BEFORE THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, DEPARTMENT OF LABOR EMPLOYEE BENEFITS SECURITY ADMINISTRATION, AND DEPARTMENT OF THE TREASURY INTERNAL REVENUE SERVICE

Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act	)))	RIN 0938-AT20 (HHS) RIN 1210-AB83 (DOL – EBSA) RIN 1545-BN92 (IRS)
Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act	)))	RIN 0938–AT46 (HHS) RIN 1210–AB84 (DOL – EBSA) RIN 1545–BN91 (IRS)

COMMENTS OF WHITMAN-WALKER HEALTH IN OPPOSITION TO THE INTERIM FINAL RULES

Pursuant to the *Interim Final Rules and Request for Comments*, 82 Fed. Reg. 47,792 and 47,838 (Oct. 13, 2017), Whitman-Walker Health ("WWH" or "Whitman-Walker") hereby submits these comments. For the reasons set forth below, we urge the Department of Health and Human Services, Department of Labor, and Department of the Treasury (collectively, "the Departments") to revoke the Interim Final Rules (the "IFRs"). The IFRs will harm women, their partners and families, and lesbian, gay, bisexual and transgender ("LGBT") people by restricting access to essential reproductive and other health care services. In addition, they create a harmful and dangerous precedent by allowing the denial of health care coverage based on religious views or moral convictions while paying scant attention to the harm such denials cause to third parties. The IFRs also violate the Administrative Procedure Act, the ACA itself, and the United States Constitution.

Interest of Whitman-Walker Health

Whitman-Walker is a federally qualified health center providing primary care, mental health and substance abuse treatment, dental care, medical adherence case management, legal services, and community health services in the greater Washington, DC metropolitan area, with specialties in LGBT health and wellness and in HIV prevention and treatment. In addition to

caring for over 16,000 people living in the Washington metropolitan region, we are one of the oldest medical-legal partnerships in the nation, and have provided both medical and legal services to our patients for more than 30 years. The populations we serve continue to be experience disproportionally high levels of health challenges and disparities, resulting from poverty, stigma and discrimination. Sexual health services, including ready access to contraceptive methods and services, are vital to many of our patients and clients. The IFRs impose unwarranted restrictions on contraception that will prove harmful to many of them. The IFRs also create a dangerous precedent that religious views and moral convictions can justify restricting access to health care through health plans, which is likely to be particularly harmful to our LGBT patients and clients.

The Benefits of Contraception Are Substantial; Restricting Access Is Harmful to Women, Their Partners and Families, and LGBT People

The fordable Care Act ("ACA") has expanded contraceptive coverage without cost-sharing to millions of people across the nation.[1] Since the implementation of the ACA, out-of-pocket spending on prescription drugs has decreased dramatically, with almost 65% of the decrease directly attributed to the contraceptive coverage provision. After the implementation of the ACA, the majority of women had no out-of-pocket costs for their contraception, representing out-of-pocket savings of approximately $1.4 billion for newly covered women.[2] Studies show that the use of long-term contraceptives methods, such as an IUD or an implant, has increased in

[1] Adara Beamesderfer, Alina Salganicoff, and Laurie Sobel, *Private Insurance Coverage of Contraception*, THE HENRY J. KAISER FAMILY FOUNDATION (Dec. 7, 2016), https://www.kff.org/womens-health-policy/issue-brief/private-insurance-coverage-of-contraception.

[2] Nora V. Becker and Daniel Polsky, *Women Saw Large Decrease in Out-Of-Pocket Spending for Contraceptives After ACA Mandate Removed Cost Sharing*, 34 HEALTH AFFAIRS 1204–11 (2015), http://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2015.0127.

recent years because the high upfront costs were removed.[3] These costs previously acted as a barrier for women who may have wanted access to these specific types of contraceptives.[4] Studies also show that decreases in cost-sharing led to better adherence to and more consistent use of the pill, which decreased the risk of unintended pregnancies.[5] Furthermore, the majority of women no longer had to choose between paying for birth control and paying for other necessities, like groceries and utilities.[6]

Contraceptives make up an estimated 30–44% of out-of-pocket health care spending for those who use them.[7] A year's worth of birth control can cost upwards of $370 – the equivalent of 51 hours of work for someone earning the federal minimum wage of $7.25 an hour.[8] Long-acting birth control methods, such as an IUD or contraceptive implant, cost more than $1,000 out of pocket[9] - almost one month's salary for a person earning the federal minimum wage. Studies have shown that insurance coverage has led to an increase in the utilization of contraception, the

---

[3] Adara Beamesderfer, Alina Salganicoff, and Laurie Sobel, *Private Insurance Coverage of Contraception*, THE HENRY J. KAISER FAMILY FOUNDATION (Dec. 7, 2016), https://www.kff.org/womens-health-policy/issue-brief/private-insurance-coverage-of-contraception.

[4] Alina Salganicoff, Laurie Sobel, and Caroline Rosenzweig, *The Future of Contraceptive Coverage*, THE HENRY J. KAISER FAMILY FOUNDATION (Dec. 7, 2016), https://www.kff.org/womens-health-policy/issue-brief/the-future-of-contraceptive-coverage.

[5] *Id*.

[6] *The Affordable Care Act's Birth Control Benefit is Working for Women*, NATIONAL WOMEN'S LAW CENTER (Dec. 16, 2016), https://nwlc.org/resources/the-affordable-care-acts-birth-control-benefit-is-working-for-women.

[7] Nora V. Becker and Daniel Polsky, *Women Saw Large Decrease in Out-Of-Pocket Spending for Contraceptives After ACA Mandate Removed Cost Sharing*, 34 HEALTH AFFAIRS 1204–11, http://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2015.0127.

[8] *The Affordable Care Act's Birth Control Benefit: Too Important to Lose*, NATIONAL WOMEN'S LAW CENTER (May 3, 2017), https://nwlc.org/resources/the-affordable-care-acts-birth-control-benefit-too-important-to-lose; *see* Elizabeth Celms, *How much do birth-control pills cost?*, CLEAR HEALTH COSTS (Apr. 29, 2013), https://clearhealthcosts.com/blog/2013/04/q-how-much-do-birth-control-pills-cost-a-9-to-63-or-68-to-112 (Birth control pills can come at very different prices. According to their study, prices ranged from $9 to $63 for Tri-Sprintec 28 and from $68 to $112 for Yaz-28).

[9] *The Affordable Care Act's Birth Control Benefit: Too Important to Lose*, NATIONAL WOMEN'S LAW CENTER (May 3, 2017), https://nwlc.org/resources/the-affordable-care-acts-birth-control-benefit-too-important-to-lose.

use of more effective methods, and a decrease in out-of-pocket costs for women.[10] Whitman-Walker has significant numbers of low-income patients and clients in our other programs – including our HIV medical care, Community Health programs, and legal services – whose families live in poverty or near-poverty, and who are disproportionately burdened with health disparities, housing instability, and incarceration. The financial strain and loss of autonomy this rule would impose of women and their families would have far-reaching harmful.

Contraceptive use benefits women and families in numerous ways. Having access to the full range of FDA-approved contraceptive methods allows women to choose the method that works best for them at a given point in their life – factoring in ease of use, side effects, risk of sexually transmitted infections, desire for confidentiality and control, as well as many other considerations. Identifying the methods that work best for them helps women use contraception more consistently and correctly, reducing unwanted pregnancies and affording them greater control over family planning.

Reducing unwanted pregnancies and affording women greater control over family planning has additional health benefits. For example, avoiding closely-spaced pregnancies reduces the risk of premature birth or low birth weight. Preventing unintended pregnancy can help women manage certain health conditions, such as diabetes, hypertension, and heart disease. Moreover, contraceptive use helps women to meet their educational and employment goals and to support their families.

---

[10] *Insurance Coverage of Contraceptives*, GUTTMACHER INSTITUTE (Oct. 1, 2017), https://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives; Adara Bearmesderfer, Alina Salganicoff, and Laurie Sobel, *Private Insurance Coverage of Contraception*, THE HENRY J. KAISER FAMILY FOUNDATION (Dec. 7, 2016), https://www.kff.org/womens-health-policy/issue-brief/private-insurance-coverage-of-contraception.

The independent National Academy of Medicine (NAM), formerly called the Institute of Medicine (IoM) echoed scientific consensus that access to contraception is an essential part of shaping women's health and well-being.[11,12] As of September 2016, there were approximately 61 million U.S. women in their childbearing years (ages 15–44).[13] About 43 million of those women (70%) are at risk of unintended pregnancy – that is, they are sexually active and do not want to become pregnant, but could become pregnant if they and their partners do not use a contraceptive method correctly and consistently.[14] Heterosexual couples who do not use any method of contraception have an approximately 85% chance of experiencing a pregnancy over the course of one year.[15] In the United States, the average desired family size is two children. To achieve this family size, a woman must use contraception for roughly three decades.[16]

Access to comprehensive family planning services, and to culturally competent providers of those services, is critically important for the LGBT community. Lesbian, gay and bisexual youth have been shown to experience more pregnancies than do youth who do not identify as a sexual minority.[17] Bisexual women and some transgender people are also at risk for pregnancy

---

[11] National Research Council. Clinical Preventive Services for Women: Closing the Gaps. Washington, DC: The. National Academies Press, 2011.
[12] Adara Beamesderfer, Alina Salganicoff, and Laurie Sobel, *Private Insurance Coverage of Contraception*, THE HENRY J. KAISER FAMILY FOUNDATION (Dec. 7, 2016), https://www.kff.org/womens-health-policy/issue-brief/private-insurance-coverage-of-contraception.
[13] Kimberly Daniels, Jill Daugherty, and Jo Jones, *Current Contraceptive Status Among Women Aged 15–44: United States, 2011–2013*, NATIONAL HEALTH STATISTICS REPORTS 173 (2014), http://www.cdc.gov/nchs/data/databriefs/db173.pdf.
[14] Jo Jones, William Mosher, and Kimberly Daniels, *Current Contraceptive Use in the United States, 2006–2010, and Changes in Patterns of Use Since 1995*, NATIONAL HEALTH STATISTICS REPORTS 60 (2012), http://www.cdc.gov/nchs/data/nhsr/nhsr060.pdf.
[15] J Trussell, *Contraceptive failure in the United States*, 83 CONTRACEPTION 297–404, (May 2011).
[16] *Fulfilling the Promise: Public Policy and U.S. Family Planning Clinics*, THE ALAN GUTTMACHER INSTITUTE (AGI) (2000), https://www.guttmacher.org/sites/default/files/pdfs/pubs/fulfill.pdf.
[17] Lisa L. Lindley, Katrina M. Walsemann, *Sexual Orientation and Risk of Pregnancy Among New York City High-School Students*, 105 AM. J. OF PUBLIC HEALTH 1379–86 (July 1, 2015); Karen Schantz, *Pregnancy Risk Among Bisexual, Lesbian, and Gay Youth: What Does Research Tell Us*, ACT FOR YOUTH CENTER OF EXCELLENCE (Apr. 2015), http://www.actforyouth.net/resources/rf/rf_lgb-prg_0415.pdf.

and are often over-looked when considering access to reproductive health care. Access to family planning is thus essential for this community and should be made more, not less, accessible.

It is deeply troubling that federal agencies charged with ensuring public health would seek to enact a rule that gives employers such sweeping veto power over the health care services their employees may access under their health care coverage. Health insurance is a form of compensation that employees earn, like wages. Allowing employers a religiously-motivated or morally-motivated veto over how an employee uses his or her earned health care coverage is bad public health policy and represents an overemphasis on the rights of an employer or other health plan sponsor to rely or their own religious or moral views to deny employees or other health plan participants the right to access the health care that they need and want. In a religiously and moral diverse society such as ours, employers and other health plan sponsors cannot be permitted to use an exaggerated notion of "complicity" to restrict other persons' rights.

The IFRs Constitute Remarkable, and Indefensible, Departures From the Affordable Care Act's Assurance of Access to Essential Preventive Care

The ACA was enacted to achieve several health care reform goals, including improving the availability of primary and preventive health care services. When preventive services coverage was written into the ACA, Congress included a provision directing HHS to identify the preventive services that should be provided to women.

HHS undertook a thorough and evidence-based process to develop this list of women's preventive services, calling on the independent National Academy of Medicine to convene experts and determine what services should be covered. It surprised no one with a background in public health or medicine that contraception was among the essential preventive services that the Academy included in its recommendations. HHS included contraception in its final rule delineating the list of women's preventive services, exempting houses of worship from covering

contraception in their health plans if they had a religious objection. Seeking a broader exemption, some employers, both for-profit and non-profit, filed lawsuits seeking to challenge the requirement to cover contraception on religious grounds.

The Supreme Court resolved the for-profit challenges in 2014, in *Burwell v. Hobby Lobby*.[18] The Court ruled that the Religious Freedom Restoration Act required that a closely held for-profit company whose owners objected to contraception on religious grounds must be permitted to use the same accommodation given to non-profit entities (described below). Importantly, the Court stressed that there would be no harm to the company's workers caused by permitting the company to use the same accommodation to provide its employees with contraceptive coverage, as the employees would still receive coverage without cost sharing.

With respect to non-profit employers, the Departments developed an accommodation to permit religiously affiliated non-profit employers to certify that they objected to contraception and notify their insurer or third-party administrator (TPA), which would arrange for contraceptive coverage for the objecting employer's employees at no cost to the employer. Following the *Hobby Lobby* decision, two more rules were adopted – one creating an additional notice mechanism for objecting non-profits (to HHS rather than to the insurer/TPA), and another allowing closely-held for- profit entities to avail themselves of the same accommodation, pursuant to the holding in *Hobby Lobby*.

The Religious Exemptions IFR, 82 Fed. Reg. 47,792, expands eligibility for the complete exemption – formerly reserved for houses of worship – to *all* nonprofit and for-profit employers. It also retains the accommodation, formerly available to non-profit and closely-held for-profit employers, as an optional alternative for any employer. This is a dramatic change in the

[18] *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2786–87 (2014).

availability of contraceptive coverage for the employees of a vast number of entities, and a significant departure from what was guaranteed to these employees under prior rulemaking and the *Hobby Lobby* decision.

The Moral Exemptions IFR, 82 Fed. Reg. 47,838, goes even further – far beyond the concerns for religious organizations that motivated Congress, the Departments, and the Supreme Court in *Hobby Lobby*. It allows any non-profit or closely-held for-profit employer, and private institutions of higher education that issue student health plans, to apply for an accommodation or exemption from contraceptive coverage based on moral convictions. The rule provides no guidance or definition for a moral conviction, allowing employers to claim an exemption without any accountability. Moreover, the rule does not provide employees with a mechanism to challenge an employer's alleged moral belief. Without accountability and safeguards, employers will be free to exploit the moral exemption for financial and business reasons. This is a huge and unprecedented change in the availability of contraceptive coverage for the employees of a vast number of entities.

Health insurance benefits earned by employees and guaranteed under federal law should not be subject to a religious veto by employers. The regulatory regime that existed prior to these IFRs was the result of several years of considered policymaking and constituted a balance between religious beliefs and health care access. These IFR overturn that careful balance and subjugate employee health care needs to the religious or even moral objections of any employer.

The IFRs Threaten to Exacerbate Health Disparities Suffered by LGBT People

The IFRs restrict access to contraception for those who need it, including lesbian and bisexual women and some transgender people.[19] Access to birth control is particularly crucial

[19] *Birth Control Access for LGBTQ People*, THE NATIONAL LGBTQ TASK FORCE (2016), http://www.thetaskforce.org/static_html/downloads/reports/fact_sheets/factsheet_birth_control_access.pdf.

for the health and well-being of lesbian and bisexual women because they are at risk for unintended pregnancies.[20]

Despite misconceptions held by policymakers and some medical providers, lesbian and bisexual women require sexual and reproductive health services similar to those needed by heterosexual women. A majority of lesbian and bisexual women have reported having had intercourse with men and at least 30% have been pregnant,[21] 50% have used oral contraceptives, and 16% reported one or more abortions.[22] Bisexual women are also subject to an increased risk of sexual violence. One study found that 46% of bisexual women have been raped as compared to 17% of heterosexual women.[23] Broadly, studies indicate that unintended pregnancies are equally as common, if not more common, for lesbian and bisexual women as for heterosexual women.[24]

Adolescent lesbian and bisexual women are at even higher risk for unintended pregnancies. Lesbian adolescent women are less likely than bisexual and heterosexual women to use contraception and bisexual adolescent women are more likely to experience teen pregnancy than are heterosexual adolescent women.[25] One study found that 12% of lesbian and bisexual

---

[20] Caroline S. Hartnett, Lisa L. Lindley and Katrina M. Walsemann, *Congruence across Sexual Orientation Dimensions and Risk*, WOMEN'S HEALTH ISSUES JOURNAL (2016).
[21] J.M. Marrazzo and K. Stine, *Reproductive Health History of Lesbians: Implications for Care*, AM. J. OF OBSTETRICS AND GYNECOLOGY (2003).
[22] Elizabeth M. Saewyc, Linda H. Bearinger, Robert Wm. Blum and Michael D. Resnick, *Sexual Intercourse, Abuse and Pregnancy Among Adolescent Women: Does Sexual Orientation Make a Difference?*, 31 FAMILY PLANNING PERSPECTIVES 127 (1999).
[23] Adara Beamesderfer, Lindsey Dawson, Jennifer Kates, Usha Ranji, and Alina Salganicoff, *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S.*, THE HENRY J. KAISER FAMILY FOUNDATION (Nov. 2016), https://www.kff.org/disparities-policy/issue-brief/health-and-access-to-care-and-coverage-for-lesbian-gay-bisexual-and-transgender-individuals-in-the-u-s.
[24] Caroline S. Hartnett, Lisa L. Lindley and Katrina M. Walsemann, *Congruence across Sexual Orientation Dimensions and Risk*, WOMEN'S HEALTH ISSUES JOURNAL (2016).
[25] Brittany M. Charlton, Heather L. Corliss, Stacey A. Missmer, Margaret Rosario, Donna Spiegelman, and Bryn Austin, *Sexual orientation differences in teen pregnancy and hormonal contraceptive use: An examination across 2 generations*, AM. J. OF OBSTETRICS AND GYNECOLOGY (2013), http://www.ajog.org/article/S0002-9378(13)00652-2/pdf.

adolescent women have experienced teen pregnancy, compared to only 5% of heterosexual adolescent women. A 2016 study by the Centers for Disease Control and Prevention found that LGBT high school students are more likely than other students to experience intimate partner violence and rape, which can result in unintended pregnancy.[26]

In sum, access to contraception is essential for the health and well-being of many members of the LGBT community, and allowing a wide range of employers to withhold coverage of contraception for religious reasons is unsound public health policy with the potential to cause significant harm.

The IFRs Violate the Administrative Procedure Act

The Administrative Procedure Act ("APA") imposes procedural requirements on the actions of executive branch agencies, including when agencies are "formulating, amending or repealing" a rule.[27] The APA is applicable here because the Religious Exemptions IFR is a final agency action and is a legislative rule within the meaning of the APA.[28] The IFRs violate pre-adoption and post-adoption procedural requirements of the APA.

The APA contains two procedural rulemaking requirements that must be followed when an agency is "formulating, amending or repealing" a rule.[29] Section 553(b) of the APA requires notice and comment rulemaking, involving a notice of proposed rulemaking and a comment period prior to finalization of regulatory requirements – except when an agency, for good cause, finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the

---

[26] *Sexual Identity, Sex of Sexual Contacts, and Health-Related Behaviors Among Students in Grades 9–12 — United States and Selected Sites, 2015*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Aug. 12, 2016), https://www.cdc.gov/mmwr/volumes/65/ss/pdfs/ss6509.pdf; *see also* Lisa L. Lindley and Katrina M. Walsemann, *Sexual Orientation and Risk of Pregnancy Among New York City High School Students*, 105 AM. J. OF PUB. HEALTH 1379 (2015).
[27] 5 U.S.C. § 551(5).
[28] *Id*.
[29] *Id*.

public interest.[30] In addition to the pre-adoption notice-and-comment requirements, section 553(d) of the APA has a post-adoption publication requirement that agencies have a 30-day period between when a final rule is published and its effective date, unless the agency has good cause.[31] "[T]he purpose of the thirty-day waiting period is to give affected parties a reasonable time to adjust their behavior before the final rule takes effect."[32]

The IFRs violate the notice and comment requirement and the 30-day "wait" period between publication and effective date. An agency will be granted reprieve from these requirements only when the agency has "good cause" for not following them. The Departments lack good cause to depart from those requirements. Good cause is limited to situations where an agency finds that compliance with notice and comment rulemaking is "impracticable, unnecessary, or contrary to the public interest."[33] Courts have found good cause in cases that involve: (1) emergencies;[34] (2) context where prior notice would subvert the underlying statutory scheme;[35] and (3) situations where Congress intends to waive section 553's requirements.[36] An agency's determination of "good cause" to abstain from following the APA's procedural requirements applies to each procedural requirement separately.[37] This means that the

---

[30] 5 U.S.C. § 553(b).
[31] 5 U.S.C. § 553(d) (Final agency action and legislative rules must be published in the Federal Register not less than 30 days before the effective date.).
[32] *Omnipoint Corp. v. F.C.C.*, 78 F.3d 620, 630 (D.C. Cir. 1996).
[33] 5 U.S.C. § 553(b).
[34] For example, in 2004, the D.C. Circuit upheld the Federal Aviation Administration's (FAA) rule, promulgated without notice and comment, covering the suspension and revocation of pilot certificates on security grounds. *See Jifry v. F.A.A.*, 370 F.3d 1174, 1179–80 (D.C. Cir. 2004).
[35] For example, the Ninth Circuit upheld the Secretary of Agriculture's invocation of good cause to bypass the APA's 30-day publication requirement when issuing rules governing the orange market. *Riverbend Farms, Inc. v. Madigan*, 958 F.2d 1479, 1486 (9th Cir. 1992) (reasoning that requiring the Secretary to give 30-day notice of each rule would cause harm by forcing the agency to predict the proper restrictions in advance of when a reasonable determination could actually be made).
[36] For instance, when Congress imposes certain procedures, which, taken together with a deadline, are irreconcilable with Section 553's requirements, then courts may read congressional intent to waive the APA's requirements. *See, e.g., Asiana Airlines v. F.A.A.*, 134 F.3d 393, 398 (D.C. Cir. 1998); *Methodist Hosp. of Sacramento v. Shalala*, 38 F.3d 1225, 1237 (D.C. Cir. 1998) (finding that the APA is inapplicable, rather than that good cause is established).
[37] *United States v. Brewer*, 766 F.3d 884, 888 (8th Cir. 2014).

Departments must have good cause to waive each requirement.

The Departments claim that this provision of the APA does not apply "because of the specific authority granted to the Secretaries by section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act."[38] While these statutes empower the Secretaries to promulgate such regulations as may be necessary or appropriate to carry out the provisions of the Health Insurance Portability and Accountability Act of 1996,[39] they do not empower the secretaries to disregard the APA's procedural requirements.

In the alternative, the Departments argue that they "have determined that it would be impracticable and contrary to the public interest to delay putting these provisions in place until a full public notice-and-comment process is completed."[40] This conclusory statement does not meet the standard Courts have enumerated for rulemaking rise to the standard of "good cause." This reasoning is similar to other instances in which agencies made claims of an emergency situation, unaccompanied by independent facts, which the courts determined were insufficient to constitute good cause.[41] Declaring that it would be impracticable and contrary to the public interest to delay putting these provisions in place until a full public notice-and-comment process is completed is not the same as being impracticable and contrary to public interest.

---

[38] Religious Exemptions and Accommodations for Coverage of Certain Preventable Services Under the Affordable Care Act, 82 Fed. Reg. at 47813; Moral Exemptions and Accommodations for Coverage of Certain Preventable Services Under the Affordable Care Act, 82 Fed. Reg. at 47855.

[39] 26 U.S.C. § 9833; 29 U.S.C. § 1191(c); 42 U.S.C. § 300gg–92.

[40] Religious Exemptions, 82 Fed. Reg. at 47813; Moral Exemptions, 82 Fed. Reg. at 47855.

[41] *See, e.g.*, *Sorenson Commc'ns Inc. v. F.C.C.*, 755 F.3d 702, 706 (D.C. Cir. 2014) (finding that no good cause existed when the agency failed to establish facts supporting a "threat of impending fiscal peril"). In addition, a number of courts rejected the Attorney General's invocation of good cause in the SORNA cases as merely restating the purpose of the statute, rather than proffering independent evidence. *See United States v. Valverde*, 628 F.3d 1159, 1167 (9th Cir. 2010) ("[T]he Attorney General did little more than restate the general dangers of child sexual assault, abuse, and exploitation that Congress had sought to prevent when it enacted SORNA."); *Brewer*, 766 F.3d at 890 (8th Cir. 2014) ("[T]he Attorney General's 'public safety rationale cannot constitute a reasoned basis for good cause because it is nothing more than a rewording of the statutory purpose Congress provided in the text of SORNA.'") (quoting *United States v. Reynolds*, 710 F.3d 498, 512 (3d Cir. 2013)); *see also United States v. Johnson*, 632 F.3d 912, 928 (5th Cir. 2011); *United States v. Cain*, 583 F.3d 408, 421 (6th Cir. 2009).

The Departments further argue that "[g]ood cause is supported by providing relief for entities and individuals for whom the Mandate operates in violation of their sincerely held religious beliefs, but who would have to experience that burden for many more months under the prior regulations if these rules are not issued on an interim final basis."[42] However, this reasoning should be weighed against the burdens that many women will face if their employer or university decides to take advantage of the Religious Exemptions IFR and cease to offer contraception without cost-sharing.

The Departments have failed to provide good cause for violating both the APA's pre-adoption notice-and-comment requirements and its post-adoption publication requirements. They have not adequately established that the APA's procedural requirements do not apply or that they have good cause for disregarding them. Because the IFRs were promulgated without adherence to the APA's procedural requirements, and without good cause for doing so, they violate 5 U.S.C. §§ 553(b) and 553(d).

The IFRs Also Violate Key Provisions of the ACA

Section 1554 of the ACA prohibits the Departments from issuing regulations that create unreasonable barriers to individuals obtaining medical care; impede timely access to health care services; interfere with communications regarding a full range of treatment options between patient and provider; restrict the ability of providers to provide full disclosure of all relevant information for making health care decisions; violate the principles of informed consent and ethical standards of health care professionals; or limit the availability of treatment for the full duration of a patient's medical needs.[43] The IFRs violate Section 1554 because they create

[42] Religious Exemptions, 82 Fed. Reg. at 47814–15; Moral Exemptions, 82 Fed. Reg. at 47855.
[43] 42 U.S.C. § 18114.

unreasonable barriers to the ability of individuals to obtain appropriate medical care and it impedes timely access to health-care services.

Section 1557 of the ACA prohibits discrimination on the basis of sex.[44] The implementing regulations for Section 1557, issued by HHS, state correctly that sex discrimination includes discrimination based on "pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity."[45] The Section 1557 regulations further state that people cannot "be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any health program or activity to which [the rule] applies."[46] By allowing the denial of a health care service used almost exclusively by women, the IFRs discriminate on the basis of sex.

The Religious Exemptions IFR Violates the Establishment Clause of the First Amendment

The Religious Exemption IFR impermissibly allows employers to impose their own religious viewpoint on employees, regardless of those employees' personal beliefs, and even when doing so causes employees serious harms.[47] Courts have held that the Establishment Clause of the First Amendment prevents the government from shifting the cost of religious accommodation to third parties.[48] While the Administration has asserted that the Religious Freedom Restoration Act[49] allows, or even requires, that the government create an avenue for

---

[44] 42 U.S.C. § 18116.
[45] 45 CFR § 92.4.
[46] 45 CFR § 92.101.
[47] *See* U.S. CONST. amend. I.
[48] *See Cutter v. Wilkinson*, 544 U.S. 709, 726 (2005) (rejecting a facial challenge to RLUIPA, a federal statute that permits accommodation of certain religious practices in prison, stating "[s]hould inmate requests for religious accommodations become excessive, *impose unjustified burdens on other institutionalized persons*, or jeopardize the effective functioning of an institution, the facility would be free to resist the imposition.") (emphasis added); *Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 710 (1985) (stating, "The First Amendment . . . gives no one the right to insist that in pursuit of their own interest others must conform their conduct to his own religious necessities."); *but see Corp. of the Presiding Bishop of the Church of Jesus Christ of Latter-Day Saints v. Amos*, 483 U.S. 327 (1987) (distinguishing the obligations imposed on churches from those imposed on other types of organizations).
[49] 42 U.S.C. § 2000bb.

exempting certain organizations from the Affordable Care Act's contraceptive coverage provision, the government can only constitutionally achieve such an outcome by replacing the current benefit with a program that provides contraception at no additional cost to employees.[50] Instead, the Rule as issued impedes access to contraceptive coverage and the ability to make personal decisions regarding reproductive health solely based on another person's religious beliefs.

Similar to benefits conferred by the Social Security Act, the Fair Labor Standards Act, the Family and Medical Leave Act, and many other federal statutes that expressly require specific employee compensation and benefits, contraceptive coverage is a legally ensured and economically valuable employee entitlement. There is nothing in First Amendment jurisprudence to distinguish between these federal statutory entitlements and the contraceptive coverage benefit in the ACA. The Religious Exemption IFR tells employers that they are empowered to reject insurance coverage for any health care service that they find religiously objectionable. Such a result would impermissibly shift the cost of religious accommodation onto third parties, subjecting employees to serious harms.

The Religious Freedom Restoration Act Provides No Support Whatever for the Moral Exemptions IFR

While the administration has asserted that the Religious Freedom Restoration Act allows, or even requires, that the government create an avenue for exempting certain organizations from the ACA's contraceptive coverage provision, RFRA provides no authority to craft moral exemptions. The Moral Exemptions Rule impedes access to contraceptive coverage and the ability to make personal decisions regarding reproductive health solely based on another person's moral convictions – which is entirely outside the scope of RFRA.

[50] *See Zubik v. Burwell*, 136 S. Ct. 1557; *Hobby Lobby*, 134 S. Ct. at 2786–87.

The IFRs Also Amount to Unconstitutional Sex Discrimination

The IFRs also violate the Fifth Amendment because they constitute impermissible sex discrimination.[51] The ACA's women's preventive services benefit, which includes the contraceptive coverage provision, was implemented in part to address the fact that women tended to pay more for insurance coverage than did men.[52] The IFRs violates the Fifth Amendment because they exclusively target benefits provided to women.

Conclusion

The ACA has expanded contraceptive coverage without cost-sharing to millions of privately insured women across the nation.[53] Since the implementation of the ACA, out-of-pocket spending on prescription drugs has decreased dramatically, with an almost 65% decrease directly attributed to oral contraception costs newly covered by the contraceptive coverage provision of the ACA.[54] It is estimated that the ACA created an out-of-pocket savings of approximately $1.4 billion for newly covered women, and ensured that a majority of women had no out-of-pocket costs for their healthcare.[55] Under the IFRs, there is no guaranteed right of contraceptive coverage for the employees, dependents, and students of these organizations who are now eligible for the exemption. While it is unclear how many organizations will avail themselves of one of these exemptions, it is certain that many women will see a dramatic increase in their reproductive healthcare costs as employers avail themselves of the newly available religious exemption.

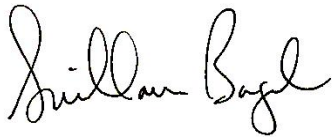
---

[51] U.S. CONST. amend. V.
[52] *See* 42 U.S.C. § 300gg-13(a)(4); 45 C.F.R. § 147.130 (2013)(a)(1)(iv).
[53] Adara Beamesderfer, Alina Salganicoff, and Laurie Sobel, *Private Insurance Coverage of Contraception*, THE HENRY J. KAISER FAMILY FOUNDATION (Dec. 7, 2016), https://www.kff.org/womens-health-policy/issue-brief/private-insurance-coverage-of-contraception.
[54] Nora V. Becker and Daniel Polsky, *Women Saw Large Decrease in Out-Of-Pocket Spending for Contraceptives After ACA Mandate Removed Cost Sharing*, 34 HEALTH AFFAIRS 1204–11 (2015), http://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2015.0127.
[55] *Id.*

The IFRs are bad public health policy, contrary to law, and create dangerous and corrosive precedents for further discrimination – against women and LGBT people – based on an employer's or health plan sponsor's particular religious beliefs or conception of morality. They should be rescinded.

Respectfully submitted,

Daniel Bruner, JD, MPP, Senior Director of Policy



Guillaume Bagal III, MA, MHA, Public Policy Associate
WHITMAN-WALKER HEALTH
1342 Florida Avenue NW
Washington, DC 20009
(202) 939-7628
dbruner@whitman-walker.org

December 5, 2017