**Submitted Electronically**

June 18, 2012

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

**Re: Advance Notice of Proposed Rulemaking on Preventive Services File Code No. CMS-9968-ANPRM**

To Whom It May Concern:

The following comments of the Susan B. Anthony List (hereinafter "SBAL") and the Charlotte Lozier Institute (hereinafter "CLI") are submitted pursuant to the Advance Notice of Proposed Rulemaking on Preventive Services, 77 Fed. Reg. 16501 (March 21, 2012) (hereinafter "Advance Notice").

SBAL is a non-profit organization and employer located in Washington, D.C. The mission of SBAL is to further legal protection for the right to life of all innocent human beings from conception until natural death primarily by encouraging pro-life women to run for political office and by providing financial and advisory support as they campaign for election. SBAL receives no government funds.

CLI is the research and education arm of SBAL. It conducts research studies on issues affecting the sanctity of human life from conception to natural death, and it publishes reports and commentaries on a wide range of issues. These reports and commentaries include both scientific findings and public policy analysis. Health care coverage of abortion and abortion-inducing drugs and devices, the behavior of human populations with respect to these practices, and ethical evaluation of public policy alternatives are central areas of concern related to CLI's mission as a non-profit organization. CLI also receives no government funds.

SBAL and CLI (hereinafter "SBAL/CLI") employ a staff of dedicated individuals who agree with and whose function is to further the organization's pro-life goals. SBAL/CLI offers a package of employment benefits that includes health insurance. In order to maintain consistency between SBAL/CLI's pro-life mission and its employee operations, SBAL/CLI refuses to purchase insurance or otherwise participate in any insurance plan that includes coverage for interventions or procedures that destroy or otherwise imperil the right to life of innocent human beings. SBAL/CLI is not a religious organization nor is it affiliated with any religion or religious entity. The organization currently employs fewer than 50 workers but collaborates with other pro-life and pro-family non-profit entities that exceed this numerical threshold.

It is in this capacity and under these circumstances that SBAL/CLI submits this Comment. The Advance Notice advises that the federal agencies charged with implementing the new medical insurance law seek "maximum input" on the "ideas and questions" outlined in the Advance Notice "as well as new suggestions" to help achieve certain administrative goals.[1]

These goals are described as ensuring the availability of a particular set of "preventive" procedures or medicines (sterilization and contraceptives) that also encompass life-threatening interventions (drugs and devices known to have abortifacient effects). At the same time, the Administration proposes to accommodate in a limited fashion one category of objectors (religious entities, narrowly defined). Accommodation would be refused to those religious organizations that fall outside the government's approved definition of religion, and also to those individuals and those secular organizations (whether religious or not) which object on ethical, moral and policy grounds.

SBAL/CLI files this Comment in response to the invitation for "maximum input" and "new suggestions." After briefly describing the overarching context which gives rise to SBAL/CLI's concerns, this Comment focuses on the question of mandated benefits and the issue of accommodation to make the following two points:

1. Using the purported capacity to "save money" as a basis for mandating insurance coverage for contraceptives—including those that have an abortifacient risk—opens the way for the federal government to mandate coverage on the same grounds for drugs and procedures whose sole or overriding purpose is to end human life, such as surgical and chemical abortions, or physician-prescribed lethal drug overdoses;
2. Any unaccommodated organization that opposes the insurance mandate on religious, ethical, moral or policy grounds, and that seeks to influence the public policy debate to eliminate or favorably amend the mandate, will be confronted as an insurance consumer with, and therefore directly handicapped in its organizational operation by, the mandate's

[1] 77 Fed. Reg. at 16508.

> internal application. This handicap will inure to the unjust advantage of organizations that lobby for or otherwise politically support the mandate and that, therefore, unlike organizations such as SBAL/CLI, see no need to alter their employment policies in ways that will effectively create turmoil within their operation. These unfairly favored organizations thus would not have to worry that their ability to function in the policy arena will be compromised by a government mandate to act in ways that violate their conscience and, in fact, contradict their very reason for existence.

SBAL/CLI strongly urges the Administration to reconsider its decision to enforce the Interim Final Rules as they presently stand,[2] which adopt the recommendations for mandatory preventive services found in the Women's Preventive Services: Required Health Plan Coverage Guidelines,[3] and which afford only an extremely narrow exemption protecting only a tiny category of religious entities.[4] We request that HHS either rescind or amend the portion of the mandate that requires insurance coverage for contraception so that the mandate no longer compels the inclusion of abortifacient measures.[5] Otherwise the Administration should broaden the present, narrowly drawn accommodation of conscience rights to include all entities and individuals with ethical and moral, and not just religious, objections.

The mandate as presently constituted creates unjust conflicts with the religious, moral and ethical principles of a broad range of conscientious objectors, including non-profit employers such as SBAL/CLI that have been and intend to continue to be engaged in the public policy debate surrounding medical insurance coverage as it pertains to the right to life. It is an outrageous abuse of governmental power that gives a decided operational advantage in the policy arena to those employers backing the mandate and its logical expansion and encroachment.

## The Context Giving Rise to SBAL/CLI's Concerns

The Patient Protection and Affordable Care Act (hereinafter "Affordable Care Act") authorizes the Executive Branch to dictate to private individuals, private employers, and private insurance providers the application of certain medical insurance requirements and threatens federal penalties for non-compliance. Individuals are required to have insurance, whether provided as an employment benefit at their place of work or purchased directly. The failure to show proof of

[2] 76 Fed. Reg. 46621.
[3] U. S. Department of Health and Human Services, Health Resources and Services Administration, Women's Preventive Services: Required Health Plan Coverage Guidelines (hereinafter "Coverage Guidelines"), available at http://www.hrsa.gov/womensguidelines/.
[4] 76 Fed. Reg. at 46626 (amending 45 CFR §147.130(a)(1)(iv)(B)).
[5] See Coverage Guidelines, supra note 3 (mandating the inclusion of "All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity").

insurance will result in severe tax penalties. Places of employment with 50 or more employees must offer insurance benefits to their workers or face stiff fines. Insurance providers must offer plans to employers and individual consumers alike that consist of a federally determined list of mandated benefits.

These changes in the way that private medical insurance is administered in the United States will federalize and thereby politicize health care insurance delivery. The consumer landscape, including that occupied by religious and other non-profit organizations involved in health care policy debates, will be altered in several significant ways.

First, the Affordable Care Act places into the hands of federal actors the overriding power to determine the scope and content of all private insurance plans. Second, it authorizes the federal government to impose a one-size-fits-all standard for basic coverage, giving rise to the potential for the inclusion of ethically and morally controversial items sparking conscientious objection. Third, this new system eliminates any opportunity for insurance consumers to select alternative packages more in line with the consumers' own values. Fourth, it empowers the sitting Administration to declare a policy "war" against political opponents and thereby turn government-dictated insurance policy-making into a sophisticated and subtle array of regulatory weapons. By pulling the federal levers of governmentalized insurance policy, instigating official measures to interfere with the internal operations of employers, including groups involved in the political debate over social ethics and health care policy, the Administration in power can directly and indirectly favor political allies and disadvantage political opponents to advance its contested policy objectives in the medical insurance field.

**Point # 1: Designating Contraceptives as a Mandated Benefit on the Ground of Preventing the Costs Associated with Unintended Pregnancies, and Including Drugs with Abortifacient Risks, Opens the Way to Justifying on Cost-Benefit Grounds the Mandated Inclusion of Surgical and Chemical Abortion and Other Lethal Measures.**

The Advance Notice states that "[a]ctuaries and experts have found that coverage of contraceptives is at least cost neutral, and may save money, when taking into account all costs and benefits for the issuer."[6] An "Issue Brief" cited in the Advance Notice[7] recommended that the expenses related to mandating insurance coverage for contraceptives be balanced against the "medical costs associated with unintended pregnancies . . . , including the costs of prenatal care, pregnancy complications, and deliveries."[8] The Institute of Medicine factored in all "public-

[6] 77 Fed. Reg. at 16503.
[7] Id. at 16503 n. 6 (citing John Bertko et al., "The Cost of Covering Contraceptives through Health Insurance" (Feb. 9, 2012) (hereinafter "Cost of Covering Contraceptives"), available at http://aspe.hhs.gov/health/reports/2012/contraceptives/ib.shtml.
[8] Cost of Covering Contraceptives, supra note 7.

sector health and social services" needed to support infants and their mothers for five years following a child's birth.[9]

Besides the objectionable feature of treating the creation of new human life as if it were an expensive disease to medicate against, the list of mandated benefits includes all methods approved by the FDA for use as contraceptives.[10] The FDA has permitted the use of "contraceptive" drugs and devices that may not always prevent conception and that then risk causing the loss of embryonic life through post-conceptive effects on the mother or embryo or both.

For example, in its September 30, 2011 comment in support of the Interim Final Rules on preventive services, the Center for Reproductive Rights acknowledged that FDA-certified emergency contraceptives can operate effectively at any moment "between intercourse and implantation of a fertilized egg,"[11] a duration that obviously includes the time between when an embryo is conceived and travels down the fallopian tube towards the womb and potential implantation. The Center, which favors both the contraceptive mandate and legal abortion,[12] recognizes Plan B, Preven, Next Choice, the copper intrauterine device (IUD), and regimens of multiple oral contraceptives as examples of federally-permitted means of emergency contraception that can "prevent pregnancy" (as defined by the Center) [13] by either preventing conception or preventing implantation.[14]

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[9] Institute of Medicine, Committee on Preventive Services for Women, Board of Population Health and Public Service Practice, Cinical Preventive Services for Women: Closing the Gaps 107 (2011) (hereinafter "IOM Report"), available at http://www.nap.edu/catalog.php?record_id=13181. Health and Human Services relied on this report in determining which insurance coverages to mandate. Advance Notice, 77 Fed. Reg. at 16502.

[10] Advance Notice, 77 Fed. Reg. at 16502.

[11] Comments of the Center for Reproductive Rights at 11 (Sept. 20, 2011) (Document ID: HHS-OS-2011-0023-80851) (quoting from ACOG Practice Bulletin No. 112 (May 2010)).

[12] See the "Our Issues" Webpage on the Center for Reproductive Rights' website, ReproductiveRights.org, available at http://reproductiverights.org/en/our-issues.

[13] The Center for Reproductive Rights, following the lead of the American College of Obstetricians and Gynecologists, refers to the object of contraception as "preventing pregnancy" (see Comments of the Center for Reproductive Rights, supra note 11 at 11), where pregnancy is defined by these organizations as beginning at implantation. This rhetorical jiu jitsu acknowledges that a "fertilized egg" may come into existence even despite the use of emergency contraceptives but refuses to categorize this entity before implantation as an "embryo" such as to make a woman pregnant at any point before implantation, and accordingly and conveniently denies that any drug or device that causes the loss of a "fertilized egg" before implantation can be considered to be an abortifacient. Unfortunately, HHS Secretary Kathleen Sebelius has engaged in the same subterfuge by insisting that the mandate does not include abortifacient drugs because, in her opinion, any of the pre-implantation effects of the approved drugs or devices inhibiting implantation do not disturb an existing pregnancy. See C-SPAN Video Library, March 1, 2012 Hearing on Health and Human Services Fiscal Year 2013 Budget, House Committee on Energy and Commerce, Exchange between Cong. Timothy Murphy (R-Pa.) and Secretary of Health and Human Services Kathleen Sebelius beginning at 01:38:37, available at http://www.c-spanvideo.org/program/304689-1.

[14] In comments opposing the interim final rules on preventive services, Americans United for Life ably documented the pre-implantation abortifacient effects of the various forms of approved emergency contraception listed by the

In including all drugs approved as contraceptives by the FDA, the insurance mandate would also require coverage for at least one intervention that has both pre-conception and post-implantation effects. The FDA has authorized for the purpose of using as an emergency contraceptive a drug, ulipristal acetate, or *ella*,[15] that research indicates may induce an abortion of an already-implanted embryo.[16] The drug employs the same chemical mechanism, blocking the production of progesterone, as employed by RU-486, the FDA-approved abortifacient. European studies involving use of the drug on women indicated that two out of every 100 women became pregnant despite taking the drug, and thus, given the drug's post-implantation toxicity: "it is inevitable that ulipristal will abort established uterine pregnancies when used in real world situations."[17]

This combination of factors lays the groundwork for inserting chemical and surgical abortions onto the list of mandated preventive "benefits" with the supposed further potential for the saving of even more dollars. Abortion rights advocates have long contended that greater access to and the public funding of abortion, especially for women of low income, would help tip the commonweal's economic balance sheet to the positive column.[18]

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Center for Reproductive Rights. See Comment submitted by Anna Franzonello, Americans United for Life (2011) (Document ID: HHS-OS-2011-0023-59496) (hereinafter "AUL Comment" at 6 nn. 10-12 and accompanying text

[15] United States Food and Drug Administration, News Release: FDA Approves Ella Tablets for Prescription Emergency Contraception (Aug. 13, 2010), available at http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm222428.htm.

[16] The FDA's labeling information warns that ella is contraindicated when women are known or suspected to be pregnant (i.e., according to the rejiggered meaning of the word, when there is the possibility that an embryo has implanted in the womb). There are no adequately conducted human studies but animal studies showed the drug caused "embryofetal loss" and "pregnancy termination." FDA Prescribing Information at no. 8.1 (Aug. 2010), available at http://www.accessdata.fda.gov/drugsatfda_docs/label/2010/022474s000lbl.pdf.

[17] Comments from Donna J. Harrison, President, American Association of Pro-Life Obstetricians and Gynecologists, Submitted to Food and Drug Administration, Advisory Committee for Reproductive Health Drugs at 3 (June 5, 2010), available at http://www.aaplog.org/wp-content/uploads/2010/06/AAPLOG-Ulipristal-Comments_2010.pdf. See also AUL Comment, supra note 14, at 4-5 (providing references to governmental authorities and abortion rights advocacy literature documenting the abortifacient properties of ella).

[18] See, e.g., Martha Robinson et al., Medicaid Coverage of Abortions in New York City: Costs and Benefits, 6 Family Planning Perspectives 202 (1974) (arguing that New York City would have to pay between $51 million and $75 million in additional first-year governmental health and social service costs if Medicaid payments were no longer available to finance abortions); Abortion Financing Prompts Emotion-Charged Debate, St. Petersburg Times, Apr. 8, 1978, at 4B (AP & UPI composite article reporting on legislative testimony of University of Miami professor of management science and health administration Howard Gitlow, who told state legislators that using state money to pay for abortions for poor women would cost Florida between $8.5 million and $9.7 million over the next 30 years, but that refusing to pay for abortions could create at least $834.4 million in "social costs," which prompted one legislator to suggest that Prof. Gitlow study the cost-savings from shooting felons in the state prison system); Aida Torres et al., Public Benefits and Costs of Government Funding of Abortion, 18 Family Planning Perspectives 111 (1986) (discussing purported cost savings from encouraging poor women to obtain abortions by offering to publicly finance them). Another statistical analysis claims that the legalization of abortion in 1973, by reducing the number of children in poor communities, is responsible for a 29 percent drop in violent crime between 1992 and 2002, which would indicate another area of for potential cost-savings. Jessica Wolpaw Reyes, National Bureau of

The most egregious example of this chilling kind of cost-benefit analysis can be found in a nationwide study published in 1986 and conducted by the Guttmacher Institute.[19] According to the authors, their calculations demonstrated that:

> if access to publicly funded abortions were available to indigent women who wanted to obtain them, federal and state medical and social welfare expenditures of $435-$540 million would be saved in the following two years—from 4.3 to 4.6 times the $95-$125 million in public funds that would have to be paid to fund abortions for Medicaid-eligible women. Were there no restrictions on public funding of abortions, the net savings in medical and social welfare costs would amount to $340-$415 million over the following two years. The net saving in the Medicaid program would be at least $194 million and the net savings in the social welfare programs would be at least $146 million. . . . Thus, for every public tax dollar spent to pay for abortions for poor women, more than four dollars is saved in medical and social welfare costs over the next two years.[20]

The same monetary dynamics would be at play in considering mandated insurance coverage for providing physician-prescribed lethal drug overdoses for individuals otherwise needing expensive forms of medical and nursing care. A recent nationwide poll found that a majority of people surveyed responded affirmatively to the question, "To help save healthcare costs, do you believe that chronically-ill, mentally able seniors should be able to end their own lives?"[21] Economic analyses purport to show net economic returns for suicide.[22] In Oregon's health care

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Economic Research Working Paper: Environmental Policy as Social Policy? The Impact of Childhood Lead Exposure on Crime at 25 (May 2007), available at http://www3.amherst.edu/~jwreyes/papers/LeadCrimeNBERWP13097.pdf.

[19] Torres et al., Public Benefits and Costs of Government Funding of Abortion, supra note 18, at 111.

[20] Id. at 117.

[21] Suffolk University National Survey of Likely General Election Voters, Question 39 (Mar. 26, 2012) (showing that 46 percent responded "yes" to the question and 44 percent responded "no"), available at http://www.suffolk.edu/images/content/FINAL_National_Survey_Tables_March_26_2012(1).pdf.

[22] Bijou Yang & David Lester, Is There an Economic Argument for Suicide Prevention? A Response to Doessel and Williams, Suicide Online (2010) (referring to an earlier article by Yang and Lester concluding that by taking into account that "the death of depressed individuals suffering from depression eliminates the need for treatment of these individuals in later years," resulting in savings "from not having to treat the psychiatric disorders of those who complete suicide," as well as savings from reduced pension and social security payments, and decreased nursing care costs, the net economic benefit to our country from not intervening to prevent suicides would amount to $5.07 billion annually), available at http://www.suicidology-online.com/pdf/SOL-2010-1-88-91.pdf; Ezekiel J. Emmanuel & Margaret P. Battin, What are the Potential Cost Savings from Legalizing Physician-Assisted Suicide?, 339 New England Journal of Medicine 167 (1998) (surmising that with the legalization of assisted suicide there would be net annual savings of $627 million in 1995 dollars, less than .07 percent of total health care expenditures in the United States, but acknowledging that certain variables may affect the calculations, resulting in a range of possible savings between $336 million and $4.67 billion); but see also Wesley J. Smith, Suicide Pays, FirstThings.com, June-July 1999 (arguing that the Emmanuel-Battin analysis severely underestimates the cost

plan, insurance payments for physician-prescribed lethal drug overdoses, which are legal in that state for the terminally ill, are guaranteed, while treatments for cancer and other serious conditions are placed on the prioritization list, with payments subject to legislative ranking and budgetary line-drawing.[23] This has resulted in instances where Oregon has informed patients that they are ineligible for life-prolonging care but may avail themselves of the state's subsidized suicide assistance.[24]

Neither chemical and surgical abortion nor physician-prescribed suicide assistance is included on the federal list of mandated preventive services *at this time*.[25] Only with intense efforts by a broad coalition of interest groups, active at various levels of the public policy process, ranging from encouraging pro-life candidates to run for office to mobilizing the public at critical times in the legislative and administrative process, can there be any assurance that this will remain the case.

But the very existence of the mandate structure, and the continuing opportunity of the federal government to manipulate the mandate list in a manner that directly interferes with the ability of opponents to maintain their effective public involvement, will make it more difficult for SBAL/CLI and its allies to continue their efforts. This opens the field to supporters of the mandate intent on its expansion by hamstringing in the policy debate their competition, the pro-life groups, and thereby renders more likely the prospect that the mandate list will be amended to

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differential by limiting assisted suicide to terminal situations), available at http://www.firstthings.com/article/2007/01/suicide-pays-33.

[23] See Office for Oregon Health Policy & Research, Health Evidence Review Commission, Prioritized List of Health Services, Statement of Intent 2, included as an appendix to the 98-page Prioritized List at page SI-1 (April 1, 2012) (indicating that all "services" required under Oregon's Death with Dignity Act shall be covered), available at http://www.oregon.gov/OHA/OHPR/HERC/docs/L/Apr12List.pdf. Treatments for various forms of cancer are included on the Prioritized List of 692 line-by-line rankings of conditions and can be found anywhere between lines 123 and 566.

[24] Susan Donaldson James, "Death Drugs Cause Uproar in Oregon," ABCNews.go.com, Aug. 6, 2008 (reporting on the case of Barbara Wagner, who was informed by insurance authorities that the state would not cover cancer treatment costing $4,000 a month but it would pay for the drugs used for physician-prescribed suicide, legal in Oregon, and costing $50), available at http://abcnews.go.com/Health/story?id=5517492&page=1#.T894NbBDOSq; Dan Springer, "Oregon Offers Terminal Patients Doctor-Assisted Suicide Instead of Medical Care," FoxNews.com, July 28, 2008 (reporting on the case of Randy Stroup, who also was informed by the state that he was eligible for suicide assistance but not cancer treatment, and indicating that other patients throughout Oregon received similar communications), available at http://www.foxnews.com/story/0,2933,392962,00.html.

[25] See Cong. Rec. S12274 (daily ed. Dec. 3, 2009) (Sen. Barbara Mikulski, sponsor of amendment authorizing HHS to create preventive services mandate list, in colloquy with Sen. Bob Casey, asserting, "There is neither legislative intent nor legislative language that would cover abortion under this amendment, nor would abortion coverage be mandated in any way by the Secretary of Health and Human Services"); 42 U.S.C. §18113 (forbidding federal, state and local government from discriminating against any entity that refuses to provide "any health care item or service for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing").

include abortion and other lethal, supposedly "cost-effective," measures. The next point focuses on this problem.

**Point # 2: Tailoring the Mandate in Such a Manner as to Impair the Policy Effectiveness of Non-Profit and Other Employers Conscientiously Opposed to Abiding By It Is Fundamentally Unjust.**

SBAL/CLI exists for the purpose of promoting the right to life of all innocent human beings, especially the most vulnerable, and opposes abortion and other lethal threats to innocent human life. Its board, employees, and contributors share this purpose and strive to provide a consistent witness for life by pursuing SBAL/CLI's mission in a manner that coheres internally as well as externally. It receives no federal funds and thus is under no obligation to abide by any contractual agreement that voluntarily relinquishes any rights in exchange for grants or other governmental assistance.

SBAL/CLI cannot in conscience contribute in any way to the implementation of any external or internal policy that endorses, supports, funds or subsidizes the practice of abortion, assisted suicide or any other measure whose object or effect is to interfere with the right to life. SBAL/CLI will never waive its or its employees' freedom of conscience.

SBAL/CLI is not a religious organization nor is it affiliated with any religion. Its pro-life mission and the pro-life principles personally upheld by its board, employees and contributors nonetheless are cognizable as protected expressions of moral and ethical conscience. Federal laws in the healthcare arena consistently recognize the broader scope of conscience by guaranteeing protection for conscientious refusals based on religious *and* moral and ethical convictions.[26] Yet the mandate overrides the conscience-based interests of SBAL/CLI and other similarly situated non-profit entities and their pro-life employees.

Like any religious entity that is not exempted from the mandate, SBAL/CLI and other secular pro-life organizations and their staff will face an organizational and personal crisis if and when the mandate is implemented.[27] The parameters of the crisis will differ according to whether the

[26] See listing of 14 specific federal provisions (and two major legislative proposals) in the May 30, 2012 Comment submitted in response to the Advance Notice on behalf of The Center for the Advancement of Catholic Higher Education et al. at 21-22 (Document ID: CMS-2012-0031-0322).

[27] See e.g. the civil rights lawsuit filed by the Thomas More Law Center on behalf of secular non-profit and for-profit employers claiming religious objections to abiding by the mandate. Complaint at 27, Legatus v. Sebelius, No. 2:12-cv-12061-RHC-MJH (E.D. Mich) (filed May 7, 2012) (describing how mandate will pressure and coerce the employers to change or violate their beliefs, expose them to substantial fines, hurt their employee recruitment efforts by creating uncertainty as to whether the employers will be able to offer insurance after the mandate goes into effect, and interfere with their ability to retain their present employees).

resisting organization employs more than 50 full-time staff, but the consequences will be stark for all objectors and their similarly situated employees.

Every pro-life, non-exempted organization that presently offers health insurance to its employees as part of a workplace benefits package will have to consider dropping this benefit as a matter of conscience. This will force the organization (especially if it has more than 50 employees) and its employees into difficult moral circumstances. The larger organizations will be confronted with stiff fines that will go towards the implementation of the government's plan.[28] Every organization, large or small, will experience workplace instability due to the turmoil caused to its employees by the lost ability of their employer to honor and reflect their consciences in the procurement of company benefits.

Each pro-life individual will have to consider how to proceed. The mandate as applied to insurance providers forecloses any opportunity for finding an insurance policy that does not include coverage for abortifacients and that therefore does not conflict with one's moral and ethical pro-life principles.[29] If the employee decides not to purchase any insurance at all to avoid cooperation of any form, then he or she not only will be penalized financially by the government[30] but also will face the uncertainties of not having any health insurance at all.

The organizational and personal stresses associated with being boxed in morally and ethically, left without adequate health insurance because no palatable plan will be available, and suffering the financial penalties and ignominy of being treated as a lawbreaker due to the conscience-based non-compliance with governmental dictates, will take their toll on the operation of every pro-life organization and its employees. The organizational and personal focus will be on survival.

Consequently, the operational ability of SBAL/CLI and its pro-life allies to focus outward and engage effectively in the public policy arena will be affected adversely. Contrast this with the positive prospects for those organizations and their allies that the government invited to help shape the health care plan and its preventive services mandate in furtherance of their own belief system and policy objectives.[31]

[28] 26 U.S.C. §4980H.
[29] 42 U.S.C. §300gg-13(a)(4).
[30] 26 U.S.C. §5000A.
[31] Americans United for Life documented the decidedly pro-abortion make-up of the Institute of Medicine committee that provided recommendations to HHS with respect to the list of mandated preventive services. AUL Comment, supra note 14, at 8-9 (describing involvement of representatives of Planned Parenthood and its many affiliates, including the Guttmacher Institute, along with other groups such as the Center for Reproductive Rights, Physicians for Reproductive Choice and Health, and the National Women's Law Center).

These organizations continue to harbor an ideological and economic interest in working in the public policy arena to defend the current mandate and eventually to expand it to expressly include chemical and surgical abortion.[32] In any ensuing public policy dispute, these groups will not be hamstrung by the application of the mandate to their internal operations and to their employees, who, it must be presumed, have no religious, moral or ethical objections to abiding by its substantive dictates.

When HHS Secretary Sebelius addressed a fundraising gathering for NARAL Pro-Choice America in October of 2011, she told the crowd of her belief that "We," meaning legal abortion advocates in alliance with the current Administration, "are in a war" regarding "comprehensive health care" (read coverage that includes abortion) for women.[33] This reveals the disturbing mindset of a political appointee and public official charged with maneuvering the levers of governmental power to install a new delivery system for providing health insurance that subordinates individual and institutional conscience to government demands at every turn.

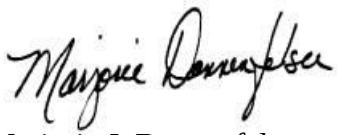
Using the coercive tools of bureaucracy to mandate coverage for controversial measures, and thereby conveniently overriding the conscientious objections of the policy opponents that Secretary Sebelius proclaims she is "warring" against, transforms the healthcare debate into a one-sided, no-holds-barred political battle. Under the guise of changing health care financing and delivery ostensibly to make it more efficient and cost-effective, the Administration is now attacking the internal operations of pro-life and other organizations, secular and religious alike, which apparently are deemed to be the government's enemy.

More bluntly, the Administration is provoking a crisis of conscience that will help those siding with the Administration to achieve the upper hand in the policy arena. This is highly unjust and the machinations leading to this result should be reversed not only as a violation of traditions of American liberty but also as an outrageous abuse of governmental power.

[32] But for current statutory restrictions in the Affordable Care Act, the IOM would have considered recommending the inclusion of abortion coverage in the list of mandated preventive services. IOM Report, supra note 9, at 21.
[33] Sec. Sebelius Speaks Out for Women's Health and Privacy at NARAL event, NARAL Pro-Choice America Blog for Choice, Oct. 6, 2011, available at http://www.blogforchoice.com/archives/2011/10/sec-sebelius-sp.html.

Respectfully submitted,
/s/
Daniel Avila, J.D.

on behalf of:



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