir. 1982); *NLRB v. St. Louis Christian Home*, 663 F.2d 60 (8<sup>th</sup> Cir. 1981).

<sup>15</sup> New York State Catholic Conference, Opposition Memorandum to A.15 (2003).

<sup>16</sup> Guttmacher Institute, "State Policies in Brief: Emergency Contraception" (June 1, 2012), available at [http://www.guttmacher.org/statecenter/spibs/spib\\_EC.pdf](http://www.guttmacher.org/statecenter/spibs/spib_EC.pdf).

contraceptive coverage to which they are entitled, nor should they be expected to make separate premium payments for this coverage. MergerWatch has signed on to comments submitted by a coalition of national women's health organizations that explain in detail the kinds of impediments that would be unacceptable. We refer you to those comments for our thinking on these matters.

In our comments, however, we want to point out that religiously-sponsored hospitals have a long history of reaching ethical accommodations when it has been necessary to achieve financially-desirable mergers with non-Catholic hospitals. In fact, some Catholic hospital systems have employed ethicists to help them resolve ethical conflicts and complete partnerships with non-Catholic hospitals. One such ethicist, Rev. Gerard Magill, told the *Wall Street Journal* that "This may shock you, but the Catholic Church is very keen on finding practical solutions to complicated problems. We certainly will not do immoral acts, but we certainly can come to arrangements."<sup>17</sup>

Such arrangements have become commonplace when they were needed to complete financially-desirable mergers with non-Catholic hospitals, especially when public officials have affirmatively required the preservation of community access to reproductive health services. For example:

- In Kingston, NY, post-partum tubal ligations have continued to be provided within historically-nonsectarian Kingston Hospital following its 2007 merger with Catholic-sponsored Benedictine Hospital under an arrangement approved by the Archdiocese of New York. Other reproductive services are being provided in a separately-incorporated ambulatory surgery center in the parking lot of Kingston Hospital. The merger required the approval of state health officials, who had expressed concerns that the community not lose access to needed reproductive health services.<sup>18</sup>
- In Elmira, NY, Arnot Ogden Medical Center continues to provide tubal ligations, vasectomies and therapeutic pregnancy terminations following consolidation with St. Joseph's Hospital into a regional health care system called Arnot Health. After receiving approval from Bishop Matthew Clark and the state, the governing boards of both facilities were disbanded and replaced with a single joint governing board.
- In Mequon, Wisconsin, the Columbia Center, a separately-incorporated maternity hospital, was established inside a new facility built by Columbia St. Mary's, the parent organization of merged (Catholic) St. Mary's Hospital and Columbia Health System. It preserves community access to the following services: tubal ligation at time of cesarean, vasectomy, medically appropriate treatment of pregnancy emergencies (ectopic, miscarriage) and birth control counseling and services.<sup>19</sup>
- In Springfield, Ohio, the Community Health Foundation (CHF) Health Service Pavilion is located adjacent to Springfield Regional Medical Center, a new hospital that opened seven years after

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<sup>17</sup> L. Lagnado, "Religious Practice: Their Role Growing, Catholic Hospitals Juggle Doctrine and Medicine," *The Wall Street Journal*, (Feb. 1999), p. A1.

<sup>18</sup> *A Plan to Stabilize and Strengthen New York's Health Care System: Final Report of the Commission on Health Care Facilities in the 21st Century*, Commission on Health Care Facilities in the 21st Century (Dec.2006), available at, <http://www.nyhealthcarecommission.org/docs/final/commissionfinalreport.pdf>

<sup>19</sup> See, The Columbia Center, available at, <http://columbiacenter.org/>.

Community Hospital and (Catholic) Mercy Health System merged in 2004. CHF Health Service Pavilion staff offer tubal ligation at the time of birth or other abdominal surgery, interval tubal ligations for high-risk patients and postpartum contraception.

- In Troy, New York, a separately-incorporated maternity hospital was constructed inside Northeast Health's Samaritan Hospital just before Samaritan merged with two Catholic hospitals, St. Peter's and St. Mary's. Services that are preserved by this arrangement include tubal ligation at time of cesarean, vasectomy, medically appropriate treatment of pregnancy emergencies (ectopic, miscarriage) and birth control counseling and services.

As several of these examples illustrate, Catholic hospitals and local Bishops commonly approve the use of third-party arrangements in order to comply with government requirements that Catholic/secular hospital mergers allow continued provision of reproductive health services needed by communities. The Catholic Health Association's rejection of any proposed use of a third-party administrator or insurer to provide contraceptive coverage for their employees ignores the more substantial compromises Catholic hospitals routinely make in business transactions with non-sectarian hospitals.

**We wish to specifically object to the suggestion made in the Catholic Health Association's June 15 comments to your Departments that contraceptive coverage for their employees, and those of other religiously-affiliated employers, should be paid for by the federal government.** CHA cites what it terms "precedent" of the Title X family planning program.

It would be bad public policy for taxpayers to foot the bill for health insurance coverage provided to the employees of religiously-affiliated entities such as Catholic hospitals. The Title X family planning program was designed to provide contraceptive services to low-income and uninsured women who do not have the benefit of employer-sponsored health insurance. It should not become a provider of contraceptive services to employed individuals whose employers refuse to comply with the generally-applicable coverage requirements of the Affordable Care Act.

We have witnessed the consequences of such a scheme in the community of Muskegon, Michigan, where employees of non-sectarian Hackley Hospital lost their contraceptive coverage in 2007 when their hospital merged with a Catholic facility, Mercy Hospital, that did not allow such coverage. After losing contraceptive coverage, some hospital employees began going to a local Title X family planning clinic. "It put a strain on the clinic, which wasn't designed to serve women who already have health insurance," said Faith Groesbeck, an employee of the local health department who monitored the impact. "Taxpayers were making up for the health coverage these employees had lost." Eventually, the clinic closed under the strain of the additional users and county budget cuts.<sup>20</sup>

It is unreasonable to expect that federal taxpayers should shoulder additional costs under Title X or any other public program to make up for the cost of contraceptive coverage for employees and dependents of Catholic hospitals. Moreover, it would be cumbersome and impracticable for employees to cope with the administrative requirements of having a separate public health insurance program just for this service.

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<sup>20</sup> Lois Uttley, *Employees Need Birth Control*, The Nation, Feb. 17, 2012, available at, <http://www.thenation.com/print/article/166335/employees-need-birth-control-coverage-mandate>.

**We strongly support your Departments' application of preemption principles that allow the continued enforcement of state contraceptive coverage laws that are more protective of consumer access to contraceptive coverage, while preempting those that undermine the federal contraceptive coverage requirement.**

We wish to support the comments being submitted by a coalition of national reproductive health organizations on this subject, which note that 28 states have existing legal requirements mandating coverage of contraception in health insurance plans.<sup>21</sup> The Departments appropriately held that when a state contraceptive coverage law has a religious employer exemption that is broader than the federal contraceptive coverage requirement's exemption – thereby allowing more employers to refuse to provide this critical coverage – the broader state religious employer exemption must be “narrowed to align with that in the final regulations.”<sup>22</sup> We further agree that when a state law does more to ensure women's access to contraceptive coverage – such as by not exempting any religious employers – it should not be preempted by the federal contraceptive coverage requirement. Because such a law is more protective of women's health than the federal requirement and helps more consumers, it does not prevent, but in fact furthers, the application of the ACA.<sup>23</sup> The Departments appropriately recognize that these state laws “will continue.”<sup>24</sup>

We wish to conclude by thanking the Departments for their strong commitment to ensuring that as many women as possible receive the benefit of contraceptive coverage without co-pays under the authority of the Affordable Care Act.

Thank you for the opportunity to submit these comments.

Sincerely,

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<sup>21</sup> “Certain Preventive Services Under the Affordable Care Act;” 77 Fed. Reg. 16,501, 16,507-08.

<sup>22</sup> *Id.* at 16,508.

<sup>23</sup> *Id.* (“State insurance laws that are more stringent than the Federal requirements are unlikely to ‘prevent the application of’ the Affordable Care Act, and be preempted.”).

<sup>24</sup> “Certain Preventive Services Under the Affordable Care Act;” 77 Fed. Reg. 16,508.