

***Testimony of
Most Reverend William E. Lori
Bishop of Bridgeport***

***On behalf of the
United States Conference of Catholic Bishops***

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

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Mr. Chairman and members of the Committee. Thank you for the opportunity to testify today on this matter of utmost importance to our Nation—religious liberty.

When I testified recently before the House Committee on Oversight and Government Reform, I drew an analogy between the HHS mandate—which forces virtually all healthcare policies nationwide to cover sterilization and contraception, including abortifacients—and a hypothetical mandate forcing virtually all restaurants nationwide to serve pork. I concluded this way:

“[I]t is absurd for someone to come into a kosher deli and demand a ham sandwich; ... it is beyond absurd for that private demand to be backed with the coercive power of the state; [and] ... it is downright surreal to apply this coercive power when the customer can get the same sandwich cheaply, or even free, just a few doors down.”

Today, I would like to continue to develop the theme of the various absurd and surreal consequences that have flowed from the HHS mandate.

In short, ever since the mandate has been announced, fair is foul, and foul is fair. For my testimony, I would like to survey briefly some of the ways in which the HHS mandate has suddenly turned the world upside down.

FIRST: “Without change” suddenly means “with change”

On Friday, February 10, 2012, the Administration finalized—and I quote from the rule itself, “without change”—the interim final rule imposing the mandate, which was announced initially in August 2011. In fact, the February 10 action uses the phrase “without change” four separate times.

That means that the mandate still classifies ways to prevent births as among ways to avoid disease; it still forces the various stakeholders in the process, who may have moral and religious objections to this coverage, to facilitate and fund it; and it still applies the same exceedingly (and offensively, and unconstitutionally) narrow definition of “religious,” to specify which religious organizations are “religious enough” to warrant the government’s respect for their religious freedom.

Despite this, a surprising number of those who objected vociferously to the August 2011 rule were suddenly and completely satisfied. Indeed, based on their reaction—rather than on the text of the rule itself—one could be forgiven the impression that there was a major change in the rule, rather than none at all.

The reason for this confusion is that the finalized rule also announced what it described as an “accommodation.” But this “accommodation” would not change the scope of the mandate and its exemption, which, as noted above, have now been finalized with the same language as in August 2011. Instead, it would take the form of additional

regulations whose precise contours are yet unknown, and that may not issue until August 2013, about eighteen months from now.

And even in broad outline, this possible future “accommodation” seems logically impossible to achieve. On the one hand, the Administration has emphasized that the “accommodation” would shift the burden of the mandate to insurers. This is no accommodation at all, since the “services” will still be paid for by virtue of enrollment in an insurance policy provided by and paid for by the objecting employer. On the other hand, the Administration occasionally suggests that it might like to lift the burden from insurers who are also employers (*i.e.*, the self-insured).

If we are looking for signs as to which way this dilemma will be resolved—and indeed, it must be resolved one way or the other, there is no in-between—we take no comfort from the recent comments of the Secretary of HHS, who is widely quoted as saying: “Religious insurance companies don’t really design the plans they sell based on their own religious tenets.” This is plainly false—for example, Congress has long exempted religious insurers specifically (and other insurers with religious objections) from having to include contraceptive coverage health plans offered to federal employees. The Secretary’s statement also bodes ill for the possibility of religious insurance companies’ getting whatever limited “accommodation” may ultimately be offered to religious self-insurers. But more to the point, it reflects the mindset that will inform any promised future accommodation for religious insurers.

In sum, for present purposes, the “accommodation” is just a legally unenforceable promise to alter the way the mandate would still apply to those who are still not exempt from it; moreover, the promised alteration appears logically impossible. Meanwhile, the mandate itself is still finalized “without change,” excluding in advance any expansion of the “religious employer” exemption. In the world-turned-upside-down that we have all entered since the mandate issued, this is not merely “no change,” but is heralded as “great change,” for which the Administration has been widely congratulated.

SECOND: “Choice” suddenly means “force”

Let me quote from the letter that I issued in my own Diocese of Bridgeport in late January. The letter is typical of many that were read in churches across the country:

The U.S. Department of Health and Human Services announced last week that almost all employers, *including Catholic employers*, will be forced to offer¹ their employees health coverage that includes sterilization, abortion-inducing drugs, and contraception. Almost all health insurers will be forced to include those “services” in the health policies they write. And almost all individuals will be forced to buy that coverage as a part of their policies.

¹ If the future “accommodation” of February 10, 2012, eventually delivers on its stated intention—which is far from assured—the word “offer” in this sentence should perhaps be changed to “fund and facilitate.” In any event, the conflict with our religious convictions remains.

I emphasize this word—“force”—precisely because it is one of the key differences between a mere dispute over reproductive health policy and a dispute over religious freedom. Those who would try to conceal that religious freedom aspect have done all in their power to conceal the key element of government coercion.

This is not a matter of whether contraception may be prohibited by the government—that question was asked and answered by the U.S. Supreme Court about two generations ago. This is not even a matter of whether contraception may be supported by the government—to our great dismay, there is already widespread government funding of contraception, at all levels of government, across the country. Instead, it is a matter of whether religious people and institutions may be forced by the government to provide coverage for contraception or sterilization, even if that violates their religious beliefs.

It is precisely that element of government coercion—of government’s conscripting unwilling religious people and groups in its effort to increase the usage of contraception nationwide—that makes this a religious freedom dispute. This is not a matter of “repackaging” or “framing” the dispute as one of religious freedom, as some have suggested. It is a matter of acknowledging the basic fact that government is forcing religious people and groups to do something in violation of their consciences.

And yet, listening to the public discourse about the mandate, it is easy to get the impression that the Catholic bishops were somehow on the cusp of prohibiting the use of contraceptives nationwide. Only in our new world-turned-upside-down does freedom require the denial of freedom; only in the post-mandate world is access to contraceptives somehow prohibited unless government begins forcing religious people and groups to fund and facilitate it.

THIRD: Liberals have suddenly abandoned liberalism

It is well known that the bishops of the United States routinely work with those on both sides of the aisle, in the service of the foundational moral principles that flow from our faith.

And so it is here. When the mandate was first proposed in August, people and groups of all political stripes—left, right, and center—came forward to join us in opposing it. And when it was announced in January that the rule would be finalized without change, there was an uproar from that same politically diverse group, and then some.

But now, the mere prospect of the indeterminate, inconsistent, inadequate future “accommodation” described above has caused some—usually those who would self-identify as “liberal”—to simply abandon their prior objection. In so doing, they undermine the values that they would otherwise espouse as good liberals:

- Freedom of choice—people and groups that are still forced by government to fund and facilitate sterilization and contraception over their religious objections have no choice.
- Separation of church and state—the mandate has the government both interfering with the internal affairs of religious organizations, and favoring some religious organizations over others by means of the restrictive 4-part test.
- Religious diversity—the mandate means that private-sector employers can no longer order themselves according to Catholic values regarding human sexuality; all are forced to reflect the government’s values on that subject instead.
- Minority rights—the Administration has repeatedly cited (in a misleading way, no less²) statistics designed to cast the Catholic Church’s teaching against contraception as the view of a small minority—as if government’s forcing people to violate their religious beliefs is justified, so long as the beliefs are unpopular enough.
- Gender equality—because the mandate only pertains to preventive services for women, it requires coverage of tubal ligations, but not vasectomies.
- Service to all in need—religious organizations lose their exemption under the 4-part test if they primarily serve those outside their faith, giving the organizations a strong incentive to curtail their work for the neediest in society.

Only in a world turned upside-down by the HHS mandate might it be considered “liberal” for the government to coerce people into violating their religious beliefs, to justify its intrusion based on the minority status of those beliefs, to intrude into the internal affairs of religious organizations, to discriminate blatantly based on sex, to crush out religious diversity in the private sector, and to incentivize religious groups to serve fewer of the needy.

FOURTH: Sterilization, contraception, and abortifacients are essential, but “essential health benefits” are not

In December of last year, it was widely overlooked that HHS acted to define another important mandate under the health care reform law—the “essential health benefits” mandate. As its name suggests, this mandate encompasses categories of services so important that they must be included in health plans, such as prescription drugs, emergency services, hospitalization, laboratory services, pediatric services, and others. But notably, in December, HHS punted on defining these most important

² See Glenn Kessler, “The claim that 98 percent of Catholic women use contraception: a media foul,” *The Washington Post* (Feb. 17, 2012) (available at http://www.washingtonpost.com/blogs/fact-checker/post/the-claim-that-98-percent-of-catholic-women-use-contraception-a-media-foul/2012/02/16/gIQAkPegIR_blog.html).

benefits, handing off to each state the decision what particular benefits should be mandated.³

Thus, although HHS will brook no dissent regarding whether sterilization and contraception, including abortifacients, must be covered as “preventive services,” HHS is essentially indifferent regarding what is—or is not—mandated as an “essential health benefit.” As a result, genuinely indispensable items under the important rubrics listed above may well be omitted from coverage, depending on the policy preferences of each state. By contrast, states have no such discretion with respect to sterilization, contraception, and abortifacients—these must be covered, even over religious objections in many cases.

Taking just one example of “essential health benefits”—prescription drugs—the state may define this category to require coverage of cancer drugs, AIDS drugs, and other life-saving treatments. But HHS has no quarrel with a state that decides not to require coverage of drugs like these. By contrast, HHS requires that state to cover drugs that, according to respected medical studies and the drugs’ manufacturers, may increase women’s risk of suffering from breast cancer, stroke and AIDS.⁴

In this context, the rigid mandate to cover sterilization, contraception, and abortifacients is especially absurd. How would HHS respond to the claims of cancer patients that they are entitled to “free access” to cancer drugs, which can mean the difference between life or death? How would HHS respond to a state that did not include such life-saving drugs as an “essential health benefit”? Whatever HHS’s response is, we know it would have to be something far less than HHS’s full-throated demand for “free access” to contraceptives in every state and in every plan. Again, under the mandate, the world is turned upside down.

In conclusion, the Respect for Rights of Conscience Act (H.R. 1179, S. 1467)—which allows those who sponsor, provide or purchase health plans the freedom to follow their moral and religious convictions in the face of new mandates under the health care reform act—would help bring the world aright again. This legislation would not expand

³ See HHS Essential Health Benefits Bulletin (Dec. 16, 2011) (available at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf).

⁴ For example, the manufacturer’s insert for Ortho Tri-Cyclen Lo Tablets, a commonly used contraceptive, states: “The use of oral contraceptives is associated with increased risks of several serious conditions including myocardial infarction, thromboembolism, stroke, hepatic neoplasia, and gallbladder disease.... The risk of having breast cancer diagnosed may be slightly increased among current and recent users of combination oral contraceptives,” with the excess risk decreasing over time once the drug is discontinued.

Regarding AIDS see P. Belluck, “Contraceptive Used in Africa May Double Risk of H.I.V.,” *The New York Times* (Oct. 3, 2011) (available at [www.nytimes.com/2011/10/04/health/04hiv.html?](http://www.nytimes.com/2011/10/04/health/04hiv.html?_r=1)). The *Times* article, in turn, cites Heffron, *et al.*, “Use of hormonal contraceptives and risk of HIV-1 transmission: a prospective cohort study,” 12 *The Lancet Infectious Diseases* 19-26 (2012) (available at [www.thelancet.com/journals/laninf/article/PIIS1473-3099\(11\)70247-X/abstract](http://www.thelancet.com/journals/laninf/article/PIIS1473-3099(11)70247-X/abstract)), which states that women using hormonal contraceptives have an increased risk of contracting and transmitting HIV, with that risk doubled among those using injectable contraceptives.

such freedom beyond its present limits, but simply retain Americans' longstanding freedom not to be forced by the federal government to violate these convictions.

Thank you for your attention.