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March 27, 2018

The Honorable Roger Severino
Director
U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Conscience NPRM, RIN 0945–ZA03
Hubert H. Humphrey Building
Room 509F
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted via the Federal Regulations Web Portal at http://www.regulations.gov

Re: NPRM on Protecting Statutory Conscience Rights in Health Care, RIN 0945–ZA03

Dear Director Severino:

America's Health Insurance Plans (AHIP) appreciates the opportunity to provide comments in response to the Notice of Proposed Rulemaking (NPRM) from the Department of Health and Human Services (HHS) on Protecting Statutory Conscience Rights in Health Care, published on January 26, 2018.[1]

AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public/private partnerships that improve affordability, value, access, and well-being for consumers.

Health plan employees represent a large and diverse workforce, made up of at least half a million Americans.[2] Our members employ Americans from diverse ideological backgrounds and are committed to providing a work environment that does not hinder employees from freely exercising their religious or moral convictions. To this end, health plans are committed to complying with federal and state laws that protect Americans' conscience rights. These protections are one feature of a complex federal and state regulatory landscape that health plans must navigate to provide Americans with access to coverage and care.

[1] 83 Fed. Reg. 3880 (2018) (to be codified at 45 C.F.R. pt. 88).
[2] "State Data Book" AHIP, October 2017

The central function of a health plan is to design and deliver coverage options that include the care consumers want at an affordable price. Those coverage options are designed to include services that are: in demand from consumers or employers; necessary to support good health outcomes; or required by state or federal law. Although many health plans do not deliver health care services, they are charged with enabling their customers to access high quality care at a reasonable price.

Some health plans, such as provider-sponsored health plans, perform health plan functions and deliver health care services, but many do not. We acknowledge that provider-sponsored health plans and other plans that deliver care are subject to many provider-specific obligations discussed in the rule. Our comments below are focused primarily on the rule's applicability to the health plan role in offering health insurance coverage and servicing the policies sold to individuals, employers, state Medicaid programs and Medicare beneficiaries. We make the following recommendations to preserve statutory conscience rights while continuing to ensure health plans meet their customers' needs.

We recommend that in the final rule HHS:

- Update the rule to define applicability to health plans in a manner that more closely aligns with the statutes referenced in the rule.

- Clarify that health plans may comply with any applicable certification or notification requirements in a manner that does not add new unnecessary regulatory burdens.

- Provide greater clarity on how individual health care providers and provider entities can comply with the rule while also complying with the anti-discrimination rights of patients.

- Allow adequate time for implementation of the new notice, certification and compliance requirements specified in the rule.

I. Improve Alignment to Statutes

Most of the statutes referenced in the proposed rule clearly apply to entities and/or individuals that provide care. Health plans that provide care directly are committed to complying with these federal and state statutory conscience rights.

When a health plan doesn't directly provide health care services, as is often the case, three of the eight statutes referenced in the preamble to the proposed rule have some applicability to health plans: Weldon, Coats-Snowe, and the Church Amendments. These laws protect health plans themselves from discrimination by the government if the health plan itself does not offer coverage for a service because of a moral or religious objection.

In addition to the recommendations below, we also provide additional legal analysis of the underlying statutes in an attachment.

A. Applicability to Health Plan Employees

The proposed rule's expansion of these statutes to health plans' employees exceeds the intent of the statutes. Because the statutes do not apply to health plan employees who do not deliver care, health plan employees cannot be included in this rule.

Specifically, the broad definitions in the rule that would permit health plan employees to object to the "referral" or "refer for" of information would sweep in routine health plan activities in a manner that exceeds the statutes. In the proposed rule the term "referral" or "refer for" is defined broadly to include prohibitions on: (1) requiring an employee to refer a customer to a provider who provides a service one might find objectionable or (2) requiring an employee to explain what funding is available for a service to which they object.[3] Although the Weldon Amendment and conscience protections for counseling and referral provisions[4] do reference the terms "referral" and "refer for," we provide detailed legal analysis in Attachment A explaining why extending the protections in those statutes to health plan workers exceeds the intent of the statutes.

If applied to health plan workers, this interpretation would create barriers for consumers who need to know which providers are included in their health plans' network and/or what their out-of-pocket costs will be for a specific service covered on their plan. No obligation should be imposed on health plans to extend an accommodation to a health plan employee who has a moral or religious objection to referring a health plan member to a doctor or hospital, for example, when the employee objects to that doctor or hospital providing certain services.

Recommendation: Clarify in the final rule that health plans, rather than their employees, may object to discrimination by the government for declining to cover a service because of a moral or religious objection.

Recommendation: Revise the definition of "referral" or "refer for" to limit its applicability, consistent with the scope and intent of the underlying statutes to physicians, including post-graduate physicians, and not sweep in health plans or their employees.

B. Require a "Reasonable Connection"

The final 2008 provider conscience rule that was rescinded in 2011 required that individuals who exercise conscience objections demonstrate a "reasonable connection" between their religious or moral beliefs and the service to which they object to "assisting in the performance.[5]" In the proposed rule, the definition of "assist in the performance" includes language that requires an "articulable connection" rather than a "reasonable connection."

[3] 83 Fed. Reg. 3880, 3924
[4] 42 U.S.C. 1395w-22(j)(3)(B) and 1396u-2(b)(3)(B)
[5] Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 50,274, at 50282 (2008).

The open-ended new terminology proposed in the new rule, "articulable connection," is subject to abuse and suggests that a worker might object to any of their job duties without being required to provide a "reasonable" explanation of the relationship between the objection and their religious or moral values driving the objection.

Recommendation: Retain the 2008 requirement[6] that objectionable activities have a "reasonable connection" to the activity the worker opposes. To preserve the integrity of the rule as a tool for protecting genuine religious and conscience objections, close the loophole of "articulable connection" by returning to the 2008 language.

II. Minimize Regulatory Burdens

The Administration has articulated a clear commitment to reducing unnecessary regulatory burdens and acting as good custodians of both public and private dollars in the imposition of any new regulatory burdens.[7] The proposed rule should be modified to reduce the regulatory burden imposed to meet the goals of the rule. Below, we describe opportunities for efficiency in the application of these requirements to health plans.

A. Duplicative Certification

Health plans currently certify that they comply with all federal laws during the annual plan filing and rate review process. For example, the qualified health plan certification process requires health plans to attest to compliance with Section 1303 of the Affordable Care Act (ACA). Medicare, Medicaid and CHIP programs all have existing federal and state certification programs administered by a variety of federal and state agencies. The proposed rule includes new requirements of certification and assurance.

Recommendation: Do not create parallel, duplicative processes requiring health plans to certify compliance or provide assurance with federal laws to the Office of Civil Rights. If necessary, update the existing program-specific certification processes at the appropriate agencies for those programs.

B. Notices

Regarding the notice requirement proposed in 88.5, because the statutes referenced do not apply to health plan employees, the required notice language proposed in Appendix A is overly broad and not applicable to health plan workers who do not deliver care. For this reason, the notice requirement should only apply to health plan workers if those workers are employed in a setting where care is delivered, such as a health-plan-owned clinic.

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[6] *Id.*
[7] *See* Exec. Order No. 13,771, 82 Fed. Reg. 9,339 (2017).

Recommendation: Do not require health plans to provide the notice required by 88.5 and specified in Appendix A. If HHS determines there are scenarios in which the statutes support a conscience rights notice for health plan employees, that notice should be specific to the rights of those workers rather than enumerating rights for workers who deliver care.

C. Private Programs

The proposed definition of "recipient" in Section 88.2 of the proposed rule recognizes that an individual or organization must comply with the provider conscience regulations if the individual or organization receives funds "directly from the Department or component of the Department" to carry out a project or program. However, the preamble and the regulations do not explain how compliance with the regulations would not be required for products or services offered by the individual or organization that are unrelated to the federal funding.

Recommendation: Limit disruption to private programs. Make it clear that compliance with the provider conscience regulations is required by an individual or organization for projects or programs funded by HHS, but not for projects or programs that may be offered by the same corporate entity that are unrelated to the receipt of HHS funds.

III. Provide Clarification on Balancing Conscience Rights and Other Rights

Even when health plans do not provide health care services directly, they do have an interest in (1) ensuring their enrollees can access needed care from a high-quality provider, and (2) preventing unnecessary administrative costs for providers that will be reflected in premiums. We make the recommendations below to support high quality care and to enable providers to comply with conscience protections without undue administrative burden.

The proposed regulations should provide more guidance for entities to understand when and how health care entities, physicians, and health care professionals can legitimately raise objections of conscience without harming the ability of individual patients or consumers to freely access health care services.

While we respect the ability of health care providers to be free from discrimination when exercising a decision of conscience, we also believe that individuals must have the ability to access health care services. Specifically, we are concerned that situations may arise when an entity, a physician, or a health care professional refuses to treat or provide services to an individual raised as a conscience objection, but in practice the refusal to perform services is instead premised on discrimination prohibited under federal, state or local law, such as discrimination based on an individual's race, color, national origin, religion, sex, sexual orientation, gender identity, age, disability or disease status.

The regulations are unclear how an entity that receives federal funding under a contract, grant, loan, or other funding instrument, (e.g., Medicaid or Medicare program, veterans services, services for servicemembers and their families, etc.), should address such a conflict

between a provider's refusal to provide services based on a moral objection and actual or alleged disparate treatment in accessing health care services in violation of discrimination laws.

Recommendation: Include an explicit prohibition against a refusal to treat an individual that would qualify as discrimination under state, federal or local law.

Recommendation: Explain how federal contractors should handle situations where an entity's, physician's, or health care professional's refusal to provide a health care service may be deemed discrimination against an individual patient.

IV. Provide Guidance on Balancing State Requirements and Federal Conscience Rights

Health plans are subject to a variety of state requirements addressing the rights of consumers and health care providers. Although those state requirements may not directly conflict with the federal statutes, there may be instances where state laws in their application could conflict with the final rule.

Recommendation: Provide clarification that the proposed rule is not intended to preempt state requirements that are permissible under federal law.

V. Allow Adequate Time to Implement New Processes

In the rule HHS cites several existing statutes with which specified entities are already required to comply. For the newly proposed requirements, HHS proposes that the new notice requirements specified in Section 88.5 must be met by April 26, 2018 and that the newly proposed assurance and certifications requirements specified in Section 88.4 will be effective as of the beginning of the next fiscal year.

The proposed notice requirement effective date of April 26, 2018 is only one month after comments on the proposed rule are due to HHS and it is unlikely the final version of the rule would be published by that date. Entities required to comply cannot implement policies, procedures, and tools to comply with the rule until the final rule is published. When the final rule is published, entities need adequate time to create materials for their workforces that accurately and clearly convey the required notice information and complaint process as specified in the final rule.

Recommendation: Make new requirements related to notice, certification and compliance (proposed Sections 88.4, 88.5 and 88.6) effective at least one year after the final rule is published. **If the effective dates for the new requirements will be sooner than twelve months from the date the rule is finalized, provide a one-year safe harbor to entities that make a good faith effort to inform their employees about these rights and come into compliance.**

Thank you for the opportunity to comment on the proposed rule.

Sincerely,

Julie S. Miller
General Counsel

Jeanette Thornton
Senior Vice President,
Product, Employer and Commercial
Policy

Attachment

Attachment A
Legal Analysis Regarding Health Plan Applicability

Of the eight statutes cited by HHS in the proposed rule that apply to health plans, HHS specifically ascribed to Weldon, Coats-Snowe, and the Church Amendments authority for expanding statutory conscience rights to health plans and their workforces. These statutes, however, do not explicitly apply conscience rights to health plans' workforces and such an expansion would in any event be considered an impermissible interpretation of the statute.[8] In the statutes cited, Congress spoke directly and clearly to *whom* protection from discrimination is afforded, whether that be health plans, doctors, medical students, or hospitals, etc., but nowhere in the cited statutes are health plans' employees included. The principle of *expressio unius est exclusion alterius* provides that expressing one term of an expression-exclusion demonstration is a "series of terms from which an omission bespeaks a negative implication."[9] Congress made a deliberate choice as to what and to whom to include under these statutes and did not in any of these instances cover health plan workforces or require health plans to apply these protections downstream.

Moreover, even if the statutes were not unambiguous, HHS' interpretation would not be awarded deference as this expansion would be "arbitrary, capricious, or manifestly contrary to the statute".[10]

We discuss Weldon, Coats-Snowe, and the Church Amendments below:

Weldon Amendment (§88.3(c))

The Weldon Amendment prohibits governmental agencies that receive federal funds from discriminating against a health care entity that does not provide, pay for, provide coverage of, or refer for abortions.[11] As a consequence, a governmental agency that discriminates against a health care entity for its failure to provide, pay for, or refer for abortions will presumably lose the federal funds provided under an Act that includes the Weldon Amendment.

The Weldon Amendment defines the term "health care entity" to "include[ ] an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan."[12] The proposed rule interprets the statutory definition of "health care entity" to include health insurance issuers and health plans, including the sponsors of health plans.[13] AHIP agrees that the Weldon Amendment, by its terms, protects health maintenance organizations and health insurance plans. Although the Amendment does not define "health insurance plan," we believe it is reasonable to interpret the term to include issuers of health insurance coverage, so that health plans are protected against discrimination by governmental agencies funded under an appropriation that includes the Weldon Amendment.

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[8] *See Chevron v. Natural Resources Defense Council*, 467 U.S. 837 (1984).
[9] *United States v. Vonn*, 535 U.S. 55, 65 (2002).
[10] *Chevron* at 845.
[11] Weldon Amendment, Consolidated Appropriations Act, 2009, Pub. L. No. 111-117, 123 Stat 3034, section 508.
[12] *Id*., section 508(d)(2).
[13] 83 Fed. Reg. 3880, 3890.

We disagree, however, with HHS' conclusion that "Because the Weldon Amendment protects not only the health insurance issuer, but also the health plan itself, [an objection] can also be raised, at minimum, by the plan sponsor on behalf of the plan, as well as by the issuer."[14] Nothing in the plain text of the Weldon Amendment suggests that employers that are not already health care entities (such as a hospital) are protected by the Amendment.[15] Had Congress intended all private entities that have any connection to "health care" to be protected under the Weldon Amendment, it could and would have said so.[16]

The Weldon Amendment regulates governmental agency behavior only. Because HHS does not have the authority to impose additional obligations on entities by virtue of the Weldon Amendment, we recommend that the rule be revised to delete Section 88.3(c) and any other obligation imposed on health care entities included in the rule as a result of the misapplication of the Weldon Amendment, including but not limited to the requirement to provide an assurance of compliance with the Weldon Amendment, a certification of compliance with the Weldon Amendment, the incorporation of such assurances in future applications, the requirement to comply with the Weldon Amendment, and any notice requirements that HHS imposed on health care entities as a result of the Weldon Amendment.

Church Amendments (§88.3(a))

Section 88.3 of the proposed rule impermissibly extends the Church Amendments to "any individual" when the context of the Church Amendments clearly limits the scope to physicians and other health care providers, as well as medical researchers.[17]

The proposed rule provides, in relevant part, that:

> (v) Any entity that carries out any part of any health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services is required to comply with paragraph (a)(2)(vi) of this section and §§ 88.4, 88.5, and 88.6 of this part.[18]

The proposed rule defines "health service program" to include:

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[14] *Id.* at 3890.

[15] As HHS itself has recognized in the context of HIPAA, "The group health plan is considered to be a separate legal entity from the employer or other parties that sponsor the group health plan." *See* https://www.hhs.gov/hipaa/for-professionals/faq/499/am-i-a-covered-entity-under-hipaa/index.html.

[16] *Connecticut Nat'l Bank v. Germain*, 503 U.S. 249 (1992) (when interpreting a statute, one should presume that a legislature says what it means and means what it says).

[17] The Church Amendments provide, in relevant part, that

> No individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions. 42 USC 300a-7(d).

[18] 83 Fed. Reg. 3880, 3925 (proposed to be codified at 45 C.F.R. 88.3(a)(1)(v)).

> "any plan or program that provides health benefits, whether directly, through insurance, or otherwise, and is funded, in whole or part, by the Department. It may also include components of State or local programs."[19]

In contrast, the proposed rule would extend this nondiscrimination prohibition to "any individual" and "any part" of "any plan or program that provides health benefits" which is funded in whole or part by HHS. The proposed rule would prohibit any health plan or program that receives funds from HHS from requiring "any individual to perform or assist in the performance of *any part of a health service program* or research activity if such performance or assistance would be contrary to the individual's religious beliefs or moral convictions."[20]

Coats-Snowe Amendment (§88.3(b))

Similar to the analysis of the Church Amendments above, the Coats-Snowe Amendment prohibits the Federal government and any State or local government or subdivision that receives federal funds from discriminating against a "health care entity" that does not undergo training to perform abortions, refuses to make arrangements for an abortion, or attends (or attended) a training program that does not (or did not) perform abortions, provide for the training of providing abortions or refer or make arrangements for such training.[21] Coats-Snowe defines the term "health care entity" to include an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions.[22]

The proposed rule extends the protections of Coats-Snowe to "any individual or institutional health care entity"[23] which is a substantially broader application than the protections provided for under Coats-Snowe.

[19] *Id*. at 3924 (proposed to be codified at 45 C.F.R. 88.2).
[20] *Id*. at 3925 (proposed 45 C.F.R. 88.3(a)(2)(vi)) (emphasis added).
[21] 42 U.S.C. 238n.
[22] 42 U.S.C. 238n(c)(2).
[23] 83 Fed. Reg. 3880, 3925 (proposed 45 C.F.R. 88.3(b)(2)).