On Wednesday, November 2, 2011, at 10:00 a.m., the Energy and Commerce Committee Subcommittee on Health held a hearing in 2322 Rayburn House Office Building entitled "Do New Health Law Mandates Threaten Conscience Rights and Access to Care?"

WITNESSES:
William J. Cox
President and CEO
Alliance of Catholic Health Care
David Stevens, MD, MA (Ethics)
Chief Executive Officer
Christian Medical Association
Jane G. Belford
Chancellor
Archdiocese of Washington
Mark Hathaway, OBYGN
Director of OB/GYN Outreach Services for Women and Infant Services
Washington Hospital Center
Jon O'Brien
President
Catholics for Choice

Committee Members:
REP. JOE PITTS, R-PA. CHAIRMAN
REP. MICHAEL C. BURGESS R-TEXAS
REP. EDWARD WHITFIELD, R-KY
REP. JOHN SHIMKUS, R-ILL
REP. MIKE ROGERS, R-MICH
REP. SUE MYRICK, R-N.C.
REP. TIM MURPHY, R-PA
REP. MARSHA BLACKBURN, R-TENN
REP. PHIL GINGREY, R-GA
REP. BILL CASSIDY, R-LA
REP. BRETT GUTHRIE, R-KY
REP. LEONARD LANCE, R-N.J.
REP. BOB LATTA, R-OHIO
REP. CATHY MCMORRIS RODGERS, R-WASH
REP. JOE L. BARTON, R-TEXAS EX OFFICIO
REP. FRED UPTON, R-MICH. EX OFFICIO
REP. FRANK PALLONE JR., D-N.J. RANKING MEMBER
REP. JOHN D. DINGELL, D-MICH
REP. EDOLPHUS TOWNS, D-N.Y.
REP. ELIOT L. ENGEL, D-N.Y.
REP. LOIS CAPPS, D-CALIF.
REP. JAN SCHAKOWSKY, D-ILL.
REP. CHARLIE GONZALEZ, D-TEXAS
REP. TAMMY BALDWIN, D-WIS.
REP. MIKE ROSS, D-ARK.
REP. HENRY A. WAXMAN, D-CALIF. EX OFFICIO

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

On August 3, 2011, the Department of Health and Human Services issued an interim final rule that would require nearly all private health plans to cover contraception and sterilization as part of their preventative services for women. While the rule does include a religious exemption, many entities feel that it is inadequate and violates their conscience rights by forcing them to provide coverage for services for which they have a moral or ethical objection.

The religious employer exemption allowed under the preventive services rule, at the discretion of the HRSA, is very narrow. And the definition offers no conscience protection to individuals, schools, hospitals, or charities that hire or serve people of all faiths in their community. It is ironic that the proponents of the health care law talked about the need to expand access to services but the administration issues rules that could force providers to stop seeing patients because to do so could violate the core tenants of their religion.

I am also concerned about the process HHS used to issue the rule. The interim final rule was promulgated before the proposed rulemaking and the formal comment period were conducted by HHS.

In issuing the rule, HHS acknowledged that it bypassed the normal rulemaking procedures in order to expedite the availability of preventive services to college students beginning the school year in August. HHS argued that there would be a year's delay in the receipt of the new benefit if the public comment period delayed the issuance of HRSA guidance for over a month.

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

Now we have the federal Department of Health and Human Services forcing every single person in this country to pay for services that they may morally oppose. Groups who have for centuries cared for the sick and poor will now be forced to violate their religious beliefs if they want to continue to serve their communities.

Whether one supports or opposes the health care law, we should universally support the notion that the federal government should be prohibited from taking coercive actions to force people to abandon their religious principles.

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

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

Each year, one in six patients in the United States are cared for in a Catholic hospital, and approximately 725,000 individuals work in Catholic hospitals. These hospitals take all who are in need. It doesn't matter their religious background or their ability to pay. Come one, come all.

But now, Obama care would actually require, with the rulemaking, Catholic hospitals to primarily serve persons who share its religious beliefs or force them to provide benefits, like abortion drugs, to employees that contradict their faith. Let me rephrase, the White House is telling Catholic hospitals to deny care for those of other faiths or be forced, as employers, to provide coverage for services that they object to on religious and moral grounds. 8

Why must President Obama insist that the price for health care reform be giving up the civil liberties through an individual mandate and the religious liberties that are the founding -- that our founding fathers guaranteed us under the Constitution? This Congress can do better than that. Obama care can do better than that.

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

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

PALLONE: Thank you, Mr. Chairman.

Today's hearing will focus on the implementation of the Affordable Care Act's prohibition of cost-sharing for preventive health services, which will include prescription birth control methods. The rule released by the Department of Health and Human Services would permit certain religious employers to opt out of the requirement of providing contraception.

But unfortunately, this is more than an examination of HHS's rule and whether or not it protects conscience rights. It's simply the latest in a series of attacks this year on the health care reform and women's health.

The federal health reform law represents unprecedented efforts to improve women's health and women's access to comprehensive health care. In fact, women will gain the most from health care reform.

First, we must not forget that the ACA makes health insurance a reality for 19 million women in this country who were uninsured. In addition, it seeks to protect women from many insurance abuses. In the individual insurance market, women were being denied coverage for such preexisting conditions as pregnancy, having had a C-section, or in some cases, breast cancer. The ACA outlaws such a practice.

Women were also often being charged substantially higher premiums than men for the same health care coverage, and the ACA outlaws these gender rating practices. In many cases, women and children with insurance have not been receiving key preventive care, from mammograms, to well baby and well child care visits, to family planning services, such as birth control, because they could not afford the copays. Now the Affordable Care Act is making groundbreaking strides in care for women by eliminating these copays and deductibles for preventive services.

The new preventative coverage rules announced by HHS remove significant financial obstacles for women seeking preventive reproductive health care. These provisions ensure that a woman has access to all preventative services regardless of who her employer is.

And this is critical because it's well known that almost all women -- 99 percent, in fact, including religious devotees -- will use contraception at some point during their reproductive lives. Meanwhile, three recent studies have found that lack of insurance is significantly associated with reduced use of prescriptions contraceptives.

While I absolutely support an individual's right to express their religious conviction, today's hearing has nothing to do with religious rights and conscience protections. In my opinion, this hearing is about women's access to comprehensive health care coverage. And whether my colleagues admit it or not, their attempts here today are meant to turn back the clock on the great strides the Affordable Care Act has and will continue to make for women's health.

We can't continue to allow obstacles to prevent us from ensuring the affordability of family planning service for millions of women.

I'd now like to yield two minutes -- or the time I have left, Mr. Chairman -- to the gentlewoman from Illinois, Ms. Schakowsky.

SCHAKOWSKY: Thank you for yielding.

The attention this committee has focused and continues to focus on the private lives of women makes it clear that one of the goals of the majority is to end access not just to abortions but to family planning. I fought for and will continue to fight for the guidelines adopted by the administration after an exhaustive and thorough scientific review by the Institutes of Medicine to ensure insurance coverage of preventive services for women.

It is no secret that substantial public health benefits and cost savings emerge when preventive services, including family planning, are accessible and affordable. As patients, caregivers, and as workers who still earn less than men, women have a particular stake in ensuring insurance coverage of prescription contraceptives and other preventive services.

The new guidelines on insurance coverage of preventive services for women should apply to all women, regardless of where they work. Allowing employers to exempt themselves from providing prescription contraceptives for their employees is counterproductive, unfair, and paternalistic.

Why should the conscience of an employer trump a woman's conscience? Why should an employer decide for a woman whether she can access the health care services that she and her doctor decide are necessary? Why are we talking about allowing some employers to put up a barrier to access at a time when women are struggling to afford and access health care?
It never used to be that family planning was considered a partisan issue, and it never used to be that family planning was equated with abortion. My, how things have changed.

Today the full continuum of reproductive health care is under assault. Believe me, these conversations are heard far and wide among women out in the public -- women of all ages, and races, and parties -- political parties -- who understand that these kinds of assaults on women's

rights to make a choice about a lot of things, including contraceptive care, and men too, who want to be able to plan their families. Unacceptable.

I yield back.

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

BURGESS: I thank the chairman for the recognition. And once again, we're here learning that those who are driving the regulatory train are, in fact, making the practice of medicine more difficult through their lack of thought, and we are left with the consequences.

The decision by Health and Human Services to issue an interim final rule, while that sounds like arcane Washington, what that means is that the transparency and accountability of the normal federal rulemaking process has now been circumvented. And as a consequence, we've got a rule being put forward that now has the force of law, as if it were legislation passed by Congress and signed by the president -- now we've got a rule that has the force of law that is unworkable yes, for faith-based facilities, but also is going to have dramatic cost implications across the board for all Americans.

A good thing or bad thing, problem is we don't know because we never had the opportunity to explore the possibilities. So the administration now has singlehandedly rendered faith-based facilities fearful of their ability to continue to serve their patients. The lack of consideration for these organizations has manifested in an extremely narrow, and in fact, an unworkable exemption.

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

The interim final rule does violate the conscience protections many health care providers rely upon, and ultimately leads to diminished access of care, as Dr. Gingrey so eloquently pointed out, and also importantly, a rising monthly premium for all Americans.

I yield now to the gentlelady from Tennessee.

BLACKBURN: Thank you, Mr. Burgess.

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

President Obama came before Congress and made a statement, and I'm quoting: "Under our plan no federal dollars will be used to fund abortions and federal conscience laws will remain in

place," end quote. Then, at Notre Dame, he said, and I'm quoting, "Let's honor the conscience of those who disagree with abortion," end quote.

But the truth is, this administration, by its actions, calls abortion "essential care." Obama care discriminates against hospitals, insurance plans, and health care professionals who don't want to violate what they know in their hearts to be true. HHS has published this new rule -- we've all spoken about this -- to force America's doctors and nurses to do the things that otherwise they would not do.

Maybe it should be called coercion backed by the taxpayer dollars. And that's a little bit of a poisonous medicine to swallow. It's unconstitutional, and unethical, and cheapens the civil rights of our medical professionals.

Smuggling abortion into PPACA was destructive, and it's another big reason why I think we need to repeal Obama care. With that, I'd like to yield the balance of the time to Dr. Murphy.

MURPHY: Thank you.

And thank you, Chairman Pitts.

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

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

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

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

PITTS: Without objection, so ordered.

The chair recognizes the ranking member of the Full Committee, Mr. Waxman, for five minutes for opening statement.

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

Department for what would be covered under preventive services, and they recommended that this be a covered preventive service.

So the question is, if somebody does not want to provide contraception because it violates their religion or their conscience would they be required to? Absolutely not.

The question then comes down to, what is the scope of the exception that church-provided insurance need not cover family planning? Well, I don't know why that should be even an exception. I disagree with the administration in providing that exception.

But the Republicans would like to first of all extend that exception to all church-related groups, whether it means that the people who are covered are of the same faith or not. But we are going to hear from a witness today who would like to have no insurance coverage for contraceptive services because it violates her point of view.

Now, we hear a lot from the other side of the aisle about government intrusion in our private lives. There can be no intrusion more significant than government telling people they cannot get contraception, they cannot get insurance to cover contraception, it should not be a provided service.

Well, that's part of what the Republican agenda appears to be, but it's much more than that because what we have is a hearing today that purports to be about the conscience protection but it is another attempt by the Republicans to undermine and undo the Affordable Care Act's provisions related to women's health. And no single piece of legislation in recent memory has done more to advance women's health and women's access to health services than the Affordable Care Act.

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

Now, the Republicans would like to take all of this away. Not just the access to contraceptive services -- they'd like to repeal the Affordable Care Act. And if they succeed, newly established health benefits and health coverage for women would disappear.

And what would they do to replace this? Nothing. They'd leave the status quo in place.

Now, let me be clear: I support policies that recognize and protect the right of individuals to express and act on their religious and moral convictions. If you have moral convictions you can keep them; just don't try to impose them on everybody else.

We cannot turn the clock back. We shouldn't let the Republicans confuse the issue. To deny health insurance coverage that includes contraceptive services to millions of American women, that's wrong.

Women who don't want that service don't have to access it if it violates their conscience. A doctor does not have to provide it if it violates his or her conscience. But tell me less about the conscience of the employer or the insurance company and why that should take precedence over all the people who are to be covered that do not share that particular point of view.

The Department's position on insurance coverage for family planning is in keeping with this goal and should move forward without delay.

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

PITTS: Chair thanks the gentleman.

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

UNKNOWN: Mr. Chairman?

PITTS: Yes?

UNKNOWN: I don't know if this is an appropriate time, but I have some things I'd like to submit for the record.

PITTS: All right. If you would...

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

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

The chair now is pleased to welcome the panel of witnesses to our hearing today, so we'd ask them to please take their seats at the witness table and I'll introduce them at this time.
Today, our witness panel includes Dr. David Stevens, CEO of the Christian Medical Association; Mark Hathaway, director of OB/GYN outreach services for women's and infants' services at Washington Hospital Center, and Title X medical director at the University Health Care, Inc.; Jane Belford, chancellor and general counsel of the Archdiocese of Washington; Jon O'Brien, president of Catholics for Choice; and Bill Cox, president and CEO of the Alliance of Catholic Health Care.

We're happy to have each of you here today and ask that you summarize your statements in five minutes. We'll enter your written testimony into the record.

And at this point, we'll start with Dr. Stevens. You're recognized for five minutes.

STEVENS: I am testifying on behalf of the over 16,000 members of the Christian Medical Association, a professional membership organization that helps health care professionals to integrate their faith and the profession. I'm the diplomat of the American Board of Family Medicine and hold a master's degree in bioethics.

Our members include physicians who hold a range of conscience convictions on controversial ethic and moral issues, including contraception, health care reform, participation in the death penalty, and other conscience issues that span the political spectrum. Virtually all medical professionals and student members we recently surveyed say it's important to personally to have the freedom to practice health care in accordance with the dictates of his or her conscience. Over nine of 10 say they would not prescribe FDA-approved contraceptives that might cause death of a developing human embryo.

Many physicians today conscientiously profess allegiance to life- affirming ethical standards, such as the Hippocratic Oath. Pro-life physicians want to retain the freedom to choose physicians whose professional judgments reflect their own life-affirming values.

The Health and Human Services' interim final regulation would force insurance plans nationwide to cover all Food and Drug Administration-approved contraceptive methods and sterilization procedures. This mandate does not exempt controversial drugs, such as Ella and the "morning-after pill," which, according to the FDA, have post-fertilization effects that may inhibit implantation of a living human embryo.

The potential religious exemption in the conception -- contraception mandate, exempting only a nano-sector of religious employers from the guidelines, is meaningless to conscientiously objecting health care professionals, insurers, and patients.

The contraception mandate can potentially trigger a decrease in access to health care by patients in medically underserved regions and populations. The administration's policies on the exercise of conscience in health care, including the gutting of the only federal conscience-protecting regulation, actually threaten to worsen a growing physician shortage. A national survey of over 2,100 faith- based physicians revealed that over nine of 10 are prepared t leave medicine over conscience rights; 85 percent of our medical professionals and students say that the policies that restrict the exercise of conscience in health care make it less likely they will practice health care in the future.

The contraception mandate further contributes to an increasingly hostile environment in which pro-life physicians, residents, and medical students face discrimination, job loss, and ostracism. Seventy-nine percent of our members surveyed said the new contraception mandate will have a negative impact on their freedom to practice medicine in accordance with the dictates of their conscience. One out of five faith-based medical students surveyed said they will not go into OB/GYN as a specialty because of abortion-related pressures.

The contraception mandate creates a climate of coercion that can prompt pro-life health care professionals to limit the scope of their medical practice. Over half of the medical professionals and students we surveyed said the new contraception mandate might cause them to restrict their practice of medicine.

The contraception mandate can potentially cause a decrease in the provision of health insurance for employees of pro-life health care employers who want to avoid conflicts of conscience regarding controversial contraceptives. Sixty-five percent of the medical professionals and students we surveyed said the contraception mandate will make them less likely to provide insurance for their employees.

The contraceptive mandate rule sweepingly tramples conscience rights, which have provided a foundation for the ethical and professional practice of medicine. The administration should rescind this mandate entirely for the ethical and practical reasons I have noted and also for the constitutional and statutory reasons outlined in our official comment letter of September 29th to HHS, which I am submitting separately and ask to be included in the record.

We encourage members of Congress to uphold conscience rights by passing the Respect for Rights of Conscience Act. Upholding a respect for conscience and our First Amendment freedoms protects all Americans -- conservatives and liberals, capitalists and socialists, atheists and people of faith.

Thank you for consideration of these views.

PITTS: Chair thanks the gentleman and recognizes Dr. Hathaway for five minutes.

HATHAWAY: Chairman Pitts, Ranking Member Pallone, and members of the committee, thank you for the opportunity to testify before you today.

Good morning. My name is Dr. Mark Hathaway. I am a board certified OB/GYN. I am the director of OB/GYN outreach services for women and infant services at the Washington Hospital Center. I am also the Title X director at Unity Health Care, Washington, D.C.'s largest federally qualified health center.

I work in several medical facilities here in Washington, D.C. My patients tend to be women of color, primarily African American and Latina, and of lower social economic status. Many of the patients I see are uninsured, underinsured, and seeking prenatal care of family planning services. Despite these obstacles, they desire to improve their lives and to have and raise healthy children.
I see every day how increasing women's ability to plan their pregnancies makes a difference in their lives. And by the same token, I also see the negative consequences of unintended and unplanned pregnancy, late prenatal care, uncontrolled medical problems, poor nutrition, and sometimes even depression. I see firsthand how cost can be a barrier.
That is why the Institute of Medicine's recommendation is so critically important. Contraceptive counseling and methods should be covered under the Affordable Care Act without cost-sharing. Any attempt to broaden exemptions to that coverage requirement would mean leaving in place insurmountable obstacles to contraceptive services for far too many women.

I know from my day-to-day experience what it means for patients who cannot afford to pay for their health services. The cost of a birth control method frequently prohibitive for many of my

patients. This is especially true for the more cost-effective, long-acting, reversible contraceptive methods, also known as LARC.

Women face many challenges in using contraception successfully. Too many women using meds like birth control pills, condoms, and even injectables will experience an unplanned pregnancy during their first year of typical use.

Long-acting reversible methods, including intrauterine contraceptives and implants, are the most cost-effective methods because they have an extremely low failure rate and are effective at preventing pregnancy for several years. The upfront costs of these methods, however, are several hundred dollars, placing them out of the reach of millions of women who would otherwise use them.

Three recent studies have found that lack of insurance is significantly associated with reduced use of prescription contraceptives. In St. Louis, researchers at Washington University have recently found that over 70 percent -- 70 percent -- of women will choose a longer-acting method if costs and barriers are eliminated.

There are those who assert that unintended pregnancy is not a health condition and therefore prevention of unintended pregnancy is not a preventive health care. From my personal practice, I can say that I cannot disagree more.

Just last week I met "Sarah." She is 22 years old, has two children under the age of three, one a recent newborn. She came in for a pregnancy test. Her diabetes had gone unchecked, which would put her in a category of a high-risk pregnancy.

She was visibly shaking waiting for her pregnancy test results. She's working over 40 hours a week at two different jobs and was told by her primary care clinic that she would need to pay a copay of $40 and $300 fee for the intrauterine device that she so desperately wants. She would have been devastated by a positive pregnancy test.

She was incredibly relieved to learn that she was not pregnant. She was also uninsured, but we used our rapidly shrinking safety net resources to provide her with long0acting contraception, lasting up to seven years.

The evidence is also conclusive regarding pregnancy spacing. It is directly linked to improved maternal and child health. Numerous U.S. and internat5ional studies have found a direct causal relationship between birth intervals, low birth weight, as well as preterm births. In other words, we need to help women plan their pregnancies for their health as well as their children's.

Using contraception is the most effective way to prevent unintended pregnancy. Again, I have seen the success of contraceptive services in my own practice, and again, the evidence on this is clear. Ninety-five percent of all unintended pregnancies in our country occur among women who use contraception inconsistently or use no method at all; indeed, couples who do not practice contraception have an 85 percent chance of experiencing an unintended pregnancy within the first year.

For all these reasons, the Institute of Medicine's recommendations are groundbreaking. Finally, all women will gain access to insurance coverage of family planning services regardless of

income. All women will be able to get the counseling, education, and access to the most effective and medically appropriate contraceptive for them.

This breakthrough has the potential to bring about major benefits for the health and wellbeing of women and their families. Most women will contracept for approximately three decades during their reproductive years. The adoption of the Institute of Medicine's recommendations holds so much promise for millions of women who currently lack basic resources, like health insurance coverage.

All of my training and experience tells me that what we are striving for is healthy women. We are also working to ensure that if and when they are ready to have a child that they have a healthy pregnancy.

The best way to achieve this is to help women and couples become as healthy as possible before pregnancy. This includes financial health, emotional health, physical health.

We should trust women and empower women to make the appropriate decisions for themselves. Therefore, I hope we can agree that guaranteeing contraceptive coverage and removing cost barriers should be at the forefront of preventive care...

PITTS: Could you wrap up, please?

HATHAWAY: ... so that women can achieve their goals.

Thank you very much.

PITTS: Chair thanks the gentleman, and now recognizes Ms. Belford for five minutes.

BELFORD: Mr. Chairman and distinguished members of the subcommittee, thank you for the opportunity to testify before you today on an issue of vital importance to religious organizations like the one I serve. My name is Jane Belford and I serve as chancellor of the Catholic Archdiocese of Washington, which includes 600 Catholics and includes 140 parish church communities in the District of Columbia and portions of Maryland. The Archdiocese is one of 195 dioceses of the Catholic Church in the United States, which represents more than 70 million Catholics.

Throughout this country's history, the Catholic Church has been one of the leading private providers of charitable, educational, and medical services to the poor and vulnerable. The Archdiocese continues that tradition of service today through its Catholic schools, medical clinics, maternal and pregnancy resource programs, social service agencies, senior and low-income housing, job training programs, and a vast number of other programs and services for persons in need, regardless of their faith or no faith, without question, without exception.

The late former archbishop of Washington, Cardinal Hickey, once said: We serve them not because they are Catholic but because we are Catholic. If we don't care for the sick, educate the young, care for the homeless, then we cannot call ourselves the church of Jesus Christ.

Until now, federal law has never prevented religious employers, like the Archdiocese of Washington, from providing for the needs of their employees with a health plan that is consistent with the Church's teachings on life and procreation. The Archdiocese provides excellent health

benefits to its nearly 4,000 employees consistent with Catholic teaching and subsidizes most of the cost.

We would lose this freedom of conscience under the mandate from the Department of Health and Human Services that the health plans of religious organizations like ours cover sterilization, contraceptive services, and drugs that in some cases act as abortifacients. This is not in line with the policy that has governed other federal health programs.

The HHS mandate provides a radically narrow test to be eligible for exemption. Essentially, under this test Catholic organizations like ours would be considered religious enough only if we primarily served Catholics, only if we primarily hired Catholics, and only if the whole purpose of our service was to inculcate our religious values. Under this analysis, organizations like ours would be only free to follow Catholic teaching on life and procreation if we stopped hiring Catholics and stopped serving -- if we stopped hiring and serving -- excuse me -- non-Catholics.
However, as in the parable of the Good Samaritan, Catholic organizations serve people of all different faiths without question or condition and without knowing their faith. Just last year, Catholic Charities of the Archdiocese served over 100,000 people; I could not tell you what their faith is.

Our Catholic schools -- 98 Catholic schools -- educate 28,000 students in the District of Columbia and Maryland, and in some locations more than 80 percent of the students are non-Catholic.

HHS has drafted an exemption that is so narrow that it will exclude virtually all Catholic hospitals, Catholic schools, colleges, and universities, and charitable organizations, none of which impose a litmus test on those they serve. Why does the government want to have us do that?

In my written testimony I allude to the vast array of services being provided right now in the Archdiocese of Washington -- the care and -- medical care, educational services, and social services that are made available. This narrow religious exemption, drafted as it has, would burden our deeply held belief not only in life and procreation but in the belief that God calls us to serve our neighbors. Both those beliefs -- our beliefs in life and procreation, and our belief in service -- are grounded in a fundamental teaching that upholds the dignity of human life, of whatever race status or creed, from the beginning of life to the end.
It is part of our central mission and religious identity to be a witness in the world through acts of service to all who are in need, regardless of religion or creed. When we are fortunate enough to be able to partner with the government in providing these services our devotion to the cause and our institutional resources can make each dollar of funding go further.

Unfortunately, the mandate poses a threat to our rights of conscience in our services for our neighbors. At a time when local, state, and federal governments have had to consider drastic cuts to their health care and social service programs, and when our citizens' need for support is so great, it is difficult to understand why the federal government would impose requirements that are designed to undermine and restrict access to these services.

We believe in the value and dignity of all human life, from beginning to end, and we believe that we are called to serve our neighbors -- all of them. We will continue to honor these beliefs. We have served, we serve now, and we will continue to serve. But I urge the committee to consider

our nation's historical commitment to religious liberty and the value and importance of the Church's service to the poor and vulnerable, and to permit us to practice our faith consistent with the teachings of our church.

Mr. Chairman and members of the committee, thank you for the opportunity to address you.

PITTS: Thank you.

The chair thanks the gentlelady, recognizes Mr. O'Brien for five minutes.

O'BRIEN: Mr. Chairman, Member Pallone, and members of the subcommittee, thank you for this opportunity to present testimony on this important question of conscience rights and access to comprehensive health care.

For nearly 40 years Catholics for Choice has served as a voice for Catholics who believe that Catholic teaching means that every individual must follow his or her own conscience and respect the rights of others to do the same. This hearing, to answer the question, "Do New Health Law Mandates Threaten Conscience Rights and Access to Care?"

I firmly believe the requirements under the Affordable Care Act and the slate of regulations being created to implement it infringe on no one's conscience, demand no one change his or her religious beliefs, discriminate against no man or woman, put no additional economic burden on the poor, interfere with no one's medical decisions, compromise no one's health. That is, if you consider the law without refusal clauses.

When the question is asked in light of these unbalanced and ever- expanding clauses, the answer becomes, yes, it would do all those things. When burdened by such refusal clauses, the new health law absolutely threatens the conscience rights of every patient seeking care for these restricted services and of every provider who wishes to provide comprehensive health care to patients.

These restrictions go far beyond their intent of protecting conscience rights for all by eliminating access to essential health care for many if not most patients, especially in the area of reproductive health services. This will make it harder for many working Americans to get the health care they need at a cost that they can afford.
Like many Catholics, I accept that conscience has a role to play in providing health care services, but recent moves to expand conscience protections beyond the simple right for individual health care providers to refuse to provide services to which they personally object to go too far. It is incredible to suggest that a hospital or an insurance plan has a conscience. Granting institutions or entities like these legal protection for the rights of conscience that properly belong to individuals is an affront to our ideals of conscience and religious freedom.

Respect for individual conscience is at the core of Catholic teaching. Catholicism also requires deference to the conscience of others in making one's own decisions. Our faith compels us to listen to our consciences in matters of moral decision-making and to respect the rights of others to do the same.

Our intellectual tradition emphasizes that conscience can be guided, but not forced in any direction. This deference for the primacy of conscience extends to all men and women and their personal decisions about moral issues.

Today, the 98 percent of sexually active Catholic women in the United States who have used a form of contraception banned by the Vatican have exercised their religious freedom and followed their consciences in making the decision to use contraception. Thus, they are in line with the totality of Catholic teaching, if not with the views of the hierarchy.

Having failed to convince Catholics in the pews, the United States Conference of Catholic Bishops and other conservative Catholic organizations are now attempting to impose their personal beliefs on all people by seeking special protection for their conscience rights. They claim to represent all Catholics when, in truth, theirs is a minority view. The majority of Catholics support equal access to contraceptive services and oppose policies that impede upon that access.

Two-thirds of Catholics -- 65 percent -- believe that clinics and hospitals that take taxpayer money should not be allowed to refuse to provide procedures or medications based on religious belief. A similar number -- 63 percent -- also believes that all health insurance, whether private or government-run, should cover contraception.

Sweeping refusal clauses and exemptions allow a few to dictate what services many others may access. They disrespect the individual capacities of women to act upon their individual conscience-based decision. They impede the rights of women and men to make their own decisions about what's best for them, their health, and their families.

Lawmakers of all political hues can come together to support a balanced approach to individual conscience rights and access to comprehensive health care. It makes sense for all those who want to provide more options to women seeking to decide when and whether to have a child; it makes sense for those who want to keep the government's involvement in health care to a minimum. Above all, it makes sense for a society that believes in freedom of religion -- a right one can't claim for oneself without extending it to one's neighbor.

The bottom line is that protecting conscience rights and preserving access to care shouldn't just be about protecting those who seek to dictate what care is and is not available, nor should it be for those who would dismiss the conscience of others by imposing their view of which consciences are worth protecting. Protecting individual conscience and ensuring access to affordable, quality care is not just an ideal. It's a basic tenet of our society and it's the right thing to do.

I thank the subcommittee for inviting me today. I look forward...

PITTS: Chair thanks the gentleman and recognizes Mr. Cox for five minutes for an opening statement.

COX: Good morning, Mr. Chairman, and members of the committee, and thank you for convening a hearing on this critically important matter...

PITTS: Push the button on your mike.

COX: Excuse me.

My name is Bill Cox and I am president and CEO of the Alliance of Catholic Health Care, which is based in Sacramento, California. We represent four Catholic systems in California that operate 54 hospitals.

My testimony focuses on the exceedingly narrow definition of religious employer in HHS's interim final rule. You have a copy of my extended remarks so I'll summarize them by making four brief points about the definition in the mandate.

First, in order to benefit from the definition a religious institution must primarily employ and serve its co-religionists, and it must proselytize. As an essential element of their religious missions, Catholic hospitals, universities, and social services hire and provide services to a broad array of people and they do not proselytize those they serve. Thus, the definition, together with the mandate, will require Catholic hospitals, universities, and social service agencies to cover in their health insurance plans contraceptives, abortifacients, and sterilizations in direct violation of their religious beliefs.

Mr. Chairman, Catholics have been providing health care services in California since 1854, when eight Sisters of Mercy arrived in San Francisco from Ireland. The following year, a cholera epidemic broke out and the sisters went to work in the county hospital.

According to San Francisco's The San Francisco Daily News of that time, and I quote, "The Sisters of Mercy did not stop to inquire whether the poor sufferers of cholera were Protestant or Catholic, American or foreigners, but with the noblest devotion applied themselves to their relief." Mr. Chairman, had HHS's definition of religious employer been in effect in 1854 the ministry of the Sisters of Mercy in San Francisco would not have been considered by the federal government to be a religious ministry.

Second, I think it is very important to emphasize this morning that neither the propriety, nor the wisdom of, nor the government's authority to impose a contraceptive mandate on all employers is at issue here. The question is actually a very narrow one related to the First Amendment, and that is whether the HHS definition of religious employer contravenes the First Amendment by putting the federal government in the position of determining what parts of a bona fide religious organization are religious and what parts are secular.

In particular, it allows the government to make such distinctions in order to infringe the religious freedom of that portion of the organization the government declares to be secular. This is exactly what the founders of this country sought to avoid by adopting the First Amendment to the Constitution.

Third, the definition is discriminatory in that it tracks identical language first enacted in a California statute that was deliberately designed to contravene the religious conduct of religious organizations such as Catholic hospitals, universities, and social services. At the time, one of the principal proponents of that definition of religious liberty said, our purpose and intent here is to close the Catholic gap. That is, we want these religious institutions -- we want to compel them by force of law to provide these services regardless of what they may think of them in terms of their religious belief.

Fourth, there is no escape from the HHS mandate. Unlike most state contraceptive mandates that have a similar definition of religious employer, religious employers cannot avoid the HHS

mandate by either dropping coverage of prescription drugs or by self-insuring through an ERISA plan.

In conclusion, I'd just like to note that Catholic hospitals provide a broad array of services not always available in other institutions. For example, in California 86 percent of our hospitals have palliative care programs, compared to only 43 percent of all California hospitals. Our palliative care programs address the physical, emotional, and spiritual needs of chronically ill and dying patients and their families.

Moreover, a recent Thompson Reuters study found that on eight key metrics Catholic health care systems in the United States were significantly more likely to out-perform their nonprofit and investor- owned counterparts on quality, efficiency, and patient satisfaction. It would be a great loss to the nation and the communities we serve if our hospitals were compelled by federal law to forego their religious mission and consciences in order to comply with the HHS contraceptive mandate.

I'd be happy to answer any questions.

PITTS: Chair thanks the gentleman and thanks all the witnesses for their opening statements. I will now begin the questioning and recognize myself for five minutes for that purpose.

Mr. Cox, the Church amendment, which became part of the Public Health Service Act in 1973, declares that hospitals' or individuals' receipt of federal funds in various health programs will not require them to participate in abortion and sterilization procedures if they object based on moral or religious convictions. Also, no state in the country except Vermont requires insurance coverage of sterilization.
How is the interim final rule on preventive services issued by HHS subsequent to passage of the health care law different in respect to conscience protections and sterilization mandates, and what are the implications for Catholic health care providers?

COX: Well, these are requirements that would force Catholic health care providers, Catholic universities, and social service agencies to include contraceptive services, sterilization, and other things in their health insurance plans in violation of their religious beliefs. And that's how it would affect them.

Under certain state laws -- under most state laws -- there are options that we have available to us. One, if, for instance, in California we can -- a religious employer can drop prescription drug benefits entirely in their health insurance plan and get out from under the -- California's contraceptive mandate. We have chosen not to do that because that would make absolutely everyone else worse off in our employ, but what we have done is moved to ERISA plans in order to self-insure and get out from under the mandate.

Now, under the HHS mandate and definition of religious employer, there -- as I said in my testimony, there is no escape. ERISA plans will be covered. All employers are required, regardless of religious views, to cover these services.

PITTS: The supporters of the interim final rule on preventive benefits argue the substance of the rule is similar to contraceptive mandates imposed by states on health plans operating within their

state. Just as you said, the question was, do state contraceptive mandates apply to self-insured plans governed under ERISA and does HHS rule differ in this respect? You spoke to that.

Do state contraceptive mandates typically require coverage of sterilization procedures?

COX: They do not. I think Vermont is the only state that does.

PITTS: Do state contraceptive mandates force plans to cover such products even if they do not provide coverage for prescriptive drugs generally?

COX: I think the laws in the various states differ with respect to that, and many of the states that have a contraceptive mandate also have pretty strong and effective conscience legislation that allows religious employers and people with -- and providers with a moral perspective on this to opt out of the mandate.

PITTS: Thank you.

Let me go to Dr. Stevens. You said that the contraceptive mandate, quote, "violates the religion and free speech clauses of the First Amendment of the Constitution by coercing faith-based health care ministry to not only violate their very faith-based tenets that have motivated patient care for millennia, but also to pay for that violation. Such conscience-violating mandates will ultimately reduce patients' access to faith-based medical care, especially depriving the poor and medically underserved population of such care."

Do you believe that the particular mandate could contribute to faith-based providers leaving the medical profession, reducing access to medical care, and are you concerned that faith-based providers might leave certain areas of medical?
STEVENS: We're seeing a pattern from the administration to restrict conscience rights, including stripping regulations -- disregulation (ph). We actually surveyed our membership and 88 percent of them say the problem's getting much worse. Issues we're talking about today I never talked about during my training.

And we're also seeing people coming under increasing discrimination in the workplace. One of my staff member's wife is a family practice doc, worked in Texas, she did not distribute contraceptives to single women, referred them across the hallway to another physician, and -- wasn't even an inconvenience for them -- and she was told she was going to lose her job and she had to go find other employment within a week.

We've seen this with anesthesiologists; we've seen it with family practice docs. Just this week 12 nurses in New Jersey have been forced to participate in abortion in the workplace, and there's a suit being brought at the medical school there.

This is a pattern that concerns all of us because -- we have 16,000 members; they have over 125,000 doctors that we're in regular communication with. They're very concerned about this and it could affect health care in this country.

PITTS: Thank you. My time is expired.

The chair recognizes the ranking member, Mr. Pallone, for five minutes for questions.

PALLONE: Thank you, Mr. Chairman. I'd ask unanimous consent to insert in the record statements from the following organizations: Concerned Clergy for Choice; National Council of Jewish Women; Religious Institute; United Church of Christ Justice and Witness Ministries; Women's Alliance for Theology Ethics and Ritual, or WATER; Physicians for Reproductive Choice; Religious Coalition for Reproductive Choice; General Board of Church and Society of the United Methodist Church. I believe you have all these.

PITTS: Without objection, so ordered.

PALLONE: Thank you.

I'm going to start with Mr. O'Brien. Your testimony discusses use of contraceptive services among both Catholic and non-Catholic women. Is it your understanding that surveys and studies have shown virtually all Catholic women have used contraceptive services at some point in their lifetimes?

O'BRIEN: Yes, Congressman. That's correct.

PALLONE: Thank you. Is it true that the use of contraceptive services among Catholic women mirrors that of non-Catholics?

O'BRIEN: It is.

PALLONE: And I'm going to go to Dr. Hathaway. I saw a recent poll of registered voters about their views on contraceptive services. I want to ask you a few questions about public support for contraception.

Do the vast majority of Americans support access to contraceptive services?

HATHAWAY: Yes.

PALLONE: And is this same view also held by people who are opposed to abortion?

HATHAWAY: Yes, indeed.

PALLONE: And back to Mr. O'Brien, if you would chime in, does research indicate that the majority of Catholics support access to contraceptive services?

O'BRIEN: Yes. During the health insurance reform debate Catholics were surveyed and six in 10 Catholics believe that contraception should be covered as part of health insurance.

PALLONE: Thank you.

For both gentleman, your answers underscore an important point, and that is that improved access to contraceptive services is supported by the majority of Americans, and I certainly agree with some of the comments made by my colleagues and the witnesses about ensuring that individual health providers not be compelled to act against their conscience, but the subject of today's hearing is regulations that address what plans are required to do. Given what we've heard

today, I think we should support coverage for contraceptive services and make these services available to the millions of women who would benefit from it.

Now I want to go to Dr. Hathaway again. In your testimony you discuss the importance of making sure that women have access to contraceptive services and information that will help them better plan and space their pregnancies. Can you briefly describe the benefits of using contraceptive services?

HATHAWAY: Briefly would be difficult. There's multiple, multiple benefits towards contraception.

A woman's ability to maintain and get herself healthy before pregnancy is incredibly important -- taking folate to reduce anomalies, getting her medical conditions under control. Many women have multiple medical conditions that are out of control before they get pregnant. There's...

PALLONE: What about the health in terms of babies themselves?

HATHAWAY: Also, also. Of course, spacing is incredibly important. We know from research that with spacing, the shorter the interval the greater likelihood of low term -- low weight birth as well as preterm births. It is an incredible burden to both a family as well as society and the health industry.

PALLONE: Well, you know there are over 60 million women of reproductive age in the country, but there are many women who do not use contraception regularly or at all. Could you elaborate on the extent to which cost is a barrier to the use of contraceptive services?

HATHAWAY: Yes. It's an incredible barrier. Many women have to jump hoops to get to contraceptives. If they have some insurance, perhaps it doesn't cover all of their contraceptive methods. And as I pointed out in my testimony, the longer-acting methods are the most cost-effective and yet the most cost-prohibitive up front, and those are the methods that we ought to be turning towards to provide better contraception in our country.

PALLONE: And what about when you have insurance coverage for contraception? I mean, does that impact the ability of women to access those health services?

HATHAWAY: In many cases, yes. Even insurance -- there's restrictions regarding copays as well as additional fees for these, as I say, most effective methods.

PALLONE: And based on your clinical experience, do you believe that elimination of out-of-pocket costs for birth control pills and other forms of contraception would increase their use?

HATHAWAY: Most definitely. Most definitely.

PALLONE: All right. I just want to thank you, Dr. Hathaway. I mean, it's clear from your testimony and responses that there are compelling policy reasons why we should promote access to contraception and also limit cost-sharing associated with those services. Thank you.

And thank you, Mr. O'Brien.

I yield back, Mr. Chairman.

PITTS: Chair thanks the gentleman and recognizes the vice chair of the subcommittee, Dr. Burgess, for five minutes.

BURGESS: Thank you, Mr. Chairman.

Dr. Hathaway, along the lines that Mr. Pallone was just exploring on the -- he said that there are valid policy reasons to consider providing contraception, but you also allude to the fact that in your world cost is a consideration. Is that correct?

HATHAWAY: I'm not sure I understand the question. Cost is a consideration for an individual patient...

BURGESS: You talk about the individual in your clinic who wanted a long-term method of contraception but it nearly exhausted your safety net dollars and...

HATHAWAY: Right.

BURGESS: ... and cost is an issue. Whether we like it or not, money is going to come from somewhere, is it not?

HATHAWAY: Indeed. And yet, if you look at a lot of the research, including Guttmacher Institute's research on cost savings for contraception, overwhelmingly...

BURGESS: Yes, let's hold that. We'll get to that in a minute. Because I'm not quite sure we've delivered on the promise of the cost savings.
And of course, we're members of the House of Representatives. We live under the rule of the Congressional Budget Office, and all of us on this -- both sides of the dais know, we're not allowed to score savings; we can only talk about costs. But that is an important point and I do want to get to it.

But here's my beef with this thing. I mean, it came to us as an interim final rule. There was obviously a rush. There were some calendar considerations -- we've got to get it done within some certain time constraints.

But it didn't really allow for the proper input and transparency of the normal federal agency process. The Affordable Care Act is a lot of pages of very densely worded instructions to federal agencies, and whether you agree with it or not, going through the process that the federal agency is -- there's a reason that it does that because it allows the public to comment, and it allows for the -- before the rule is put forward it allows for the people to weigh in on it.

But in an interim final rule, that's kind of a different world because although it sounds like, well, it's only interim and you could come back and do -- you really can't. I mean, this thing comes out of the agency with the force of law, and you see right now in this environment how difficult it is for Congress -- the House and Senate -- to get together and pass any law that the president will sign.

But this thing can come out with the force of law in a relatively condensed period of time with maybe public input, but maybe it ignores public input. Now, I worked my residency in Parkland

Hospital -- a long time ago, I grant you, but we provided a lot of health care to women who were very, very poor, and I never wrote a prescription for an oral contraceptive except Ortho-Novum 1/50 for four years time because that was the formulary that Parkland Hospital used.

In order to provide the services for the vast numbers of people that they had to serve they got a deal with the contraceptive manufacturer and that was the birth control pill. It was a learning experience for me to be out in private practice and see all of the choices that were out there. But those choices come with a cost, don't they?

HATHAWAY: Yes. Yes, indeed.

BURGESS: Can you give us an idea of what kind of the range of costs -- let's just stick with oral contraceptives for right now. I know you're interested in long-term contraception, but just for oral contraceptives right now, there's a pretty wide variation of cost, is there not?

HATHAWAY: The brand name contraceptives probably run in the neighborhood of upwards of $50 per month. The generics are probably in the neighborhood of $30, or somewhere in that neighborhood...

BURGESS: Well, due to the miracle of the iPad and Leslie's List, I can tell you that there is a cost differential of about $20 a month for a generic Ortho-Novum 1/35, Necon -- funny name for that pill -- and there's another one called Seasonique that's, according to research done by my staff, is $1,364 a year, so about $110 a month. So that's a pretty wide discrepancy, isn't it?

HATHAWAY: Indeed. And yet, if we were able to help a woman with a longer-acting method for that year...

BURGESS: Let's not go there just yet because...

HATHAWAY: ... save a lot of dollars...

BURGESS: ... the Institute of Medicine and the interim final rule says without regard to cost we have to provide all methods, now, across the board. And this is the problem with having an interim final rule. I didn't get to go to the federal agency and say, you know what, this is a pretty wide cost discrepancy here. You can provide five women with the same type of oral contraceptive protection that one woman gets for Seasonique.

And there are reasons that patients want to take that. I get that. Perhaps it should be available with a copay, or paying a little extra for that premium contraceptive coverage. This would be something that I think would have been useful to the federal agency. But unfortunately, we didn't get to have input on that because it was promulgated as an interim final rule.

Mr. Chairman, you've been generous with my time. If we have time for a second round I would -- I do want to talk about the cost benefit stuff.

PITTS: Chair thanks the gentleman and now recognizes the ranking member of the Full Committee -- is Mr. Waxman not here?

All right, the ranking member emeritus, Mr. Dingell, for five minutes?

DINGELL: (OFF-MIKE) ... and the questions here I direct at Mr. O'Brien and I hope that the answers will be by yes or no.

The interim rule issued by HHS on August 3, 2011 regarding coverage of preventive services under ACA included language that exempted certain religious employers from covering contraceptive services without cost-sharing. A religious employer is defined by one that has religious values as the purpose of the organization, primarily employs and serves persons who share the religious tenets of the organization, and is a nonprofit organization.

Isn't it true that this definition of religious employer set forth by HRSA in the interim rule is not wholly a new definition of a religious employer? Yes or no?

O'BRIEN: Yes, Congressman.

DINGELL: Now, isn't it also true that the 20 states that exempt certain religious employers from having to cover contraceptive -- they allow them to be exempt from providing contraceptive services and at least half of these states use a definition of a religious employer similar to that in the definition used by HRSA in the interim final rule? Yes or no?

O'BRIEN: Yes.

DINGELL: Isn't it also true that two state supreme courts -- in California and New York -- upheld a definition of religious employer similar to the definition of a religious employer in the legislation as constitutional? Yes or no?

O'BRIEN: Yes.
DINGELL: So I think everybody in this room should agree that individuals have the right to decline to provide certain medical treatment if they conscientiously object to their religious beliefs. That is not interfered with under the regulations, is it?

O'BRIEN: Yes.

DINGELL: The answer is, it's not interfered with. Thank you.

(LAUGHTER)

DINGELL: And under current health care professionals who conscientiously object to providing certain medical services or procedures due to their religious beliefs are allowed to, again, not provide those services, is that right?

O'BRIEN: That's right.

DINGELL: But isn't it true that the broadening definition of a religious employer would allow an employer -- say a hospital or health insurer -- to deny coverage for contraceptives or other preventive services based on their religious beliefs? Yes or no?

O'BRIEN: Yes.

DINGELL: Now, isn't it also true that the broadening of the religious exemption would limit access to contraceptives to nearly 1 million people and their dependents who work at religious hospitals and nearly 2 million students and workers at universities with a religious affiliation? Yes or no?

O'BRIEN: Yes.

DINGELL: One of the ways the Affordable Care Act works to address the need of lower cost -- of lowering costs in our health system is by putting renewed emphasis on prevention and wellness programs to help American families to live healthier lives and to reduce the need for more costly treatments later in life. The Affordable Care Act does this by eliminating copays and cost-sharing for preventive service. Is that correct?

O'BRIEN: Yes.

DINGELL: He doesn't have a nod button, so you've got to answer yes or no.

HHS has asked the Institute of Medicine, an independent organization, with convening a panel of experts to make recommendations about what preventive services for women would qualify for no cost-sharing. The Institute of Medicine identified eight preventive services as being necessary to improving women's health and wellbeing, including all FDA-approved contraceptive methods and patient education and counseling, amongst other benefits.

HHS adopted these recommendations in full. Is that correct?

O'BRIEN: Yes.

DINGELL: Now, wouldn't you agree that -- by the way, was that yes or no?
O'BRIEN: Yes.

DINGELL: Wouldn't you agree that broadening the religious exemption would limit or prevent access to critical preventive services that are intended to improve the health and wellbeing of women? Yes or no?

O'BRIEN: Yes, absolutely.

DINGELL: Now, wouldn't you also agree that the limiting or preventing of access to critical preventive services is counter to the goal of the Affordable Care Act to help make prevention affordable and accessible to all Americans? Yes or no?

O'BRIEN: Yes, that's true.

DINGELL: Now, I note in the testimony that I have heard this morning I have heard no complaints that what we have done here is to expand the right to abortion or to change the basic language of the legislation in the Affordable Care Act on that point. Am I correct in that understanding?

O'BRIEN: You are correct.

DINGELL: Thank you.

Mr. Chairman, I note I yield back two seconds.

PITTS: Chair thanks the gentleman and recognizes the gentleman, Mr. Shimkus, for five minutes for questions.

SHIMKUS: Thank you, Mr. Chairman.

About a year ago we had some theologians here on climate change and I quoted some scripture, got myself in trouble, made myself a name. But, I mean, if we're going to go down the ride and talk about faith, then especially for Christians God's word is the final arbiter of truth.

Jeremiah 1, verse 5, "Before I formed you in the womb I knew you." Psalm 71, verse 6, "You brought me forth from my mother's womb."

Those are just a few of numerous scriptural references on the pro-life debate for confessional Christians, and this is why I really appreciate my fellow Christians in the Catholic Church. I'm Lutheran by faith tradition, so we hold a really distinct, close bond, but their strong position on the right to life.

And what we've done in the national health care law is attacked the very providers of health care and social services for the poor in this country, which are church, faith-based institutions.

And, Mr. O'Brien, what we're doing is we're depriving them of their choice. That's what we're doing.

And Illinois, as an aside, has just done this in the adoption realm, where now the Catholic Church is suing the state of Illinois because of now the Illinois legislation that grants same-sex couples, under the state law, all the rights of married couples. So when a faith-based institution, like a Christian denomination -- and in this case, Catholic Charity does 20 percent of all adoptions in the state of Illinois; you take the other faith-based, I think it's up to 33 percent -- they now have to make a moral decision of whether they're going to continue adoption services or comply with their faith-based teaching.

So that's going on in Illinois. That's exactly what's going on here with the health care law.

So I'll follow up with these questions to Ms. Belford, Mr. Cox, Mr. Stevens. Should individuals or institutions lose their rights to follow their moral and religious beliefs once they decide to enter a health care profession?

Ms. Belford?

BELFORD: No, they should not lose that right.

SHIMKUS: Mr. Cox?

COX: Absolutely not.

SHIMKUS: Mr. Stevens?

STEVENS: (OFF-MIKE)

SHIMKUS: Yes, I think your microphone needs to be on, Mr. Stevens, unless you can pull it closer.

PITTS: Would you repeat the answer, please?

STEVENS: I said, we shouldn't be asking our medical schools to ethically neuter health care professionals based upon only what the state decides is right.

SHIMKUS: To the same three, should we compel providers to act in violation of their conscience?

COX: Absolutely not. It's a violation of the First Amendment of the Constitution.

SHIMKUS: OK. That was Mr. Cox.

Ms. Belford?

BELFORD: No. No, we shouldn't. That is a right enshrined in our history, in our Constitution, in our laws, the right not to violate our firmly held, sincerely held religious beliefs.

SHIMKUS: And Dr. Stevens?

STEVENS: I agree. We cannot ask people to take a professional license and lay aside their personal morality.
SHIMKUS: Another question: When a provider makes a conscience objection is there anything that prevents a patient from going to another willing health care provider for service?

Dr. Stevens?

STEVENS: Absolutely not.

SHIMKUS: Ms. Belford?

BELFORD: No.

SHIMKUS: Mr. Cox?

COX: No.

SHIMKUS: Ms. Belford, in order to qualify for the religious employer exemption to HHS's interim final rule on preventive services an employer would have to meet all four criteria delineated in the rule, including that it primarily serves persons who share its religious tenets. What would be the impact on sick and needy people in the Archdiocese in Washington if the Archdiocan (ph) organizations had to limit the provision of their services in such manner?

BELFORD: Well, Congressman, let me just say right at the outset, we have served, we are serving, and we will continue to serve the people who need help. We would hope that our

government would recognize the value of those services and the importance of those services, and the right that has been granted to us under the Constitution and the laws of this country to be able to provide those services without violating our religious beliefs.

But we will serve. We have been here for hundreds of years in this country serving. One of our oldest agencies in the Archdiocese in St. Ann's Infant and Maternity Home. It was chartered by President Lincoln and it's still here serving. We'll be here.

SHIMKUS: And let me personally thank you for your service.

And I yield back.

PITTS: Chair thanks the gentleman and recognizes the gentlelady from Illinois, Ms. Schakowsky, for five minutes for questions.

SCHAKOWSKY: I just wanted to note the number of religious organizations that Mr. Pallone inserted testimony into the record, and I note that one of them was the National Council of Jewish Women, which I am a proud member of.

So let me understand from Mr. -- Dr. Stevens and Ms. Belford and Mr. Cox, we're not talking about, as my colleague from Illinois would say, individual health care providers. You are talking about health care systems, am I right -- institutions and networks of institutions that would be exempted from having to provide contraception.

Is that true, Dr. Stevens?

STEVENS: Yes.
SCHAKOWSKY: Ms. Belford?

BELFORD: In the case of the Archdiocese of Washington, we conduct our ministries through separate organizations. But in addition to what we as Church do...

SCHAKOWSKY: In your testimony are you asking to...

(CROSSTALK)

BELFORD: Excuse me?
SCHAKOWSKY: In your testimony are you saying that the narrow exemption should be broadened if not dropped, and to include systems as well -- and broader?

BELFORD: It should include religious organizations that operate in accordance with their teachings and beliefs, yes.

SCHAKOWSKY: And, Mr. Cox, hospital systems, as well, and hospitals?

COX: The definition puts HHS in the position of trolling through the religious beliefs and practices of religious organizations...

SCHAKOWSKY: So that would include institutions...

COX: ... and determining, Congresswoman, which ones it agrees with and which ones it doesn't agree with, and if it doesn't agree with them then it uses the force of law to compel that organization to follow its beliefs.

SCHAKOWSKY: And let me ask the three of you, then, if this law were not -- if this regulation were not changed would you recommend -- would you drop your health insurance coverage?

Dr. Stevens?

STEVENS: I think it would be something we'd have to consider because it's a problem when you're dispensing an abortifacient and paying for it. It's called moral complicity.

SCHAKOWSKY: OK.

Ms. Belford?

BELFORD: It is unthinkable that we would drop our health insurance coverage, but we would not provide coverage for contraception and sterilization as required by this law.

SCHAKOWSKY: Mr. Cox?

COX: We'll have to challenge it in court if it isn't dropped.

SCHAKOWSKY: OK.

So I just want to make sure that the word goes forth into the country that this is about depriving women of contraception by large hospital systems, smaller organizations, and potentially even all health care coverage of the employees of those organizations, despite the fact, as was pointed out, that all but perhaps 5 percent of Catholic women also use contraception, that virtually all Americans in recent surveys -- women -- use contraception.

Mr. O'Brien, this issue of conscience is so important because I perceive that as an individual right of conscience. Can you elaborate on the difference between individuals and institutions and the right of conscience that you mentioned before?

O'BRIEN: You're absolutely correct, Congresswoman. I think one of the things that's interesting with this is the Catholic Church is not actually asking for an exemption. The Catholic Church is all of the people in the Church, which includes the 98 percent of Catholic women who use a contraceptive. The consciences of these women, of the people in the Church, are absolutely essential.

The Catholic hierarchy -- the United States Conference of Catholic Bishops -- represents about 350 bishops. It's the bishops and the people involved in the Catholic health care industry who are asking for these exemptions.

The conscience of an individual within Catholicism -- and St. Thomas Aquinas told us very clearly that it's a mortal sin not to follow your conscience -- your individual conscience -- even if you have to go against church teaching. And I think that Catholics do that every day on an individual basis.

The idea that an institution or a health insurance plan in some way has a conscience -- and there's no tradition of that, and the reality is that consciences apply to real people and individuals.

SCHAKOWSKY: And since we're getting into very personal and private matters dealing with women, I'm just curious from Dr. Stevens, Ms. Belford, and Mr. Cox, do you have any problem with the insurance companies providing prescription drugs for erectile dysfunction -- Cialis or Viagra? Just curious.

STEVENS: I don't have any problem at all. But I also don't have any trouble with contraceptives -- most of them. But that doesn't mean I'm going to prescribe all of them or that my Catholic brothers and sisters should not have the right to decide they're not going to pay for them.

COX: Our plans don't cover those services.
BELFORD: I think as I indicated, Congresswoman, in my testimony, our plan does not cover contraceptive coverage, sterilization, and the drugs that are mandated here. And if I would just add, I recognize that the teachings of the Catholic Church on procreation and life may not be the majority view and may not be popular. But I also understand from all the testimony that I've just heard this morning that contraception is widely available and universally used.

So the issue here is not whether or not women are using it or have access to it. The issue for me and why I came here today is because Catholic Church has a teaching about procreation and life, and we're talking about whether us, as an employer -- the Archdiocese of Washington -- would be required to provide coverage for something that we teach is morally wrong. I know not everyone...

SCHAKOWSKY: And I hope you inform all of your women employees of that policy. Thank you.

PITTS: Chair thanks the gentlelady and recognizes the gentleman from Pennsylvania, Dr. Murphy, for five minutes.

MURPHY: Thank you, Mr. Chairman.

Dr. Hathaway, in your testimony you spoke of your many uninsured patients and the cost barrier they face to access contraceptives. Just to be clear, because this interim final rule is directed at those providing insurance, nothing in this rule would actually change your uninsured patients' ability to access contraceptives. Is that correct?

HATHAWAY: I'm not a legal scholar and I can't truly point to that, but I do know...

MURPHY: They'd still have access to that?

HATHAWAY: ... access, and copays, and coverage for some of the most effective methods are prohibitive for many, many, many insured and uninsured women in our country. It's...

MURPHY: I'm asking, under this interim rule, would -- nothing that would change the uninsured patient's ability to access contraceptives in this?

HATHAWAY: No, I think it would.

MURPHY: Excuse me. Now, there are many business owners in my district guided by their faith who are struggling with whether or not they can continue to provide health insurance to their employees in light of this new rule. Do you honestly think that thousands of individuals and families in my district who could lose their health insurance all together are really better off as a result of this rule?

HATHAWAY: I feel that this rule -- the Institute of Medicine's evidence-based looking into this issue is pretty clear that removing copays, removing cost barriers will have a dramatic positive impact on reducing unintended...

MURPHY: And what the issue before us here is also one of people's ability to practice their faith, that the government is not saying that people cannot access these at all, but the question really before us is whether or not government has the right to force faith- based hospitals, or clinics, or providers, or employers certain services that violate their church teachings. And the question is whether the secretary of HHS can act unilaterally to force employers, medical providers, hospitals, clinics, and others to act in ways that violate their faith and conscience.

And to that, Mr. O'Brien, I strongly disagree with your analysis of the Catholic Church. Conscience is at the core of Catholic teaching, you said, but slavery (ph) was not left to personal decisions in conscience, thank goodness.

Conscience, according to Father Anthony Fisher, tells us that it's the inner core of human beings whereby, compelled to seek the truth, they recognize there is an objective standard of moral conduct and they make a practical judgment of what is to be done here and now in applying those standards. Vatican (ph), too, it teaches us the moral character of actions is determined by objective criteria, not merely by the sincerity of intentions or the goodness of motives. And the Church of the modern world and all people are called to form their conscience accordingly and to fit with that, as opposed to rewrite their image of the Church and of the Lord's teachings.

It is not -- I repeat, it is not -- our duty as Catholics to tell God what He should do or the image that He should adhere to, or what He should think. But it is up to us to shape our conscience to conform with the teachings He's given us.

When Moses came down with the 10 Commandments he didn't put it up for a vote or ask for a referendum or say to people, "So, what do you think, folks?" Our life is spent in continuous struggle to learn that which is good, and conscience is not merely to declare it in terms of humanism and then form some image of God based upon some desires. Conscience, sir, is not convenience.

Father Fisher goes on to say that deep within their conscience human persons discover a law which they have not themselves made, but which they must obey. Conscience goes astray through ignorance, and the key here is to shape our conscience to conform to the laws of God, not to practicality or solecism (ph).

Conscience, he goes on to say, is formed through prayer, attention to the sacred, and adhering to certain teachings of the Church and the authority of Christ's teachings in the Church. Conscience is not that which described by Shakespeare when he says in Hamlet, "Nothing is either good or bad, but thinking makes it so."

So asking a group in a survey whether or not they have ever acted or thought of acting in a certain way that runs counter to the Church's teachings is no more a moral code than asking people if they ever drove over the speed limit as a foundation for eliminating all traffic laws.

With that, I end with a quote from John Adams, which he said in 1776 when he was writing our Declaration of Independence of the United States. He said, "It is the duty of all men in society, publicly, and at stated seasons, to worship the supreme being, the creator and preserver of the universe, and no subject shall be hurt, molested, or restrained in his person, liberty, or estate for worshipping God in the manner most agreeable to the dictates of his own conscience, or for religious profession or sentiments, provided he doth not disturb the public peace or obstruct others in their religious worship.

Foundation of our nation is not to impose laws which restrict person's ability to practice their faith, sir.

With that, I yield back.

PITTS: Chair thanks the gentleman and recognizes the gentlelady from California, Ms. Capps, for five minutes.

CAPPS: Thank you, Mr. Chairman.

One thing that does trouble me in today's testimony is some confusion about what the preventive service rule applies to and what it doesn't. I'd like to set the record straight as I understand it.

The rule we are discussing today is whether or not an employer, as in a hospital or a university system, can ban the coverage of a medical service, but it would not mandate that any individual prescribe birth control or that any woman or man take birth control, period. Today's hearing is yet another example of how out of touch the majority side is with the American people.

My constituents tell me that we should be spending our time here on considering jobs and the economy, not blocking women's access to contraceptive services. But instead, here we are again, poised to attack another important piece of the health care law to rile up an extremist constituency at women's expense.

The Institute of Medicine report illustrates the strong evidence and sound science that proper birth spacing and planning of pregnancy does improve the health of a woman and her future children. The HHS rule then translates the science into provisions to give women options to choose if, when, and how to space their pregnancies, something they should be discussing with their medical provider, not with their boss.

As we've heard, especially in these tough economic times, women are sometimes forced to choose between paying for their birth control prescription or paying for other necessities. These economic concerns are the threat to public health we should be discussing, not whether or not your boss' conscience is more important than your own.

Now, Mr. Cox, I want to praise the good work of your institutions in California because many of them are serving my constituents in my congressional district...

COX: Thank you.

CAPPS: ... on the Central Coast. In your testimony you say that you represent Catholic health care organizations in California, including 54 hospitals. Is that correct?

COX: That's correct.

CAPPS: So to be clear, you're not speaking for or representing the views of all Catholic hospitals or nursing homes in the United States.

COX: No, but I would believe that my views would be consistent with...

CAPPS: Right. But you do not represent any other than the ones in California.

COX: That's correct.

CAPPS: As I understand it, California has a requirement for coverage of contraception that is very much like the one that HHS has now proposed, and that includes the religious exemption that you are now saying is too narrow. I also understand that this coverage requirement has been reviewed by the California Supreme Court and found not to be religious discrimination and that the United States Supreme Court refused to review that decision.

So my question to you: I assume that your hospitals, in their role as employers, comply with the California law and do provide insurance coverage for your employees for contraceptive services. Is that correct?

COX: Most of our members have moved or are moving toward self insurance under ERISA, which would be denied to us by the HHS rule.

CAPPS: But they do now?

COX: Pardon?

CAPPS: They do now?

COX: That is, they're moving towards -- yes, they either have or are moving towards...

CAPPS: But they do now use it?

COX: ... self-insured ERISA plans in order to get out from under state...

CAPPS: But they do provide insurance coverage now, as required?

COX: Yes, of course we do.

CAPPS: OK. I wondered if you would tell us all, have any of your hospitals closed as a result of this requirement?

COX: No, because we...

CAPPS: Yes or no, please.

COX: We have other options.

CAPPS: So they have not?

COX: They have not.

CAPPS: Have any of your hospitals dropped insurance coverage for its employees as a result of this requirement?

COX: No.

CAPPS: Have any of the Catholic bishops severed ties with your hospitals over this requirement?

COX: No.
CAPPS: Thank you.

Now I would like to address Mr. Hathaway. I only have a few seconds left. But if there was an expansion of refusal provisions for employers, in some estimates that would affect over a million employees and their families. Where would these women go for their care?

HATHAWAY: My guess is they would end up in a safety net system somehow and struggle to make ends meet.

CAPPS: Like a Title -- and a clinic like the one you described, with certain of the patients that you serve, gets Title X funding to provide these services for women who can afford them?

HATHAWAY: Correct.

CAPPS: Thank you.

HATHAWAY: I think it can be pointed out, the areas of the United States, where there is less access to health care are also the areas where there's higher epidemic rates of unintended pregnancies, and those are the population -- if I'm here representing anyone I'm representing the thousands of women that I've seen daily that just don't have access to good health care, and those that are -- I truly hope we can move forward on this Preventive Care Act.

CAPPS: That's exactly what I wanted to allow you the opportunity to say, because as a former public health nurse in the school system, I see those faces before me every single day as I serve here in Congress. Thank you very much.

HATHAWAY: Thank you.

CAPPS: I yield back.

PITTS: Chair thanks the gentlelady and recognizes the gentlelady from Tennessee, Ms. Blackburn, for five minutes.

BLACKBURN: Thank you, Mr. Chairman.

And thank the panel for their time.

Dr. Stevens, I want to talk with you for a couple of minutes. But before I do, the gentlelady from California mentioned that we should be talking about jobs. I would like to say that straightening out this Obama care bill is a way for us -- to repeal it, to replace it is a way to deal with jobs because we heard from CBO that passage of this bill would cost us about 800,000 jobs. So I appreciate that we're looking at the dynamic that this has.

Dr. Stevens, I want to talk with you. Since you're from Tennessee and you're familiar with the impact the TennCare program had on Tennesseans, I want to look at this access to care issue, because as I've told my colleagues here in this committee many times over the past few years that what we saw happen in Tennessee was individuals had access to the queue but they didn't have access to the care. And there is an enormous difference that is there, and I want to be sure – on the contraceptive mandate I want to be certain that I'm quoting you right.

And your quote was, "It violates the religion and free speech clauses of the First Amendment of the Constitution by coercing faith- based health care ministries to not only violate the very faith-based tenets that have motivated patient care for millennia, but also to pay for that violation. Such conscience-violating mandates will ultimately reduce patients' access to faith-based medical care, especially -- especially depriving the poor and medically underserved populations of such care," end quote.

STEVENS: That's very much the case. You know, the intention may be to expand coverage but actually what this is going to do, I believe, if it's carried forward it will reduce care as faith-based professionals, because they're forced into a situation, begin not providing those services or not providing insurance for the staff that are working with them. So that's a great concern because the bottom line is we want to take care of the poor, we want to provide good services, but we cannot violate our conscience.

BLACKBURN: OK. And you also noted a national survey at freedom2care.org of over 2,100 faith-based physicians revealed that nine of 10 are prepared to leave the practice of medicine if pressured to compromise their ethical and moral commitment. So, do you believe that this particular mandate could contribute to more faith-based providers leaving the medical profession and thereby reducing patients' access to medical care, and are you concerned that faith- based providers might leave certain or particular areas of medical care in especially large numbers?

STEVENS: I know that's happening. We work on 222 medical and dental (ph) campuses across the country, where we have student chapters, and I remember meeting with five students down at the University of Texas -- five girls -- and I said, "What are you guys interested in?" And they all said, "OB/GYN."

"How many of you are going into it?" Only one. "Why not?" Because of right of conscience issues, because of pressures in residency, coercion to participate in abortions or do things that violate their conscience. So we're already beginning to change the face of health care.

The sad thing, Congresswoman, is that I think that's what some people want. I was debating a Planned Parenthood lawyer on National Public Radio on right of conscience, and he said, "You have no business being in health care if you're not willing to provide legal services." And I think there are some that would love to see faith- based people out of the whole health care equation.

BLACKBURN: OK. Let me go to Mr. Cox, and Dr. Stevens, and Ms. Belford with this one.

And, Dr. Stevens, starting with you and working across, let me just ask you -- this is a yes or no -- and then you can explain if you would choose. We only have a minute -- 45 seconds left. Does this preventive services rule adequately protect freedom of conscience?

STEVENS: Absolutely not. It's not most constrictive thing we've had in federal law in history.

BLACKBURN: So the fears of the students would be realized under...

STEVENS: Absolutely.

BLACKBURN: OK.

Ms. Belford?
BELFORD: I agree.

BLACKBURN: OK.

COX: Completely agree.

BLACKBURN: Thank you. Thank you very much.

And with that, I will yield back my time so that we can move through the rest of the panel.

PITTS: Chair thanks the gentlelady, recognizes the gentleman, Mr. Towns, for five minutes for questions.

TOWNS: Thank you very much, Mr. Chairman. Let me thank you and the ranking member for holding this hearing.

The Supreme Court and law courts throughout this land have repeatedly ruled that a law that is applied generally is enforceable even if some religious groups oppose the action or the inaction that it requires. Let me give you a few examples.

The Quakers must pay taxes that support wars. Native Americans may not use traditional drugs. Mormon men may not have multiple wives. Some courts have ruled that the Muslim women must remove their veils for photo identification cards, and et cetera, et cetera, going on, and on, and on.

The question for the court is whether the government is pursuing a legitimate goal. Family planning is a legitimate goal.

We have reams of data and medical consensus that family planning improves health outcomes for mother and child. We have shelves of studies that show that unintended pregnancies are likely to result in worse health and are much more likely to result in abortion.

The government, of course, cannot require individuals to use family planning. It cannot require individuals to provide family planning. But it can require employers to pay for insurance that covers family planning, and it should.

Let me go to you, I guess, Dr. O'Brien. I fully respect the rights of an individual provider to exercise his or her conscience.

However, I believe that this right must be carefully balanced by the rights of patients to access -- access to safe, legal health care. We must be certain that any right of refusal provided is solely granted to an individual and not to an institution to ensure that we strike the right balance.

Dr. O'Brien, do you believe that the Affordable Care Act's refusal clauses have the potential to compromise the health of women?

O'BRIEN: I believe the Affordable Care Act is an absolutely marvelous initiative that would greatly improve the lives and the health care of women, men, and families. I think the difficulty really comes about when what we hear -- what we're hearing all the time is trying to bestow

conscience rights on institutions. I fully agree with you that, with regards to doctors, nurses, pharmacists, individuals have a right of conscience. They have a right to refuse to provide services.

If they find themselves in that situation obviously the onus is to ensure that somebody can access those services, because within Catholicism -- and also, I believe, within fair play in the United States of America -- the idea that someone cannot access services, there's something wrong with that. I think there's a real difficulty that we didn't hear a lot today from some members about the conscience rights of those individuals who would be denied service.

What these clauses -- these refusal clauses -- are really intending to do would be to have the state sanction discrimination against individual workers just because they happen to work in an institution that's a Catholic institution. The idea that an employer can decide what services you do or do not get, I think there's something very wrong with that, something very un-American about it.

TOWNS: Thank you very much. I must admit that I agree.

Dr. Hathaway, why do you, as a medical professional, support the ACA preventative coverage provision? As a doctor who specializes in women's health, could you please explain why unintended pregnancy is considered by doctors as a health condition?

And I only have a few seconds left because I want to make a statement in reference to -- I know we keep using the work Obama care; I'm going to suggest for this committee, which is the Health Committee, refer to it as President Obama care. Thank you.

HATHAWAY: Thank you, Chairman.

After I'd been practicing in a public health clinic for several years I took some time to go to public health school, and it was for the exact reason as we're speaking about today, that I found many, many, many women of -- my patients coming in with unplanned, unintended pregnancies, and I felt as though we had to be doing -- we need to be doing something about that. And when this recommendation came out from the Institute of Medicine many of my colleagues across the country -- OB/GYNs, family nurse practitioners, midwives, family medicine doctors, pediatricians -- all, to my knowledge, are overwhelmingly supportive of this recommendation that preventive health care should include contraception care, family planning care, as well as a multitude -- seven or other eight points that they recommend.

Public health is an incredibly important issue for our country and preventive health is paramount.

TOWNS: I yield back.

PITTS: Chair thanks the gentleman and recognizes the gentleman from Georgia, Dr. Gingrey, for five minutes.

GINGREY: Mr. Chairman, thank you for yielding.
And I thank our witnesses. I want them to know, if they don't already know, that prior to Congress I spent 26 years practicing obstetrics and gynecology in Marietta, Georgia, my hometown.

I'm going to address my first questions to Dr. Stevens, Ms. Belford, and Mr. Cox, and I will get each of you to quickly answer these questions that are pretty straightforward, yes or no.
Are you aware that President Obama promised every American that they could, and I quote, "keep what they have if they liked it," unquote, when referring to health insurance?

STEVENS: Yes.

BELFORD: Yes.

COX: Yes.

GINGREY: And the second question for the same three, I referenced the Catholic hospitals in my opening statement. Does this interim rule, in your opinion, support President Obama's promise that workers, including the 750,000 of the Catholic Hospital Association, could keep what they have if they like it?

STEVENS: No.

BELFORD: No.

COX: No.

GINGREY: Thank you.
The next question I want to address to Mr. O'Brien. Mr. O'Brien, you stated that you believe in choice, and Mr. Waxman referenced in his statement the need for employees to have the choice to access services. I'm glad to hear that, because I basically agree with the two of you.

I also believe that choice is a two-way street, both to do and not to do. In 2014, according to supporters of the new health law, President Obama care, every single person will have numerous choices in their health plan through these exchanges. So instead of forcing every person to pay for a service they may have a moral conscience objection to, don't you, Mr. O'Brien, don't you agree it would be better to allow them to choose whether they want these services and if they want to pay for them?

O'BRIEN: I think that there's a lot of people in the United States of America who have problems with taxes, and problems paying taxes -- the amount of taxes they pay. But we don't get to pick and choose what we pay and what we don't pay for.

Some people disagree with the wars. Some people disagree with the incarceration system in the United States. Other people feel that, as regards Welfare, that they don't feel like paying for it.
But we do. As a society, this is an important way for a society to be constructed so that it can actually operate. So we don't always get to pick and choose.

I think the idea that one religious group would receive a free pass, I think that that's very unfair and I don't think that that's right.
GINGREY: Well, I'm going to interrupt you because I think that your answer is no, and no matter how long you talk the answer is going to be no. It seems to me, quite honestly, the only choice you believe people should have are choices that fit with your own philosophical views -- the views that you espouse are not choices, but rather, imposing of those views on people regardless

of their moral or religious views or convictions. Quite honestly, Mr. O'Brien, that doesn't sound very American to me.

I am going to go back to Dr. Stevens, and Ms. Belford, and Mr. Cox in the remaining time that I have. In looking at this interim rule, I guess that Catholic hospitals and providers could limit their hires to Catholics, and of course, only deliver care to Catholics. Is that the health care system that we ultimately want -- one in which Catholics treat Catholics, Protestants treat Protestants, Muslims treat Muslims? Or should this government instead encourage hospitals and providers, the doctors, to treat all patients?

STEVENS: It should encourage to treat all patients.

BELFORD: That is a fundamental tenet of our faith, that we care for our neighbor and love our neighbor as ourselves. So yes, we should care for all.

COX: It would be inconsistent with our religious mission to limit our services only to Catholics.

GINGREY: Well, I thank the three of you. I certainly agree with that.

Mr. Cox, I'm going to conclude with you in the half minute I have left. Going back to previous questions, can you explain to us the difference between California's law on benefits and the impending HHS rule that we're discussing here today?

COX: They're very similar, and particularly with respect to the definition of religious employers. The HHS borrowed or utilized the definition that was first developed by California in its contraceptive mandate statute.

They differ in this regard, that you can get out from under the mandate in California if you decide not to provide prescription drug benefits in your health insurance plan, or cover those prescription drugs in your health insurance plan. And our members are also able to self-insure under ERISA -- they have been up until now -- self-insure under ERISA and get out from under the mandate.

Also, the California statute does not cover sterilization, which the HHS rule does and compels -- will compel us to cover in our health insurance plans.

GINGREY: Thank you, Mr. Cox.

Mr. Chairman, I yield back. Thanks for the patience.

PITTS: Chair thanks the gentleman and recognizes the gentlelady from Wisconsin, Ms. Baldwin, for five minutes for questions.

BALDWIN: Thank you, Mr. Chairman.

I have a few questions for our witnesses, but I'd like to first point out that here we are again, once again in the middle of what's been described as the Republic war on women, at a time when our committee and our Congress should be coming together to put America back to work, putting partisan divisions aside in the interest of the people, once again our committee is advancing

issues that divide Americans, and in this case, issues that infringe on women's rights. Today the majority is focusing on yet another effort to limit women's access to essential and medically necessary treatment options, and in particular, my colleagues would like to limit the number of new group or individual health insurance plans that will be required to provide preventative services for women without cost-sharing requirements.

The Affordable Care Act makes significant strides in expanding access and making health care affordable for women. Thanks to this law, being a woman can no longer be considered a preexisting condition, and thanks to a provision in the Affordable Care Act that we are discussing today, women will now have access to preventative services that have been too costly for so many up until now.

That is, unless Republicans succeed in their efforts to limit the number of health plans that are required to cover such preventative services. I'd like to explore this issue further and ask our witnesses some questions.

Dr. Stevens, Mr. Cox, and Ms. Belford, as you know, I believe Congressman Fortenberry has introduced a bill, H.R. 1179, the Respect for Rights of Conscience Act. This bill would amend the Affordable Care Act such that health plans would not be required to provide coverage or pay for coverage for any service that -- and I'm now quoting from the legislation -- quote, "is contrary to the religious or moral convictions of the sponsor or issuer of the plan."

Just so the record is clear -- and this question is for each of you -- do you support this legislation?

Dr. Stevens?

STEVENS: I do support that legislation.

BALDWIN: Mr. Cox?

COX: We support it.

BALDWIN: Ms. Belford?

BELFORD: Yes.

BALDWIN: Thank you.

Now, Ms. Belford, as the attorney on the panel, I want to ask you some questions related to the provision of H.R. 1179. As I read it, an employer can exclude from its insurance coverage for its employees coverage of any service that is contrary to the religious or moral convictions of that employer.

So if you can answer the following with a yes or no that would be greatly appreciated, with our time constraints: Under this language that I quoted, could a plan exclude coverage for certain infertility services because the plan's sponsor has a religious objection to such services?
BELFORD: I can only speak to what our plan provides and what our...

BALDWIN: No, the quoted provision of Mr. Fortenberry's bill, if it were to be passed into law, I'm wondering if under that language I quoted, could a plan exclude coverage for certain infertility services because the plan's sponsor has a religious objection to such services?

BELFORD: Hypothetically, I think it probably could.

BALDWIN: Thank you. Under that language, could a plan exclude coverage for alcohol and drug addiction services because a plan's sponsor believes that use of alcohol or drugs is sinful?

BELFORD: I honestly don't know the answer to that question because these are all services that we provide under our health plan.

BALDWIN: But if, under the language of the Fortenberry bill, "health plans would not be required to provide coverage or pay for coverage of any service that is contrary to the religious or moral convictions of the sponsor or issuer." So, under that language, could a plan exclude coverage for alcohol and drug addiction because the plan's sponsor believes that the use of alcohol or drugs is sinful?

BELFORD: Theoretically. I'm not aware of religions that do, and I guess I would have to look with reference to what our federal laws and constitutional cases have indicated with regard to what our moral and religious...

BALDWIN: So you don't know the answer to that question?

BELFORD: I really don't.

BALDWIN: OK. Under the language I quoted, could a plan exclude coverage for HIV and AIDS patients because the plan's sponsor expresses moral objections to homosexuality?

BELFORD: This is a hypothetical question, but I just have to say, in our church we care for all people, and we don't decline services...

BALDWIN: That's not the question...

BELFORD: No, I think it's an important point to make, because...

BALDWIN: We're considering legislation that will have impacts if passed.
Mr. Chairman, would I be able to be granted an additional 30 seconds?

PITTS: Without objection.

BALDWIN: Under the language that I quoted, could a plan exclude coverage for blood transfusions because a plan's sponsor is religiously opposed to this medical service, even in an emergency situation?

BELFORD: I don't know the answer to that.

BALDWIN: Under this language, could a plan exclude coverage for unmarried pregnant women because the plan's sponsor has a religious objection to premarital sex?

BELFORD: We don't exclude such coverage so I don't know...

BALDWIN: I'm not asking about your plan.

BELFORD: ... I don't know whether that would be the case.

BALDWIN: Well, I hope that you see the point that I'm trying to make here. The scope of H.R. 1179 is broad enough to exclude anything to which an employer decides it is religiously or morally opposed. There is absolutely no standard, no guidelines in place for making such a decision.

This bill would also undo state law and it would completely undermine the Affordable Care Act.

UNKNOWN: Would the gentlelady yield to me when she has a little time?

UNKNOWN: I would point out, she's way over 30 seconds.

PITTS: Gentlelady's time is expired.

BALDWIN: Thank you, Mr. Chairman.

PITTS: Chair thanks the gentlelady and recognizes Dr. Cassidy for five minutes for questions.

CASSIDY: Folks, I've got five minutes, so if I interrupt you it is not to be rude, it's just because I have five minutes.

Now, Mr. O'Brien, Dr. Stevens raised an interesting point on moral complicity, but it appears, then, frankly, if we view the employer as merely an extension of the state, we could take Representative Baldwin's point and extend it to terrible things where the state might demand something terrible and the employer is merely an extension, a puppet being dictated by a law, would have to comply. So I think this cuts both ways, but I gather that you feel as if moral complicity is not an issue if an employer is mandated to cover a service which he particularly finds objectionable.

O'BRIEN: Within Catholicism, and I think within...

CASSIDY: No, no, no, just in general.

O'BRIEN: ... within general fairness, I think that a properly formed conscience requires us to have respect for the consciences of others. So I think that...

CASSIDY: That said, we also are responsible for...

(CROSSTALK)

CASSIDY: I've got five minutes. And so we are responsible for ourselves, so if the employer is -- finds something objectionable, again, if you say that it's incredible to suggest that a health care plan has a conscience, but it's not really the health care plan, it is the purchaser of the health care plan that has a conscience, I gather that you think it's incredible that the purchaser of that health care plan would manifest her conscience through the benefits covered. Is that correct?

O'BRIEN: I believe that due deference to the consciences of others is an essential element of...

CASSIDY: No, but is it correct that you would find it incredible that the purchaser of a health care plan would manifest her conscience as regards what services she would elect to cover for her employees?

O'BRIEN: I think if you're talking about individuals I believe in the right of individual conscience, but...

(CROSSTALK)

CASSIDY: So I'm thinking as a small business owner, and a small business owner, she's got 35 employees. And she's making a decision as to what benefits to cover. It is she that is making it; she is the individual. And you find it, I gather, incredible that she would reflect her values through the services provided.

O'BRIEN: I think an employer, a company, an institution -- I think that the job of an institution is to give due deference to the consciences of all...

CASSIDY: So she's also filing as an S Corp, so she's actually taking income from the business as her own income. If you will, there's an identity that is respected in other aspects of the law that is recognized by our IRS and others. But again, you seem to find it incredible -- I just -- I'm not quite getting the yes or no.

In fact, let me do what Ms. Baldwin did, or Mr. Pitts, which is a yes or no: Do you find it incredible that that small...

O'BRIEN: No.

CASSIDY: ... business owner would attempt to reflect her values in the services she covers?

O'BRIEN: I don't think that an employer has a right to insist that their values -- that, for example, if an employer...

(CROSSTALK)

CASSIDY: OK. That's fine. No, you've made your point. You don't think so.

(CROSSTALK)

CASSIDY: So at that point it just -- again, I only have five minutes.

O'BRIEN: Sorry.

CASSIDY: So at that point the employer's conscience merely becomes an extension of what the majority party is able to put through without an open hearing through HHS. Ultimately, that's in, correct? Yes, no?

O'BRIEN: I believe that it's the job of the institution to facilitate the consciences of all people.

CASSIDY: So again, all people is interesting, because we're not really facilitating the conscience of that small business owner who would like her values to be reflected in the benefits she provides.

And you also reject moral complicity. So if that small business owner puts out a product -- somehow you've divorced her from the actions of her company. So if she puts out a product which is harmful there is no moral complicity there?

O'BRIEN: I don't think that it's speaking to what the actual issue...

CASSIDY: No, the question is...

O'BRIEN: The issue is whether...

CASSIDY: I only have five minutes. I only have five minutes.

O'BRIEN: OK.

CASSIDY: And so again, if we are going to take a holistic viewpoint of what this small business owner is doing, if she put out something which was known to be harmful we would call that -- in terms of a product, we'd call that morally reprehensible and we would ask her conscience to be sharper. But then we can turn around and say she has no right to judge what product should be covered by her insurance that she provides for her employees. That is a cognitive dissonance.

That said, let's also make the point, Dr. Hathaway, that this is really not about access for preventive services for those who are poor. They are currently covered through Medicaid and SCHIP, that I've been told IUDs can be placed right after delivery, which is a long-term form of birth control. I'm not an OB/GYN; I'm a gastroenterologist, you know, so whatever that's worth.

But that said, this is not about access for the poor, and for those who have coverage I see that a generic birth control pill can cost $14 a month through 340B pricing. If we are going to say through legislation that everything has to be covered equally then really we're saying to people, "Don't choose the $14 a month pill; choose the $100 a month pill," which is also bad social policy. We just run out of money at some point in our good will.

I yield back. Thank you.

PITTS: Chair thanks the gentleman and we have a...

UNKNOWN: Mr. Chairman?

PITTS: ... unanimous consent request from Dr. Gingrey for one minute to respond, since our friend, Ms. Baldwin, went one minute over. So without objection.

GINGREY: And I thank my colleagues for allowing me the minute because Ms. Baldwin was going down a line of hypotheticals in regard to objection to blood transfusions, objection to treating AIDS patients, and I want to make sure -- and I want to particularly direct this to the three panelists that I asked questions of before -- in regard to the Catholic principle that the intimate relationship between husband and wife is for the purpose of procreation of children and not simply recreation, as a number one principle. And the second principle, even more important, is the Catholic principle is that life begins at conception and should never be deliberately terminated.

I would think that this is a reason that the three of you are opposed to this intimate -- interim rule, and I just want to get your response on that because this is a very narrow area in which you would be opposed to sterilization, you would be opposed to abortion, you would be opposed to your hospital prescribing birth control pills or abortifacients. Is that not the crux of this problem?

Very quickly, yes or no.

STEVENS: Yes.

BELFORD: Yes.

COX: Yes. We have not been covering those services in our health insurance plans for a very, very, very long time. It is only now that the government comes forward and says, "We're going to require you to abandon that practice and violate your conscience."

GINGREY: Thank you all very much.

And, Mr. Chairman, thank you for...

PITTS: Chair thanks the gentleman. That concludes the first round of questioning. We'll go to one follow-up per side.

Dr. Burgess, for five minutes?

BURGESS: Dr. Hathaway, if I could -- and I won't use the entire five minutes; the question I'm going to ask is likely going to require a longer response, and if you wish to respond in writing that's perfectly acceptable. First, let me ask you, we talked -- you talked a little bit in your testimony about the amount of money that is spent. Can you tell us, between Title X, Medicaid, and Temporary Assistance for Needy Families, how much money is spent on family planning by the federal government every year?

HATHAWAY: I don't know that number.

BURGESS: But it's a lot, right?

HATHAWAY: I presume so. I don't know that number.
BURGESS: Yes. I don't either. That's why I'm asking you. But it's likely to be well in excess of $1 billion, and in fact, it may be a multiple of that.

And you referenced...

HATHAWAY: Pardon me, Chairman. I think also we need to recognize that what this Institute of Medicine's recommendation has to do with is insurers would cover contraceptive family planning methods. We're not talking exclusively about public assistance programs; we're talking about insurers throughout the board. So we're now paying a tremendous amount of money -- those of us that have private insurance...

(CROSSTALK)

HATHAWAY: ... so we're not talking about an incredibly...

BURGESS: Reclaiming my time, and we're going to pay more under the IOM's guidelines.

Dr. Cassidy is a gastroenterologist. He doesn't prescribe birth control pills. But I would submit that if the IOM were to require that everyone who comes into his clinic be able to get whatever proton pump inhibitor that they want, regardless of cost, nobody's going to buy the generic Walmart $4 a month prescription, which is available for the generics of Tagamet, and Zantac, and some of the early products. Everyone's going to get Nexium because that's the best, and why wouldn't you want the best?

But the cost differential is substantial between $4 a month and $200 a month. That is going to have the effect of driving up the cost of the product for everyone, whether they be on public assistance or not. Everyone who's on employer-sponsored insurance is going to bear the brunt of that cost. That's the way insurance works, is it not?

HATHAWAY: Well, my understanding is that insurers, insurance systems, have formularies for just that reason, to reduce...

BURGESS: Correct, and that's a good point, because that's the point I was trying to make with my experience at Parkland Hospital. But under the interim final rule, my read of the federal register is you don't get to use a formulary. You get to have any product that is marketed as being used for that, and that's the reason for the comparison between Necon and Seasonique. There is a vast difference in the price differential of those two compounds.

HATHAWAY: So, can I...

BURGESS: Yes.

HATHAWAY: Let me put it this way: You know, it's interesting. I'm sitting here...

BURGESS: Well here, let me just ask you the question. I have Aetna, a health savings account. I use a formulary with them. I only go to their Web site and buy the products they tell me I can buy.

But under -- as I understand it, under the IOM guidelines there would be no such prohibition. There would be no allowance for a formulary for contraception. Is that correct?

HATHAWAY: I'm not aware of that. I don't know the...

BURGESS: Well, that's my read of the federal register. Now again, this is the problem with an interim final rule. We didn't get to talk about any of that. We didn't get any transparency.
And, you know, forgive me if I make the leap of faith and say the reason for the interim final rule was precisely for these conscience protections that are getting so much discussion this morning. There was a reason that they followed that trajectory, so there is a reason that they went there with -- so we can't wait past August because we've got this to get out there.

Well, that's nonsense. This argument's going to be going on a for a long time, but just so you could get this year's student population covered under these rules to me was not a valid assertion unless you have a political calculation that may be geared for November 2012, and that may very well have been the case with this. But in the meantime, the individuals who claim that their conscience provisions are going to violated, and I think they're exactly right with that, they're the ones who are suffering as a consequence of what is very bad policy and a very bad way of going about that.

Let me ask you, though, you mentioned that child spacing, and that there is a societal benefit, and I don't disagree with that. I'm an OB/GYN myself. I agree with what you're saying, but I'm certainly interested in -- with the billions that we're spending on family planning through all areas of the federal government, what's our return on investment for that?

We already know, for example, that many of the people who are counted as uninsured actually have access to SCHIP, Medicaid, maybe even a COBRA program that they don't avail themselves of, but if you really scrutinize emergency room populations you'll come across those folks. So what is the evidence that providing these dollars in a family planning area gives us that benefit in child spacing?

HATHAWAY: Lots and lots of evidence. For every dollar spent on family planning services there's about $4 or $5 saved...

BURGESS: And I would appreciate it very much, because we're out of time, if you could provide me references for those, I'd be interested in looking at that.

(CROSSTALK)

HATHAWAY: I'd be delighted. Thank you so much. Thank you.

BURGESS: Thank you very much.

And I'll yield back.

PITTS: Chair thanks the gentleman and recognizes the gentleman, Mr. Engel, for five minutes for the follow-up.

ENGEL: Thank you very much, Mr. Chairman.

First of all, I want to say that I respect people's conscience -- people's consciences. This is a sensitive issue, and it's sensitive all the way around. And while I don't think anyone should be forced to provide services that morally they feel that they cannot do, I think conversely it works

the other way, as well. I think that people who make their own choices and their own decisions should not be impeded from getting the services that they want and they need.
I think this is an important hearing to discuss this very important issue of coverage for preventive services. And I believe that there have been many significant advances that the Affordable Care Act made in access to quality and affordable care for women.

I'm sorry we have another hearing which seems designed to attack the significant advances that the Affordable Care Act made for women. HHS's final interim rule is a significant step in the right direction of providing women access to coverage to a whole range of health care needs that are very specific to women, and I applaud their efforts and I'm just concerned, once again, we are undermining, or attempting to undermine, these benefits that women have. The cost that's placed on women in order to get access to all their health care needs is something that we ought to be concerned with.

And again, with respect to the religious exemptions, I'd say that the Department of Health and Human Services has made a significant effort to allow religious organizations to opt out of the requirements to provide coverage for contraception. I support that. I don't think anyone should be forced to do it. But I think that works, again, both ways, and we need to be sensitive both ways.

So my first question's for Dr. Hathaway. HHS's interim final rule has already accounted for the concern of providing coverage for contraception. In your testimony you mentioned that cost is a barrier for many women who cannot afford access to quality medical information.

In your opinion, Doctor, what will be some of the most significant benefits for women who can now have access to coverage for preventive services?

HATHAWAY: You know, I'm sitting here thinking, some days I feel as though I'm pretty passionate about this; there's other days that I wish I could be more passionate. And the only way I think I could do that is if I were a woman, or a woman of color, or a woman of social -- lower socioeconomic strata.

And since I can't do that I have to hope that I can present the voice that I try to do as best I can. Preventive health care, contraception care, family planning services are incredibly important for multitudes of women in our country, and I think we are fooling ourselves if we are not looking at the cost savings and the amount of despair that we've put women into for years, and years, and years.

We've moved to a whole different era of contraception. You know, this is the 50th anniversary of oral contraceptive pills, and yet, they've saved and helped many, many women for years throughout our country as well as many other countries.

And yet, we're in a different era. You know, if I were to ask any of us in this room how easy it is to take a pill every day, most of us will say it's pretty darn difficult. Most women would say they would like to wait at least a year or more to avoid the next pregnancy, or a pregnancy, or a pregnancy at all. And therefore, we ought to be able to help them, whether it's private insurance or no insurance. We need to be able to help those women space and prevent the pregnancies when they want to.

ENGEL: So let me just follow up with that, because you mention in your testimony, which is consistent with what you just said, that access to coverage for counseling, education, and

contraception is very important for women of all socioeconomic backgrounds, but specifically to women who cannot afford access. So what impact would efforts to roll back this interim rule have on women's health and what would a continued cost barrier mean for women who cannot afford the access to care?

HATHAWAY: Detrimental. You know, the women who are currently not using the most effective methods or have no access to any method at all are still going to struggle without this moving forward. I think the IOM's -- Institute of Medicine's recommendations are very, very strong, and I applaud them. I think it's a wonderful move for our country.

ENGEL: Thank you, Dr. Hathaway.

Thank you, Mr. Chairman. I yield back.

PITTS: Chair thanks the gentleman. That concludes the final round of questioning.

I'd like to thank the witnesses for your testimony today, and this concludes today's hearing. I remind members that they have 10 business days to submit questions for the record and I ask that the witnesses please agree to respond promptly to these questions.

With that, thank you. The subcommittee is adjourned.

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