IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

WHEATON COLLEGE, *Plaintiff*, v. KATHLEEN SEBELIUS, Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMANSERVICES; THOMAS PEREZ, Secretary of the United States Department of Labor; UNITED STATES DEPARTMENT OF LABOR; JACOB LEW, Secretary of the United States Department of the Treasury; and UNITED STATES DEPARTMENT OF THE TREASURY, *Defendants*.	Civ. Action No. _____ Jury Demanded

COMPLAINT

Comes now Plaintiff, Wheaton College, by and thr**o**ugh its attorneys, and states as follows:

NATURE OF THE ACTION

1. This is a challenge to regulations issued under the 2010 "Affordable Care Act" that force employee and student health insurance plans to provide free coverage of contraceptives, sterilizations, and drugs and devices that cause early abortions (the "Final Mandate").

2. Plaintiff, Wheaton College ("Wheaton"), is a Christian liberal arts college located in Wheaton, Illinois. Wheaton's religious beliefs forbid it from participating in, providing access to, paying for, designating others to pay for, training others to engage in, or otherwise supporting abortion. Wheaton is among the many American religious organizations that hold these beliefs.

3. In light of these religious beliefs, Wheaton cannot participate in the government's regulatory scheme to promote, encourage, and subsidize the use of drugs and devices that cause abortions. Under the Final Mandate, however, Wheaton faces millions of dollars in fines for this religious exercise.

4. Defendants have exempted thousands of plans, covering tens of millions of employees, from the Final Mandate. These exemptions have been granted for a wide variety of reasons, from the purely secular exemption for plans in existence before a certain date ("grandfathered plans") to a narrow religious exemption for certain "religious employers."

5. Despite its obvious religious nature, Wheaton does not qualify for any exemptions. While "religious employers" are exempted, Defendants have limited that exemption to protect only "churches, their integrated auxiliaries, and conventions or associations of churches" and "the exclusively religious activities of any religious order." That is because, in the eyes of the government, Wheaton's work educating students "For Christ and His Kingdom" is not an "exclusively religious activity."

6. The regulations do offer Wheaton and other non-exempt religious organizations what Defendants have labeled an "accommodation." But the "accommodation" still requires Wheaton to play a central role in the government's scheme, because it must designate an agent to pay for the objectionable services on Wheaton's behalf, and it has to take steps to trigger and

facilitate that coverage. Wheaton cannot take these actions to facilitate this coverage without violating its religious beliefs.

7. The supposed "accommodation" also continues to treat Wheaton as a second-class religious organization, not entitled to the same religious freedom rights as other religious organizations, including any religious schools that are "integrated auxiliaries" of churches.

8. The "accommodation" also creates administrative hurdles and other difficulties for Wheaton, forcing it to seek out and contract with companies willing to provide the very drugs and services it speaks out against.

9. If Wheaton does not compromise its religious convictions and comply with the regulations, however, it faces severe penalties that could exceed $25.7 million each year.

10. By placing Wheaton in this impossible position, Defendants have violated the Religious Freedom Restoration Act, as well as the Free Exercise, Establishment, and Free Speech Clauses of the First Amendment of the United States Constitution, The Due Process Clause of the Fifth Amendment, and the Administrative Procedure Act.

11. Wheaton therefore respectfully requests declaratory and permanent injunctive relief.

JURISDICTION AND VENUE

12. The Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1331 and § 1361. This action arises under the Constitution and laws of the United States. This Court has jurisdiction to render declaratory and injunctive relief under 28 U.S.C. §§ 2201 and 2202, and 42 U.S.C. § 2000bb-1.

13. Venue lies in this district pursuant to 28 U.S.C. § 1391(e). A substantial part of the events or omissions giving rise to the claim occurred in this district, and Plaintiff resides in this district.

IDENTIFICATION OF PARTIES

14. Plaintiff Wheaton College is a liberal arts college in Wheaton, Illinois. Founded in 1860 by abolitionist Jonathan Blanchard, Wheaton's mission is to "serve[] Jesus Christ and advance[] his kingdom through excellence in liberal arts and graduate programs that educate the whole person to build the church and benefit society worldwide." Wheaton's motto is "For Christ and His Kingdom."

15. Defendants are appointed officials of the United States government and the United States governmental agencies responsible for issuing the Mandate.

16. Defendant Kathleen Sebelius is the Secretary of the United States Department of Health and Human Services ("HHS"). In this capacity, she has responsibility for the operation and management of HHS. Sebelius is sued in her official capacity only.

17. Defendant HHS is an executive agency of the United States government and is responsible for the promulgation, administration, and enforcement of the Mandate.

18. Defendant Thomas Perez is the Secretary of the United States Department of Labor. In this capacity, he has responsibility for the operation and management of the Department of Labor. Perez is sued in his official capacity only.

19. Defendant Department of Labor is an executive agency of the United States government and is responsible for the promulgation, administration, and enforcement of the Mandate.

20. Defendant Jacob Lew is the Secretary of the Department of the Treasury. In this capacity, he has responsibility for the operation and management of the Department of the Treasury. Lew is sued in his official capacity only.

21. Defendant Department of Treasury is an executive agency of the United States government and is responsible for the promulgation, administration, and enforcement of the Mandate.

FACTUAL ALLEGATIONS

I. Wheaton's Religious Beliefs and Practices Related to Insurance for Abortion

22. Wheaton is a liberal arts college located in Wheaton, Illinois. It was founded in 1860 by abolitionist Jonathan Blanchard.

23. Today, Wheaton "is an institution of higher learning, a rigorous academic community that takes seriously the life of the mind." See http://www.wheaton.edu/About-Wheaton/Community-Covenant. Wheaton offers 59 undergraduate degree programs and 22 graduate degree programs, including five doctoral programs.

24. Faith is central to the education mission of Wheaton. Wheaton aspires "to live, work, serve, and worship together as an educational community centered around the Lord Jesus Christ." Wheaton College, Community Covenant, http://www.wheaton.edu/about-wheaton/community-covenant.

25. Wheaton's purpose is expressed in its mission statement: "Wheaton College serves Jesus Christ and advances his kingdom through excellence in liberal arts and graduate programs that educate the whole person to build the church and benefit society worldwide."

26. Wheaton's motto is "For Christ and His Kingdom."

27. In order to further its mission, Wheaton has a longstanding conviction that appropriate "institutional standards" help to "foster the kind of campus atmosphere most

conductive to becoming the Christian community of living, learning, and serving that Wheaton College aspires to be."

28. Each year, all Wheaton students and full-time employees voluntarily commit themselves to this community by signing Wheaton's Community Covenant.

29. In addition to signing the Community Covenant, Wheaton's Board of Trustees, faculty, and staff annually reaffirm Wheaton's doctrinal statement, which provides a summary of biblical doctrine that is consonant with Evangelical Christianity. See http://www.wheaton.edu/About-Wheaton/Statement-of-Faith-and-Educational-Purpose.

30. Wheaton's Community Covenant recognizes that Scripture condemns the taking of innocent life. (Wheaton College, Community Covenant, http://www.wheaton.edu/about-wheaton/community-covenant.)

31. Wheaton holds religious beliefs that include traditional Christian teachings on the sanctity of life. Wheaton believes and teaches that each human being bears the image and likeness of God, and therefore that all human life is sacred and precious, from the moment of conception. Wheaton therefore believes and teaches that abortion ends a human life and is a sin.

32. Wheaton is registered as a tax-exempt organization under 26 U.S.C. § 501(c)(3).

33. Wheaton is not a church, an integrated auxiliary of a church, or a convention or association of churches as defined by 26 U.S.C. § 6033(a)(3)(A)(i).

34. Wheaton is not a religious order as defined by 26 U.S.C. § 6033(a)(3)(A)(iii).

35. Wheaton is not a church or a convention or association of churches as defined by 26 U.S.C. § 414(e).

36. Wheaton has about 2,400 undergraduate and 600 graduate students.

37. Wheaton has about 709 full-time and 161 part-time employees as of December 2, 2013.

38. As part of its religious convictions, Wheaton promotes the well-being and health of its students and employees. This includes provision of generous health services and health insurance for its students and employees.

39. Wheaton's religious beliefs prohibit it from deliberately providing insurance coverage for drugs, procedures, or services inconsistent with its faith, in particular abortion-inducing drugs, abortion procedures, and related services.

40. It is similarly a violation of Wheaton's religious beliefs to deliberately provide health insurance that would facilitate access to abortion-causing drugs, abortion procedures, and related services, even if those items were paid for by an insurer or a plan administrator and not by Wheaton.

41. Wheaton has no religious objection to providing coverage for contraceptive drugs and devices that prevent conception (as opposed to interfering with the continued survival of a human embryo).

42. Wheaton's employees and students choose to work at or attend Wheaton because they share its religious beliefs and wish to help Wheaton further its mission. Wheaton would violate their implicit trust in the organization and detrimentally alter its relationship with them if it were to violate its religious beliefs regarding abortion.

43. Wheaton has expended significant resources working with its insurers and plan administrators to ensure that its health insurance policies reflect Wheaton's religious beliefs.

44. On September 27, 2011, Wheaton submitted public comments on the Interim Final Rule on Preventative Services published on August 3, 2011 (76 Fed. Reg. 46621).[1] Wheaton's comments expressed its concern that the interim final rule failed to recognize it as a religious employer and that the rule violates Wheaton's rights of conscience.

45. On June 19, 2012, Wheaton submitted public comments on the Advance Notice of Proposed Rulemaking on Preventative Services published on March 21, 2012 (77 Fed. Reg. 16501). Wheaton's comments reiterated its concerns about the interim final rule, particularly Defendants' refusal to provide it and similar religious employers with the same exemption afforded to churches.

46. The plan year for Wheaton's employee insurance plans began on July 1, 2013 and a new plan year will begin on July 1, 2014.

47. Wheaton made certain changes to its employee insurance plans effective April 1, 2012, that render Wheaton healthcare plans ineligible for grandfathered status. *See* 45 C.F.R. § 147.140(a)(1)(i), 26 C.F.R. § 54.9815-1251T(a)(1)(i); 29 C.F.R. § 2590.715-1251(a)(1)(i). In particular, Wheaton removed coverage for prescription drugs from two of its employee insurance plans and created new drug benefit plans for employees. None of these plans are grandfathered.

II. The Affordable Care Act and Preventive Care Mandate

48. In March 2010, Congress passed, and President Obama signed into law, the Patient Protection and Affordable Care Act, Pub. L. 111-148 (March 23, 2010), and the Health Care and Education Reconciliation Act, Pub. L. 111-152 (March 30, 2010), collectively known as the "Affordable Care Act."

[1] Letter from President Philip G. Ryken, President, Wheaton College, to IRS Commissioner Douglas H. Shulman (Sept. 27, 2011), available at http://www.regulations.gov/#!documentDetail;D=IRS-2010-0017-0975.

49. The Affordable Care Act regulates the national health insurance market by directly regulating "group health plans" and "health insurance issuers."

50. One provision of the Act mandates that any "group health plan" or "health insurance issuer offering group or individual health insurance coverage" must provide coverage for certain preventive care services. 42 U.S.C. § 300gg-13(a).

51. The services required to be covered include medications, screenings, and counseling given an "A" or "B" rating by the United States Preventive Services Task Force;[2] immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and "preventive care and screenings" specific to infants, children, adolescents, and women, as to be "provided for in comprehensive guidelines supported by the Health Resources and Services Administration." 42 U.S.C. § 300gg-13(a)(1)-(4).

52. The statute specifies that all of these services must be provided without "any cost sharing." 42 U.S.C. § 300gg-13(a).

[2] The list of services that currently have an "A" or "B" rating include medications like aspirin for preventing cardiovascular disease, vitamin D, and folic acid; screenings for a wide range of conditions such as depression, certain cancers and sexually-transmitted diseases, intimate partner violence, obesity, and osteoporosis; and various counseling services, including for breastfeeding, sexually-transmitted diseases, smoking, obesity, healthy dieting, cancer, and so forth. *See* U.S. Preventive Services Task Force, USPSTF A and B Recommendations, http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm (last visited Dec. 2, 2013) (Ex. A); *see also* 75 Fed. Reg. 41726, 41740 (2010).

The Interim Final Rule

53. On July 19, 2010, HHS[3] published an interim final rule promulgating directives concerning the Affordable Care Act's requirement for coverage of preventive services without cost sharing. 75 Fed. Reg. 41726, 41728 (2010).

54. The interim final rule was enacted without prior notice of rulemaking or opportunity for public comment, because Defendants determined for themselves that "it would be impracticable and contrary to the public interest to delay putting the provisions . . . in place until a full public notice and comment process was completed." 75 Fed. Reg. at 41730.

55. Although Defendants suggested in the Interim Final Rule that they would solicit public comments after implementation, they stressed that "provisions of the Affordable Care Act protect significant rights" and therefore it was expedient that "participants, beneficiaries, insureds, plan sponsors, and issuers have certainty about their rights and responsibilities." *Id*.

56. Defendants stated they would later "provide the public with an opportunity for comment, but without delaying the effective date of the regulations," demonstrating their intent to impose the regulations regardless of the legal flaws or general opposition that might be manifest in public comments. *Id*.

57. In addition to reiterating the Affordable Care Act's preventive services coverage requirements, the Interim Final Rule provided further guidance concerning the Act's restriction on cost sharing.

58. The Interim Final Rule made clear that "cost sharing" refers to "out-of-pocket" expenses for plan participants and beneficiaries. 75 Fed. Reg. at 41730.

[3] For ease of reading, references to "HHS" in this Complaint refer to all Defendants, unless context indicates otherwise.

59. The Interim Final Rule acknowledged that, without cost sharing, expenses "previously paid out-of-pocket" would "now be covered by group health plans and issuers" and that those expenses would, in turn, result in "higher average premiums for all enrollees." *Id.*; *see also id*. at 41737 ("Such a transfer of costs could be expected to lead to an increase in premiums.").

60. In other words, the prohibition on cost-sharing was simply a way "to distribute the cost of preventive services more equitably across the broad insured population." 75 Fed. Reg. at 41730.

61. After the Interim Final Rule was issued, numerous commenters warned against the potential conscience implications of requiring religious individuals and organizations to include certain kinds of services—specifically contraception, sterilization, and abortion services—in their health care plans.

62. HHS directed a private health policy organization, the Institute of Medicine (IOM), to make recommendations regarding which drugs, procedures, and services should be considered in comprehensive guidelines for preventive care for women.

63. IOM was not tasked with making insurance coverage recommendations and explicitly excluded cost considerations and other considerations relevant to coverage recommendations from its determinations regarding effective preventive care for women.

64. In developing its guidelines, IOM invited a select number of groups to make presentations on the preventive care that should be mandated by all health plans. These were the Guttmacher Institute, the American Congress of Obstetricians and Gynecologists (ACOG), John Santelli, the National Women's Law Center, National Women's Health Network, Planned Parenthood Federation of America, and Sara Rosenbaum.

65. No religious groups or other groups that opposed government-mandated coverage of contraception, sterilization, abortion, and related education and counseling were among the invited presenters.

66. On July 19, 2011, the IOM published its preventive care guidelines for women, including a recommendation that preventive services include all "Food and Drug Administration approved contraceptive methods [and] sterilization procedures." Institute of Medicine, *Clinical Preventive Services for Women: Closing the Gaps*, at 102-10 and Recommendation 5.5 (2011).

67. FDA-approved contraceptive methods include birth-control pills; prescription contraceptive devices such as IUDs; Plan B (also known as the "morning-after pill"); ulipristal (also known as "ella" or the "week-after pill"); and other drugs, devices, and procedures.

68. Some of these drugs and devices—including the "emergency contraceptives" Plan B, ella, and certain IUDs—are known abortifacients, in that they can cause the death of an embryo by preventing it from implanting in the wall of the uterus.

69. Indeed, the FDA's own Birth Control guide states that both Plan B and ella can work by "preventing attachment (implantation) to the womb (uterus)."[4]

70. Although it mentioned emergency contraceptives in passing, the IOM Report included no separate analysis of known abortifacients like Plan B and ella. *See generally* Institute of Medicine, *Clinical Preventive Services for Women: Closing the Gaps*, at 102-10 and Recommendation 5.5 (2011).

71. The conditions under which the IOM Report was prepared prompted one member of the drafting committee to file a dissent, in which he stated that "the committee process for evaluation of the evidence lacked transparency and was largely subject to the preferences of the

[4] FDA, Birth Control: Medicines to Help You, http://www.fda.gov/ForConsumers/ByAudience/ForWomen/FreePublications/ucm313215.htm (last visited Dec. 2, 2013) (Ex. B).

committee's composition. Troublingly, the process tended to result in a mix of objective and subjective determinations filtered through a lens of advocacy." *Institute of Medicine, Clinical Preventive Services for Women: Closing the Gaps,* at 232-233 (2011). The dissent deemed the evidence evaluation process a "fatal flaw" and concluded that "the committee erred [in] their zeal to recommend something despite the time constraints and a far from perfect methodology" and "failed to demonstrate [transparency and strict objectivity] in the Report." *Id.*

72. On August 1, 2011, thirteen days after IOM issued its recommendations, HHS's Health Resources and Services Administration ("HRSA") issued guidelines adopting them in full.[5]

The "Religious Employers" Exemption

73. That same day, HHS promulgated an additional Interim Final Rule. 76 Fed. Reg. 46621 (published Aug. 3, 2011).

74. This Second Interim Final Rule granted HRSA "*discretion* to exempt certain religious employers from the Guidelines where contraceptive services are concerned." 76 Fed. Reg. 46621, 46623 (emphasis added). The term "religious employer" was restrictively defined as one that (1) has as its purpose the "inculcation of religious values"; (2) "primarily employs persons who share the religious tenets of the organization"; (3) "serves primarily persons who share the religious tenets of the organization"; and (4) "is a nonprofit organization as described in section 6033(a)(1) and section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended." 76 Fed. Reg. at 46626.

[5] HRSA, Women's Preventive Services Guidelines, http://www.hrsa.gov/ womensguidelines (last visited Dec. 2, 2013) (Ex. C).

75. The fourth of these requirements refers to "churches, their integrated auxiliaries, and conventions or associations of churches" and the "exclusively religious activities of any religious order." 26 U.S.C.A. § 6033.

76. Thus, the "religious employers" exemption was severely limited to formal churches, their integrated auxiliaries, and religious orders whose purpose is to inculcate faith and that hire and serve primarily people of their own faith tradition.

77. HRSA exercised its discretion to grant an exemption for religious employers via a footnote on its website listing the Women's Preventive Services Guidelines. The footnote states that "guidelines concerning contraceptive methods and counseling described above do not apply to women who are participants or beneficiaries in group health plans sponsored by religious employers."[6]

78. Although religious organizations like Wheaton share the same religious beliefs and concerns as objecting churches, their integrated auxiliaries, and objecting religious orders, HHS deliberately ignored the regulation's impact on their religious liberty, stating that the exemption sought only "to provide for a religious accommodation that respects the unique relationship between a house of worship and its employees in ministerial positions." 76 Fed. Reg. at 46623.

79. Thus, thousands of religious organizations that cannot comply with the mandate for religious reasons were excluded from the "religious employers" exemption.

80. Like the original Interim Final Rule, the Second Interim Final Rule was made effective immediately, without prior notice or opportunity for public comment.

[6] HRSA, Women's Preventive Services Guidelines, http://www.hrsa.gov/ womensguidelines (Ex. C).

81. Defendants acknowledged that "while a general notice of proposed rulemaking and an opportunity for public comment is generally required before promulgation of regulations," they had "good cause" to conclude that public comment was "impracticable, unnecessary, or contrary to the public interest" in this instance. 76 Fed. Reg. at 46624.

82. Upon information and belief, after the Second Interim Final Rule was put into effect, over 100,000 comments were submitted opposing the narrow scope of the "religious employers" exemption and protesting the contraception mandate's gross infringement on the rights of religious individuals and organizations.

83. HHS did not take into account the concerns of religious organizations in the comments submitted before the Second Interim Rule was issued.

84. Instead the Second Interim Rule was unresponsive to the concerns, including claims of statutory and constitutional conscience rights, stated in the comments submitted by religious organizations.

The Safe Harbor

85. The public outcry for a broader religious employer exemption continued for many months and, on January 20, 2012, HHS issued a press release acknowledging "the important concerns some have raised about religious liberty" and stating that religious objectors would be "provided an additional year . . . to comply with the new law."[7]

86. On February 10, 2012, HHS formally announced a "safe harbor" for non-exempt nonprofit religious organizations that objected to the Mandate. *See* HHS Center for Consumer Information and Insurance Oversight, Guidance on the Temporary Enforcement Safe Harbor for Certain Employers (Feb. 10, 2012); *see also* HHS Center for Consumer Information and

[7] Press Release, A Statement by U.S. Department of Health and Human Services Secretary Kathleen Sebelius (Jan. 20, 2012), http://www.hhs.gov/news/press /2012pres/01/20120120a.html (Ex. D).

Insurance Oversight, Guidance on the Temporary Enforcement Safe Harbor for Certain Employers (Aug. 15, 2012) (changing the safe harbor eligibility criteria).

87. Under the safe harbor, HHS agreed it would not take any enforcement action against an eligible organization during the safe harbor, which would remain in effect until the first plan year beginning on or after August 1, 2013. HHS later extended the safe harbor to the first plan year beginning on or after January 1, 2014. HHS Center for Consumer Information and Insurance Oversight, Guidance on the Temporary Enforcement Safe Harbor for Certain Employers (June 28, 2013).

88. HHS also indicated it would develop and propose changes to the regulations to accommodate the objections of non-exempt, nonprofit religious organizations following August 1, 2013.

89. Despite the safe harbor and HHS's accompanying promises, on February 15, 2012, HHS published a final rule "finaliz[ing], without change," the contraception and abortifacient mandate and narrow religious employers exemption. 77 Fed. Reg. 8725-01 (published Feb. 15, 2012).

The Advance Notice of Proposed Rulemaking

90. On March 21, 2012, HHS issued an Advance Notice of Proposed Rulemaking (ANPRM), presenting "questions and ideas" to "help shape" a discussion of how to "maintain the provision of contraceptive coverage without cost sharing," while accommodating the religious beliefs of non-exempt religious organizations. 77 Fed. Reg. 16501, 16503 (2012).

91. The ANPRM conceded that forcing religious organizations to "contract, *arrange*, or pay for" the objectionable contraceptive and abortifacient servicers would infringe their "religious liberty interests." *Id*. (emphasis added).

92. In vague terms, the ANPRM proposed that the "health insurance issuers" for objecting religious employers could be required to "assume the responsibility for the provision of contraceptive coverage without cost sharing." *Id.*

93. For self-insured plans, the ANPRM suggested that third party plan administrators "assume this responsibility." *Id.*

94. For the first time, and contrary to the earlier definition of "cost sharing," Defendants suggested in the ANPRM that insurers and third party administrators could be prohibited from passing along their costs to the objecting religious organizations via increased premiums. *See id.*

95. "[A]pproximately 200,000 comments" were submitted in response to the ANPRM. 78 Fed. Reg. 8456, 8459 (published February 6, 2013). Many of these comments reiterated previous comments that the ANPRM's proposals would not resolve conscientious objections, because the objecting religious organizations, by providing a health care plan in the first instance, would still be coerced to arrange for and facilitate access to religiously-objectionable drugs and services.

The Notice of Proposed Rulemaking

96. On February 1, 2013, HHS issued a Notice of Proposed Rulemaking (NPRM) purportedly addressing the comments submitted in response to the ANPRM. 78 Fed. Reg. 8456.

97. The NPRM proposed two changes to the then-existing regulations. 78 Fed. Reg. 8456, 8458-59.

98. First, it proposed revising the religious employers exemption by eliminating the requirements that religious employers have the purpose of inculcating religious values and primarily employ and serve only persons of their same faith. 78 Fed. Reg. at 8461

99. Under this proposal a "religious employer" would be one "that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or [](iii) of the Internal Revenue Code." 78 Fed. Reg. at 8474.

100. HHS emphasized, however, that this proposal "would not expand the universe of employer plans that would qualify for the exemption beyond that which was intended in the 2012 final rules." 78 Fed. Reg. at 8461.

101. In other words, religious organizations like Wheaton that are not formal churches would continue to be excluded from the exemption.

102. Second, the NPRM reiterated HHS's intention to "accommodate" non-exempt, nonprofit religious organizations by making them "designate" their insurers to provide plan participants and beneficiaries with free access to contraceptive and abortifacient drugs and services.

103. The proposed "accommodation" did not resolve the concerns of religious organizations like Wheaton because it continued to force them to deliberately provide health insurance and take actions that would trigger access to religiously-objectionable drugs and related education and counseling.

104. In issuing the NPRM, HHS requested comments from the public by April 8, 2013. 78 Fed. Reg. at 8457.

105. "[O]ver 400,000 comments" were submitted in response to the NPRM, 78 Fed. Reg. 39870, 39871 (published July 2, 2013), with religious organizations again overwhelmingly decrying the proposed accommodation as a gross violation of their religious liberty because it would conscript their health care plans as the main cog in the government's scheme for expanding access to contraceptive and abortifacient services.

106. Wheaton submitted comments on the NPRM, stating essentially the same objections stated in this complaint.[8]

107. On April 8, 2013, the same day the notice-and-comment period ended, Defendant Secretary Sebelius answered questions about the contraceptive and abortifacient services requirement in a presentation at Harvard University.

108. In her remarks, Secretary Sebelius stated:

> We have just completed the open comment period for the so-called accommodation, and by August 1st of this year, every employer will be covered by the law with one exception. Churches and church dioceses as employers are exempted from this benefit. But Catholic hospitals, Catholic universities, other religious entities *will be providing coverage* to their employees starting August 1st. . . . [A]s of August 1st, 2013, every employee who doesn't work directly for a church or a diocese *will be included* in the benefit package.[9]

109. It is clear from the timing of these remarks that Defendants gave no consideration to the comments submitted in response to the NPRM's proposed "accommodation." It is also clear that the Secretary recognizes that even under the accommodation, "religious entities" like Wheaton "will be providing coverage" for the drugs required by the Mandate.

The Final Mandate

110. On June 28, 2013, Defendants issued a final rule (the "Final Mandate"), which ignores the objections repeatedly raised by religious organizations and continues to co-opt objecting religious employers into the government's scheme of expanding free access to contraceptive and abortifacient services. 78 Fed. Reg. 39870.

[8] Letter from President Philip G. Ryken, President, Wheaton College, to HHS Secretary Kathleen Sebelius (April 8, 2013) (Ex. E).

[9] The Forum at Harvard School of Public Health, A Conversation with Kathleen Sebelius, U.S. Secretary of Health and Human Services, Apr. 8, 2013, http://theforum.sph.harvard.edu/events/conversation-kathleen-sebelius (last visited Dec. 2, 2013) (from 51:20 to 53:56) (emphases added) . A permanent link to the relevant section of Sec. Sebelius' remarks is available here: http://www.youtube.com/watch?v=py6aSwQl-2g&feature=youtu.be (last visited Dec. 2, 2013).

111. Under the Final Mandate, the discretionary "religious employers" exemption, which is still implemented via footnote on the HRSA website, Ex. C, remains limited to formal churches and religious orders "organized and operate[d]" as nonprofit entities and "referred to in section 6033(a)(3)(A)(i) or (iii) of the [Internal Revenue] Code." 78 Fed. Reg. at 39874.

112. All other religious organizations, including Wheaton, are excluded from the exemption.

113. The Final Mandate creates a separate "accommodation" for certain non-exempt religious organizations. 78 Fed. Reg. at 39874.

114. An organization is eligible for the accommodation if it (1) "[o]pposes providing coverage for some or all of the contraceptive services required"; (2) "is organized and operates as a nonprofit entity"; (3) "holds itself out as a religious organization"; and (4) "self-certifies that it satisfies the first three criteria." 78 Fed. Reg. at 39874.

115. The self-certification must be executed "prior to the beginning of the first plan year to which an accommodation is to apply." 78 Fed. Reg. at 39875.

116. The Final Rule extends the current safe harbor through the end of 2013. 78 Fed. Reg. at 39889; *see also* HHS Center for Consumer Information and Insurance Oversight, Guidance on the Temporary Enforcement Safe Harbor for Certain Employers (June 28, 2013) (extending the safe harbor to the first plan year that begins on or after January 1, 2014).

117. Thus, an eligible organization would need to execute the self-certification prior to its first plan year that begins on or after January 1, 2014, and deliver it to the organization's insurer or, if the organization has a self-insured plan, to the plan's third party administrator. 78 Fed. Reg. at 39875.

118. By the terms of the accommodation, Wheaton will be required to execute the self-certification and deliver it to its insurers and plan administrators before July 1, 2014.

119. By delivering its self-certification to its insurers and third-party administrators, Wheaton would trigger their obligations to "provide[] payments for contraceptive services," including abortion-causing contraceptives like Plan B and Ella. 78 Fed. Reg. at 39876 (insurers) *see also id.* at 39879 (third party administrators).

120. In the case of its self-insured plan, Wheaton's self-certification acts as "a designation of the third party administrator(s) as plan administrator and claims administrator for contraceptive benefits pursuant to section 3(16) of ERISA." 78 Fed. Reg. at 39879.

121. The administrator or insurer would be required to "provide payments for contraceptive services for plan participants and beneficiaries." 78 Fed. Reg. at 39876 (insurers); *see also id.* at 39879 (third-party administrators).

122. In order for this obligation to be effective, Wheaton would have to identify its employees to the insurer or third-party administrator for the distinct purpose of enabling the government's scheme to facilitate free access to contraceptive and abortifacient services.

123. The insurer's obligation to make direct payments for contraceptive and abortion services would continue only "for so long as the participant or beneficiary remains enrolled in the plan." 78 Fed. Reg. at 39876.

124. Thus Wheaton would have to coordinate with its insurer or third-party administrator regarding when it was adding or removing employees and beneficiaries from its healthcare plan and, as a result, from the abortifacient services payment scheme.

125. Insurers and third-party administrators would be required to notify plan participants and beneficiaries of the contraceptive payment benefit "contemporaneous with (to

the extent possible), but separate from, any application materials distributed in connection with enrollment (or re-enrollment) in coverage . . . ." 78 Fed. Reg. at 39880 (third-party administrators); *see also id.* at 39876 (insurers).

126. This would also require Wheaton to coordinate the notices with its insurers and administrators.

127. Thus, even under the accommodation, Wheaton and every other non-exempt objecting religious organization would continue to play a central role in facilitating free access to abortifacient drugs.

128. The insurer would be required to provide the contraceptive benefits "in a manner consistent" with the provision of other covered services. 78 Fed. Reg. at 39876-77.

129. Thus, any payment or coverage disputes presumably would be resolved under the terms of Wheaton's existing plan documents.

130. Under the accommodation, group health insurance issuers "may not impose any cost-sharing requirements (such as a copayment, coinsurance, or a deductible), *or impose any premium, fee, or other charge, or any portion thereof, directly or indirectly*, on the eligible organization." 78 Fed. Reg. at 39896 (emphasis added).

131. For all other preventive services, including non-contraceptive preventive services for women, only cost-sharing (*i.e.*, out-of-pocket expense) is prohibited. There is no restriction on passing along costs via premiums or other charges.

132. Defendants state that they "continue to believe, and have evidence to support," that providing payments for contraceptive and abortifacient services will be "cost neutral for issuers," because "[s]everal studies have estimated that the costs of providing contraceptive

coverage are balanced by cost savings from lower pregnancy-related costs and from improvements in women's health." 78 Fed. Reg. at 39877.

133. On information and belief, the studies Defendants rely upon to support this claim are severely flawed.

134. Nevertheless, even if the payments were—over time—to become cost neutral, it is undisputed that there will be up-front costs for making the payments. *See, e.g.,* 78 Fed. Reg. at 39877-78, 39880 (addressing ways insurers and administrators can cover up-front costs).

135. Moreover, if cost savings arise that make insuring an employer's employees cheaper, the savings would have to be passed on to employers through reduced premiums, not retained by insurance issuers.

136. HHS suggests that, to maintain cost neutrality, issuers may simply ignore this fact and "set the premium for an eligible organization's large group policy as if no payments for contraceptive services had been provided to plan participants." 78 Fed. Reg. at 39877.

137. This encourages issuers to artificially inflate the eligible organization's premiums.

138. Under this methodology—even assuming its legality—the eligible organization would still bear the cost of the required payments for contraceptive, sterilization, and abortifacient services in violation of its conscience, as if the accommodation had never been made.

139. Defendants have suggested that "[a]nother option" would be to "treat the cost of payments for contraceptive services . . . as an administrative cost that is spread across the issuer's entire risk pool, excluding plans established or maintained by eligible organizations." 78 Fed. Reg. at 39878.

140. There is no legal authority for forcing third parties to pay for services provided to eligible organizations under the accommodation.

141. Furthermore, under the Affordable Care Act, Defendants lack authority in the first place to coerce insurers to directly purchase contraceptive, sterilization, and abortifacient services for an eligible organization's plan participants and beneficiaries.

142. Thus, the accommodation fails to protect objecting religious organizations for lack of statutory authority.

143. Currently, Wheaton operates a self-insured prescription drug plan administered by Blue Cross Blue Shield of Illinois. Because under the Affordable Care Act Wheaton would be required to identify and designate an administrator willing to administer the abortifacient services, Wheaton's religious beliefs preclude it from complying with the accommodation.

144. For all these reasons, the accommodation does nothing to relieve non-exempt religious organizations—such as Wheaton—from being co-opted as the central cog in the government's scheme to expand access to free abortifacient services.

145. The Final Rule sets forth complex means through which a third party administrator may seek to recover its costs incurred in making payments for contraceptive and abortifacient services.

146. The third party administrator must identify an issuer who participates in the federal exchanges established under the Affordable Care Act and who would be willing to make payments on behalf of the third party administrator.

147. Cooperating issuers would then be authorized to obtain refunds from the user fees they have paid to participate in the federal exchange as a means of being reimbursed for making payments for contraceptive and abortifacient services on behalf of the third party administrator.

148. Issuers would be required to pay a portion of the refund back to the third party administrator to compensate it for any administrative expenses it has incurred.

149. These machinations, ostensibly employed only to shift the *cost* of the Final Mandate, are severely flawed.

150. There is no way to ensure that the cost of administering the contraceptive and abortifacient services would not be passed on to religious organizations through the third party administrator's fees.

151. Moreover, taking the user fees intended for funding the federal exchanges and using them to provide contraceptive and abortifacient services to employees not participating in the federal exchanges would violate the statute authorizing the user fees. *See* 78 Fed. Reg. 15410, 15412 (published March 11, 2013); 31 U.S.C. § 9701.

152. In sum, for non-exempt religious organizations like Wheaton, the accommodation is nothing more than a shell game that attempts to disguise the religious organization's role as the central cog in the government's scheme for expanding access to abortifacient services.

153. Despite the accommodation's convoluted machinations, a religious organization's decision to offer health insurance and its self-certification continue to serve as the sole triggers for creating access to free abortifacient services.

154. Wheaton cannot participate in or facilitate the government's scheme in this manner without violating its religious convictions.

Wheaton's Health Care Plan and Its Religious Objections

155. The plan year for Wheaton's student healthcare plan begins on July 1 of each year.

156. Wheaton's student health care plan consists of an insured plan issued by Companion Life Insurance Company.

157. The Final Mandate declares that the rules concerning contraceptive, sterilization, and abortifacient services will "apply to student health insurance coverage arranged by an eligible organization that is an institution of higher education in a manner comparable to that in which they apply to group health insurance coverage provided in connection with a group health plan established or maintained by an eligible organization that is an employer." 78 Fed. Reg. at 39897.

158. Thus, beginning on or about July 1, 2014, Wheaton faces the choice of either including free coverage for abortifacient services in its student health plan or else forcing its insurance issuer to provide the exact same services.

159. The next plan year for Wheaton's employee healthcare plan begins on July 1, 2014. Wheaton provides three health insurance plans to its full-time employees. Those plans include two HMO plans offered through BlueCross/BlueShield of Illinois and one PPO plan, which is self-funded and administered by BlueCross/BlueShield of Illinois. As a supplement to the HMO plans, Wheaton now offers two self-funded prescription drug plans.

160. Wheaton's self-insured PPO insurance plan has not changed significantly since March 23, 2010, and meets the definition of a "grandfathered" plan. *See* 45 C.F.R. § 147.140(a)(1)(i); 26 C.F.R. § 54.9815-1251T(a)(1)(i); 29 C.F.R. § 2590.715-1251(a)(1)(i).

161. However, Wheaton's insured HMO plans and its self-funded prescription drug plans have changed significantly since March 23, 2010, and due to the changes they have not included the statements regarding grandfathered status required under federal law. Thus, Wheaton's insured HMO healthcare plans do not meet the definition of a "grandfathered" plan.

See 45 C.F.R. § 147.140(a)(1)(i); 26 C.F.R. § 54.9815-1251T(a)(1)(i); 29 C.F.R. § 2590.715-1251(a)(1)(i).

162. Thus, beginning on or about July 1, 2014, Wheaton faces the choice of either including free coverage for abortifacient services in its insured HMO employee health plans and its self-funded prescription drug plans or else designating its administrator to provide the exact same services.

163. Wheaton has no objection to including, and already does include, free coverage for women's preventive services such as mammograms. It also has no conscientious objection to providing access contraceptives that do not inhibit implantation of an embryo, and currently covers those drugs.

164. However, Wheaton's religious convictions forbid it from including free coverage for abortifacient drugs in any of its healthcare plans.

165. Wheaton's religious convictions equally forbid it from hiring or designating its insurer to provide free access to abortifacient drugs.

166. From Wheaton's perspective, there is little difference between forcing its insurance issuer to provide free access to abortifacient drugs and directly providing that access.

167. Wheaton's religious convictions forbid it from participating in any way in the government's scheme to promote and provide free access to abortifacient drugs through Wheaton's health care plans.

168. Wheaton is not eligible for the religious employers exemption because it is not an organization "described in section 6033(a)(1) and section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended." 76 Fed. Reg. at 46626.

169. Because Wheaton is unable to comply with the Final Mandate as a result of its religious beliefs, and because it is unable to force its insurer to carry out the Final Mandate by submitting a self-certification, it faces crippling fines of $100 each day, for "each individual to whom such failure relates." 26 U.S.C. § 4980D(b)(1).

170. Dropping its insurance plans would unfairly and severely burden Wheaton's employees and students, and would place Wheaton at a severe competitive disadvantage in its efforts to recruit and retain employees and students.

171. Wheaton would also face fines of $2000 per year for each of its employees for dropping its insurance plans.

172. Although the government has recently announced that it will postpone implementing the annual fine of $2000 per employee for organizations that drop their insurance altogether, the postponement is only for one year, until 2015. This postponement does not delay the crippling daily fines under 26 U.S.C. § 4980D.

173. Wheaton's Christian faith compels it to promote the spiritual and physical well-being of its students and employees by providing them with generous health services.

174. The Final Mandate forces Wheaton to violate its religious beliefs or incur substantial fines for either excluding objectionable coverage without forcing its insurance issuer to provide the same coverage, or terminating its employee and student health insurance coverage altogether.

175. The Final Mandate forces Wheaton to deliberately provide health insurance that would facilitate free access to abortifacient drugs regardless of the ability of insured persons to obtain these drugs and services from other sources.

176. The Final Mandate forces Wheaton to facilitate government-dictated education and counseling concerning abortion-causing drugs that are incompatible with its religious beliefs and teachings.

177. Facilitating this government-dictated speech is incompatible and irreconcilable with the express speech and messages concerning the sanctity of life that Wheaton seeks to convey.

The Lack of a Compelling Government Interest

178. The government lacks any compelling interest in coercing Wheaton to facilitate access to abortifacient drugs.

179. The required abortifacient drugs are already widely available at non-prohibitive costs.

180. There are multiple ways in which the government could provide access without co-opting religious employers and their insurance plans in violation of their religious beliefs.

181. For example, the government could pay for the objectionable services through its existing network of family planning services funded under Title X, through direct government payments, or through tax deductions, refunds, or credits.

182. The government could also simply exempt all religious organizations, just as it has already exempted nonprofit religious employers referred to in Section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code.

183. HHS claims that its "religious employers" exemption does not undermine its compelling interest in making abortifacient services available for free to women because "houses of worship and their integrated auxiliaries that object to contraceptive coverage on religious grounds are more likely than other employers to employ people who are of the same faith and/or

adhere to the same objection, and who would therefore be less likely than other people to use contraceptive services even if such services were covered under their plan." 78 Fed. Reg. at 39887.

184. Wheaton's employees and students commit to further its mission of serving "Christ and his kingdom," and its students and faculty members voluntarily sign its community covenant, which affirms their shared commitment to "uphold the God-given worth of human beings, from conception to death, as the unique image-bearers of God (Gen. 1:27; Psalm 8:3-8; 139:13-16)."

185. Because of Wheaton's religious obligation under its Community Covenant to proclaim Christian teaching regarding the sanctity of life, the students and employees that have chosen to join the Wheaton community are just as likely as employees of exempt organizations to adhere to the same values, and thus are less likely than other people to use the objectionable drugs.

186. In one form or another, the government also provides exemptions for (1) grandfathered plans, 42 U.S.C. § 18011; 75 Fed. Reg. 41726, 41731 (2010); (2) small employers with fewer than 50 employees, 26 U.S.C. § 4980H(c)(2)(A); and (3) certain religious denominations, 26 U.S.C. § 5000A(d)(2)(a)(i) and (ii) (individual mandate does not apply to members of "recognized religious sect or division" that conscientiously objects to acceptance of public or private insurance funds); 26 U.S.C. § 5000A(d)(2)(b)(ii) (individual mandate does not apply to members of "health care sharing ministry" that meets certain criteria).

187. These broad exemptions further demonstrate that the government has no compelling interest in refusing to include religious organizations like Wheaton within its religious employers exemption.

188. Employers who follow HHS guidelines may continue to use grandfathered plans indefinitely.

189. Indeed, HHS has predicted that a majority of large employers, employing more than 50 million Americans, will continue to use grandfathered plans through at least 2014, and that a third of medium-sized employers with between 50 and 100 employees may do likewise. 75 Fed. Reg. 34538 (published June 17, 2010).[10]

190. According to the administration, 96% of American employers are exempt from the employer mandate because they employ fewer than 50 people.[11]

191. The government's recent decision to postpone the mandatory insurance requirement of the Affordable Care Act—i.e., the annual fine of $2000 per employee for not offering any insurance—also demonstrates that there is no compelling interest in coercing universal compliance with the Final Mandate concerning contraceptive and abortifacient services, since employers can now simply drop their insurance without any penalty, at least for one additional year.

192. These broad exemptions also demonstrate that the Final Mandate is not a generally applicable law entitled to judicial deference, but rather is constitutionally flawed.

193. The government's willingness to exempt various secular organizations and postpone the employer mandate, while adamantly refusing to provide anything but the narrowest

[10] *See also* Centers for Medicare & Medicaid Services, Amendment to Regulation on "Grandfathered" Health Plans under the Affordable Care Act, https://www.cms.gov/CCIIO/Resources/Files/factsheet_grandfather_amendment.html (noting that amendment to regulations "will result in a small increase in the number of plans retaining their grandfathered status relative to the estimates made in the grandfathering regulation") (last visited Dec. 2, 2013) (Ex. F).

[11] WhiteHouse.Gov, The Affordable Care Act Increases Choice and Saving Money for Small Business at 2, http://www.whitehouse.gov/files/documents/ health_reform_for_small_businesses.pdf (Ex. G).

of exemptions for religious organizations also shows that the Final Mandate is not neutral, but rather discriminates against religious organizations because of their religious commitment to promoting the sanctity of life.

194. Indeed, the Final Mandate was promulgated by government officials, and supported by non-governmental organizations, who strongly oppose Wheaton's religious teachings and beliefs regarding marriage and family.

195. Defendant Sebelius, for example, has long been a staunch supporter of abortion rights and a vocal critic of religious teachings and beliefs regarding abortion and contraception.

196. On October 5, 2011, six days after the comment period for the original interim final rule ended, Defendant Sebelius gave a speech at a fundraiser for NARAL Pro-Choice America. She told the assembled crowd that "we are in a war."[12]

197. On July 16, 2013, Secretary Sebelius further compared opponents of the Affordable Care Act generally to people who opposed civil rights legislation in the 1960s, stating that upholding the Act requires the same action as was shown "in the fight against lynching and the fight for desegregation."[13]

198. Consequently, on information and belief, Wheaton alleges that the purpose of the Final Mandate, including the restrictively narrow scope of the religious employers exemption, is to discriminate against religious organizations that oppose abortion.

[12] William McGurn, *The Church of Kathleen Sebelius*, Wall St. J., Dec. 13, 2011, *available at* http://online.wsj.com/news/articles/ SB10001424052970203518404577094631979925326 (Ex. H).

[13] *See* Kathleen Sebelius, Remarks at the 104th NAACP Annual Conference, July 16, 2013, http://www.hhs.gov/secretary/about/speeches/sp20130716.html (Ex. I).

CLAIMS

COUNT I

Violation of the Religious Freedom Restoration Act
Substantial Burden

199. Wheaton incorporates by reference all preceding paragraphs.

200. Wheaton's sincerely held religious beliefs prohibit it from deliberately providing health insurance that would facilitate access to abortifacients, or to related education and counseling. Wheaton's compliance with these beliefs is a religious exercise.

201. The Final Mandate creates government-imposed coercive pressure on Wheaton to change or violate its religious beliefs.

202. The Final Mandate chills Wheaton's religious exercise.

203. The Final Mandate exposes Wheaton to substantial fines for its religious exercise.

204. The Final Mandate exposes Wheaton to substantial competitive disadvantages, in that it will no longer be permitted to offer health insurance.

205. The Final Mandate imposes a substantial burden on Wheaton's religious exercise.

206. The Final Mandate furthers no compelling governmental interest.

207. The Final Mandate is not narrowly tailored to any compelling governmental interest.

208. The Final Mandate is not the least restrictive means of furthering Defendants' stated interests.

209. The Final Mandate and Defendants' threatened enforcement of the Final Mandate violate Wheaton's rights secured to it by the Religious Freedom Restoration Act, 42 U.S.C. § 2000bb *et seq.*

210. Absent injunctive and declaratory relief against the Final Mandate, Wheaton has been and will continue to be harmed.

COUNT II
Violation of the First Amendment to the United States Constitution
Free Exercise Clause
Burden

211. Wheaton incorporates by reference all preceding paragraphs.

212. Wheaton's sincerely held religious beliefs prohibit it from deliberately providing health insurance that would facilitate access to abortifacients, or to related education and counseling. Wheaton's compliance with these beliefs is a religious exercise.

213. Neither the Affordable Care Act nor the Final Mandate is neutral.

214. Neither the Affordable Care Act nor the Final Mandate is generally applicable.

215. Defendants have created categorical exemptions and individualized exemptions to the Final Mandate.

216. The Final Mandate furthers no compelling governmental interest.

217. The Final Mandate is not the least restrictive means of furthering Defendants' stated interests.

218. The Final Mandate creates government-imposed coercive pressure on Wheaton to change or violate its religious beliefs.

219. The Final Mandate chills Wheaton's religious exercise.

220. The Final Mandate exposes Wheaton to substantial fines for its religious exercise.

221. The Final Mandate exposes Wheaton to substantial competitive disadvantages, in that it will no longer be permitted to offer health insurance.

222. The Final Mandate imposes a burden on Wheaton's religious exercise.

223. The Final Mandate is not narrowly tailored to any compelling governmental interest.

224. The Final Mandate and Defendants' threatened enforcement of the Final Mandate violate Wheaton's rights secured to it by the Free Exercise Clause of the First Amendment of the United States Constitution.

225. Absent injunctive and declaratory relief against the Final Mandate, Wheaton has been and will continue to be harmed.

COUNT III
Violation of the First Amendment to the United States Constitution
Free Exercise Clause
Intentional Discrimination

226. Wheaton incorporates by reference all preceding paragraphs.

227. Wheaton's sincerely held religious beliefs prohibit it from deliberately providing health insurance that would facilitate access to abortifacients, or to related education and counseling. Wheaton's compliance with these beliefs is a religious exercise.

228. Despite being informed in detail of these beliefs beforehand, Defendants designed the Final Mandate and the religious employer exemption to the Final Mandate to target religious organizations like Wheaton because of their religious beliefs.

229. Defendants promulgated both the Final Mandate and its religious employer exemption in order to suppress the religious exercise of Wheaton and others.

230. The Final Mandate and Defendants' threatened enforcement of the Final Mandate thus violate Wheaton's rights secured to it by the Free Exercise Clause of the First Amendment of the United States Constitution.

231. Absent injunctive and declaratory relief against the Final Mandate, Wheaton has been and will continue to be harmed.

COUNT IV
Violation of the First Amendment to the United States Constitution
Free Exercise and Establishment Clauses
Discrimination Among Religions and Religious Institutions

232. Wheaton incorporates by reference all preceding paragraphs.

233. The Free Exercise Clause and Establishment Clause of the First Amendment mandate the equal treatment of all religious faiths and institutions without discrimination or preference.

234. This mandate of equal treatment protects organizations as well as individuals.

235. The Final Mandate's narrow exemption for "religious employers" but not others discriminates among religions and religious institutions on the basis of religious views or religious status.

236. The Final Mandate and Defendants' threatened enforcement of the Final Mandate thus violate Wheaton's rights secured to it by the First Amendment of the United States Constitution.

237. Absent injunctive and declaratory relief against the Final Mandate, Wheaton has been and will continue to be harmed.

COUNT V
Violation of the First Amendment to the United States Constitution
Selective Burden (*Larson* v. *Valente*)

238. Wheaton incorporates by reference all preceding paragraphs.

239. By design, Defendants imposed the Final Mandate on some religious organizations but not on others, resulting in a selective burden on Wheaton.

240. The Final Mandate and Defendants' threatened enforcement of the Final Mandate therefore violate Wheaton's rights secured to it by the First Amendment of the United States Constitution.

241. Absent injunctive and declaratory relief against the Final Mandate, Wheaton has been and will continue to be harmed.

242. The Final Mandate vests HRSA with unbridled discretion in deciding whether to allow exemptions to some, all, or no organizations meeting the definition of "religious employers."

COUNT VI

Interference in Matters of Internal Religious Governance Free Exercise Clause and Establishment Clause

243. Wheaton incorporates by reference all preceding paragraphs.

244. The Free Exercise Clause and the Establishment Clause protect the freedom of religious organizations to decide for themselves, free from state interference, matters of internal governance as well as those of faith and doctrine.

245. Under these Clauses, the Government may not interfere with a religious organization's internal decisions concerning the organization's religious structure, leadership, or doctrine.

246. Under these Clauses, the Government may not interfere with a religious organization's internal decision if that interference would affect the faith and mission of the organization itself.

247. Wheaton has made an internal decision, dictated by its Christian faith, that any health plans it makes available to its employees and students may not subsidize, provide, or facilitate access to abortifacient drugs or related services.

248. The Final Mandate interferes with Wheaton's internal decisions concerning its structure and mission by requiring it to subsidize, provide, and facilitate practices that directly conflict with its Christian beliefs.

249. The Final Mandate's interference with Wheaton's internal decisions affects its faith and mission by requiring it to subsidize, provide, and facilitate practices that directly conflict with its religious beliefs.

250. Because the Final Mandate interferes with Wheaton's internal decision making in a manner that affects its faith and mission, it violates the Establishment Clause and Free Exercise Clause of the First Amendment.

251. Absent injunctive and declaratory relief against the Final Mandate, Wheaton has been and will continue to be harmed.

COUNT VII
Religious Discrimination
Violation of the First and Fifth Amendments to the United States Constitution
Establishment Clause and Due Process

252. Wheaton incorporates by reference all preceding paragraphs.

253. By design, Defendants imposed the Final Mandate on some religious organizations but not on others, resulting in discrimination among religious objectors.

254. Religious liberty is a fundamental right.

255. The "religious employer" exemption protects many religious objectors, but not Wheaton.

256. The "accommodation" provides no meaningful protection for Wheaton.

257. The Final Mandate and Defendants' threatened enforcement of the Final Mandate therefore violate Wheaton's rights secured to it by the Establishment Clause of the First Amendment and the Due Process Clause of the Fifth Amendment to the United States Constitution.

258. Absent injunctive and declaratory relief against the Final Mandate, Wheaton has been and will continue to be harmed.

COUNT VIII
Violation of the Fifth Amendment to the United States Constitution
Due Process and Equal Protection

259. Wheaton incorporates by reference all preceding paragraphs.

260. The Due Process Clause of the Fifth Amendment mandates the equal treatment of all religious faiths and institutions without discrimination or preference.

261. This mandate of equal treatment protects organizations as well as individuals.

262. The Final Mandate's narrow exemption for "religious employers" but not others discriminates among religions on the basis of religious views or religious status.

263. The Final Mandate and Defendants' threatened enforcement of the Final Mandate thus violate Wheaton's rights secured to it by the Fifth Amendment of the United States Constitution.

264. Absent injunctive and declaratory relief against the Final Mandate, Wheaton has been and will continue to be harmed.

COUNT IX

Violation of the First Amendment to the United States Constitution
Freedom of Speech
Compelled Speech and Compelled Silence

265. Wheaton incorporates by reference all preceding paragraphs.

266. Wheaton teaches that abortion and contraception that interferes with the survival of a human embryo violate its religious beliefs.

267. The Final Mandate would compel Wheaton to subsidize activities that Wheaton teaches are violations of its religious beliefs.

268. The Final Mandate would compel Wheaton to provide education and counseling related to abortifacients.

269. Defendants' actions thus violate Wheaton's right to be free from compelled speech as secured to it by the First Amendment of the United States Constitution.

270. The Final Mandate also prevents Wheaton from speaking to its third-party administrator about its religious beliefs and preference that the administrator not provide the services at issue.

271. The Final Mandate's speech restrictions are not narrowly tailored to a compelling governmental interest.

272. Absent injunctive and declaratory relief against the Final Mandate, Wheaton has been and will continue to be harmed.

COUNT X

Violation of the First Amendment to the United States Constitution
Freedom of Speech
Expressive Association

273. Wheaton incorporates by reference all preceding paragraphs.

274. Wheaton teaches that contraception, sterilization, and abortion violate its religious beliefs.

275. The Final Mandate would compel Wheaton to facilitate activities that Wheaton teaches are violations of its religious beliefs.

276. The Final Mandate would compel Wheaton to facilitate access to government-dictated education and counseling related to abortifacients.

277. Defendants' actions thus violate Wheaton's right of expressive association as secured to it by the First Amendment of the United States Constitution.

278. Absent injunctive and declaratory relief against the Final Mandate, Wheaton has been and will continue to be harmed.

COUNT XI

Violation of the First Amendment to the United States Constitution Free Exercise Clause and Freedom of Speech Unbridled Discretion

279. Wheaton incorporates by reference all preceding paragraphs.

280. By stating that HRSA "may" grant an exemption to certain religious groups, the Final Mandate vests HRSA with unbridled discretion over which organizations can have its First Amendment interests accommodated.

281. Defendants have exercised unbridled discretion in a discriminatory manner by granting an exemption via footnote in a website for a narrowly defined group of "religious employers" but not for other religious organizations like Wheaton.

282. Defendants have further exercised unbridled discretion by indiscriminately waiving enforcement of some provisions of the Affordable Care Act while refusing to waive enforcement of the Final Mandate, despite its conflict with the free exercise of religion.

283. Defendants' actions therefore violate Wheaton's right not to be subjected to a system of unbridled discretion when engaging in speech or when engaging in religious exercise, as secured to it by the First Amendment of the United States Constitution.

284. Absent injunctive and declaratory relief against the Final Mandate, Wheaton has been and will continue to be harmed.

COUNT XII

Violation of the Administrative Procedure Act Lack of Good Cause, Failure to Follow Notice and Comment Rulemaking, and Improper Delegation

285. Wheaton incorporates by reference all preceding paragraphs.

286. The Affordable Care Act expressly delegates to HRSA, an agency within Defendant HHS, the authority to establish guidelines concerning the "preventive care" that a group health plan and health insurance issuer must provide.

287. Given this express delegation, Defendants were required to engage in formal notice-and-comment rulemaking in a manner prescribed by law before issuing the guidelines with which group health plans and insurers must comply. Proposed regulations were required to be published in the Federal Register and interested persons were required to be given an opportunity to participate in the rulemaking through the submission of written data, views, or arguments.

288. Defendants promulgated the "preventive care" guidelines without engaging in formal notice-and-comment rulemaking in a manner prescribed by law. Defendants, instead, wholly delegated their responsibilities for issuing preventive care guidelines to a non-governmental entity, the IOM.

289. The IOM did not permit or provide for the broad public comment otherwise required under the APA concerning the guidelines that it would recommend. The dissent to the IOM report noted both that the IOM conducted its review in an unacceptably short time frame, and that the review process lacked transparency.

290. Within two weeks of the IOM issuing its guidelines, Defendant HHS issued a press release announcing that the IOM's guidelines were required under the Affordable Care Act.

291. Defendants have never explained why they failed to enact these "preventive care" guidelines through notice-and-comment rulemaking as required by the APA.

292. Defendants' stated reasons that public comments were unnecessary, impractical, and opposed to the public interest are false and insufficient, and do not constitute "good cause."

293. Without proper notice and opportunity for public comment, Defendants were unable to take into account the full implications of the regulations by completing a meaningful "consideration of the relevant matter presented." This failure prejudiced Wheaton.

294. Defendants did not consider or respond to the voluminous comments they received in opposition to the interim final rule or the NPRM.

295. Therefore, Defendants have taken agency action not in observance with procedures required by law, and Wheaton is entitled to relief pursuant to 5 U.S.C. § 706(2)(D).

296. Absent injunctive and declaratory relief against the Final Mandate, Wheaton has been and will continue to be harmed.

COUNT XIII

Violation of the Administrative Procedure Act
Arbitrary and Capricious Action

297. Wheaton incorporates by reference all preceding paragraphs.

298. In promulgating the Final Mandate, Defendants failed to consider the constitutional and statutory implications of the Final Mandate on Wheaton and similar organizations.

299. Defendants' explanation for its decision not to exempt Wheaton and similar religious organizations from the Final Mandate runs counter to the evidence submitted by religious organizations during the comment period.

300. Defendant Secretary Sebelius, in remarks made at Harvard University on April 8, 2013, essentially conceded that Defendants completely disregarded the religious liberty concerns submitted by thousands of religious organizations and individuals.

301. Thus, Defendants' issuance of the interim final rule was arbitrary and capricious within the meaning of 5 U.S.C. § 706(2)(A) because the rules fail to consider the full extent of their implications and they do not take into consideration the evidence against them.

302. Absent injunctive and declaratory relief against the Final Mandate, Wheaton has been and will continue to be harmed.

COUNT XIV

Violation of the Administrative Procedure Act
Agency Action Without Statutory Authority

303. Wheaton incorporates by reference all preceding paragraphs.

304. Defendants' authority to enact regulations under the Affordable Care Act is limited to the authority expressly granted them by Congress.

305. Defendants lack statutory authority to coerce insurance issuers and third party administrators to pay for contraceptive and abortifacient services for individuals with whom they have no contractual or fiduciary relationship.

306. Defendants lack statutory authority to prevent insurance issuers and third party administrators from passing on the costs of providing contraceptive and abortifacient services via higher premiums or other charges that are not "cost sharing."

307. Defendants lack statutory authority to allow user fees from the federal exchanges to be used to purchase contraceptive and abortifacient services for employees not participating in the exchanges.

308. Because the Final Mandate's "accommodation" for non-exempt, nonprofit religious organizations lacks legal authority, it is arbitrary and capricious and provides no legitimate protection of objecting organization's First Amendment rights.

309. Absent injunctive and declaratory relief against the Final Mandate, Wheaton has been and will continue to be harmed.

COUNT XV

Violation of the Administrative Procedure Act
Agency Action Not in Accordance with Law
Weldon Amendment
Religious Freedom Restoration Act
First Amendment to the United States Constitution

310. Wheaton incorporates by reference all preceding paragraphs.

311. The Final Mandate is contrary to the provisions of the Weldon Amendment of the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act of 2009, Pub. L. 110-117, 123 Stat. 3034 (Dec. 16, 2009).[14]

312. The Weldon Amendment provides that "[n]one of the funds made available in this Act [making appropriations for Defendants Department of Labor and Health and Human Services] may be made available to a Federal agency or program . . . if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions."

313. The Final Mandate requires issuers, including Wheaton, to deliberately provide health insurance that facilitates access to all Federal Drug Administration-approved contraceptives.

314. Some FDA-approved contraceptives cause abortions.

315. As set forth above, the Final Mandate violates RFRA and the First Amendment.

[14] *Available at* http://www.hhs.gov/ocr/civilrights/understanding/ConscienceProtect/publaw111_117_123_stat_3034.pdf (Ex. J).

316. Under 5 U.S.C. § 706(2)(A), the Final Mandate is contrary to existing law, and is in violation of the APA.

317. Absent injunctive and declaratory relief against the Final Mandate, Wheaton has been and will continue to be harmed.

COUNT XVI

Violation of the Administrative Procedure Act
Agency Action Not in Accordance with Law
Affordable Care Act

318. Wheaton incorporates by reference all preceding paragraphs.

319. The Final Mandate is contrary to the provisions of the Affordable Care Act.

320. Section 1303 of the Affordable Care Act states that "nothing in this title"—*i.e.*, title I of the Act, which includes the provision dealing with "preventive services"—"shall be construed to require a qualified health plan to provide coverage of [abortion] services . . . as part of its essential health benefits for any plan year."

321. Section 1303 further states that it is "the issuer" of a plan that "shall determine whether or not the plan provides coverage" of abortion services.

322. Under the Affordable Care Act, Defendants do not have the authority to decide whether a plan covers abortion; only the issuer does.

323. The Final Mandate requires group health plans to provide coverage of all Federal Drug Administration-approved contraceptives.

324. The Final Mandate requires third-party administrators, like Wheaton's, to provide or contract to provide coverage of all Federal Drug Administration-approved contraceptives.

325. Some FDA-approved contraceptives cause abortions.

326. Under 5 U.S.C. § 706(2)(A), the Final Mandate is contrary to existing law, and is in violation of the APA.

327. Absent injunctive and declaratory relief against the Final Mandate, Wheaton has been and will continue to be harmed.

PRAYER FOR RELIEF

Wherefore, Wheaton requests that the Court:

a. Declare that the Final Mandate and Defendants' enforcement of the Final Mandate against Wheaton violate the First Amendment of the United States Constitution;

b. Declare that the Final Mandate and Defendants' enforcement of the Final Mandate against Wheaton violate the Fifth Amendment of the United States Constitution;

c. Declare that the Final Mandate and Defendants' enforcement of the Final Mandate against Wheaton violate the Religious Freedom Restoration Act;

d. Declare that the Final Mandate was issued in violation of the Administrative Procedure Act;

e. Issue a permanent injunction prohibiting Defendants from enforcing the Final Mandate against Wheaton and other organizations that object on religious grounds to providing insurance coverage for abortifacient contraceptives and related education and counseling;

f. Award Wheaton the costs of this action and reasonable attorney's fees, including but not limited to awarding fees pursuant to 42 U.S.C. § 1988(b); and

g. Award such other and further relief as it deems equitable and just.

JURY DEMAND

Wheaton requests a trial by jury on all issues so triable.

Dated: December 13, 2013

Respectfully submitted,

s/ Christian Poland

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Exhibit A

U.S. Preventive Services Task Force

USPSTF A and B Recommendations

The following is a list of preventive services that have a rating of A or B from the U.S. Preventive Services Task Force that are relevant for implementing the Affordable Care Act. The preventive services are listed alphabetically. For a list of preventive services by date of release of the current recommendation, go to http://www.uspreventiveservicestaskforce.org/uspstf/uspsrecsdate.htm.

For more information about the Affordable Care Act and preventive services, go to https://www.healthcare.gov/what-are-my-preventive-care-benefits/.

Topic	Description	Grade	Release Date of Current Recommendation
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.	B	February 2005
Alcohol misuse: screening and counseling	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.	B	May 2013*
Anemia screening: pregnant women	The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.	B	May 2006
Aspirin to prevent cardiovascular disease: men	The USPSTF recommends the use of aspirin for men ages 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.	A	March 2009
Aspirin to prevent cardiovascular disease: women	The USPSTF recommends the use of aspirin for women ages 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.	A	March 2009
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	A	July 2008
Blood pressure screening in adults	The USPSTF recommends screening for high blood pressure in adults age 18 years and older.	A	December 2007
BRCA screening, counseling about	The USPSTF recommends that women whose family history is associated with an increased risk for deleterious mutations in *BRCA1* or *BRCA2* genes be referred for genetic counseling and evaluation for BRCA testing.	B	September 2005

Breast cancer preventive medications	The USPSTF recommends that clinicians engage in shared, informed decisionmaking with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.	B	September 2013
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.	B	September 2002†
Breastfeeding counseling	The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.	B	October 2008
Cervical cancer screening	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.	A	March 2012*
Chlamydial infection screening: nonpregnant women	The USPSTF recommends screening for chlamydial infection in all sexually active nonpregnant young women age 24 years and younger and for older nonpregnant women who are at increased risk.	A	June 2007
Chlamydial infection screening: pregnant women	The USPSTF recommends screening for chlamydial infection in all pregnant women age 24 years and younger and for older pregnant women who are at increased risk.	B	June 2007
Cholesterol abnormalities screening: men 35 and older	The USPSTF strongly recommends screening men age 35 years and older for lipid disorders.	A	June 2008
Cholesterol abnormalities screening: men younger than 35	The USPSTF recommends screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.	B	June 2008
Cholesterol abnormalities screening: women 45 and older	The USPSTF strongly recommends screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.	A	June 2008
Cholesterol abnormalities screening: women younger than 45	The USPSTF recommends screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.	B	June 2008
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.	A	October 2008
Dental caries prevention: preschool children	The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than age 6 months whose primary water source is deficient in fluoride.	B	April 2004
Depression screening: adolescents	The USPSTF recommends screening adolescents (ages 12-18 years) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.	B	March 2009
Depression screening: adults	The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis,	B	December 2009

	effective treatment, and follow-up.		
Diabetes screening	The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.	B	June 2008
Falls prevention in older adults: exercise or physical therapy	The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B	May 2012
Falls prevention in older adults: vitamin D	The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B	May 2012
Folic acid supplementation	The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.	A	May 2009
Gonorrhea prophylactic medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.	A	July 2011*
Gonorrhea screening: women	The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).	B	May 2005
Healthy diet counseling	The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.	B	January 2003
Hearing loss screening: newborns	The USPSTF recommends screening for hearing loss in all newborn infants.	B	July 2008
Hemoglobinopathies screening: newborns	The USPSTF recommends screening for sickle cell disease in newborns.	A	September 2007
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.	A	June 2009
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.	B	June 2013
HIV screening: nonpregnant adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.	A	April 2013*
HIV screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	A	April 2013*
Hypothyrodism screening: newborns	The USPSTF recommends screening for congenital hypothyroidism in newborns.	A	March 2008
Intimate partner violence screening: women of childbearing age	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who	B	January 2013

	do not have signs or symptoms of abuse.		
Iron supplementation in children	The USPSTF recommends routine iron supplementation for asymptomatic children ages 6 to 12 months who are at increased risk for iron deficiency anemia.	B	May 2006
Obesity screening and counseling: adults	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions.	B	June 2012*
Obesity screening and counseling: children	The USPSTF recommends that clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.	B	January 2010
Osteoporosis screening: women	The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.	B	January 2012*
Phenylketonuria screening: newborns	The USPSTF recommends screening for phenylketonuria in newborns.	A	March 2008
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	A	February 2004
Rh incompatibility screening: 24–28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	B	February 2004
Sexually transmitted infections counseling	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) in all sexually active adolescents and for adults at increased risk for STIs.	B	October 2008
Skin cancer behavioral counseling	The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.	B	May 2012
Tobacco use counseling and interventions: nonpregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.	A	April 2009
Tobacco use counseling: pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.	A	April 2009
Tobacco use interventions: children and adolescents	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.	B	August 2013
Syphilis screening: nonpregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.	A	July 2004
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.	A	May 2009
Visual acuity screening in children	The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.	B	January 2011*

†The Department of Health and Human Services, in implementing the Affordable Care Act under the standard it sets out in revised Section 2713(a)(5) of the Public Health Service Act, utilizes the 2002 recommendation on breast cancer screening of the U.S. Preventive Services Task Force. To see the USPSTF 2009 recommendation on breast cancer screening, go to http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca.htm.
* Previous recommendation was an “A” or “B.”

Current as of November 2013

Internet Citation:

USPSTF A and B Recommendations. U.S. Preventive Services Task Force. http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm

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Exhibit B

Birth Control: Medicines To Help You

Introduction

If you do not want to get pregnant, there are many birth control options to choose from. No one product is best for everyone. The only sure way to avoid pregnancy and sexually transmitted infections (STIs or STDs) is not to have any sexual contact (abstinence). This guide lists FDA-approved products for birth control. Talk to your doctor, nurse, or pharmacist about the best method for you.

There are different kinds of medicines and devices for birth control:

Some things to think about when you choose birth control:

- Your health.
- How often you have sex.
- How many sexual partners you have.
- If you want to have children in the future.
- If you will need a prescription or if you can buy the method over-the-counter.
- The number of pregnancies expected per 100 women who use a method for one year. For comparison, about 85 out of 100 sexually active women who do not use any birth control can expect to become pregnant in a year.
- This booklet lists pregnancy rates of **typical use**. Typical use shows how effective the different methods are during actual use (including sometimes using a method in a way that is not correct or not consistent).
- For more information on the chance of getting pregnant while using a method, please see Trussell,J. (2011)."Contraceptive failure in the United States." Contraception 83(5):397-404.

Tell your doctor, nurse, or pharmacist if you:

- Smoke.
- Have liver disease.
- Have blood clots.
- Have family members who have had blood clots.
- Are taking any other medicines, like antibiotics.
- Are taking any herbal products, like St. John's Wort.

To avoid pregnancy:

- No matter which method you choose, it is important to follow all of the directions carefully. If you don't, you raise your chance of getting pregnant.
- The best way to avoid pregnancy and sexually transmitted infections (STIs) is to practice total abstinence (do not have any sexual contact).

BARRIER METHODS: Block sperm from reaching the egg

Male Condom

What is it?

- A thin film sheath placed over the erect penis.

How do I use it?

- Put it on the erect penis right before sex.
- Pull out before the penis softens.
- Hold the condom against the base of the penis before pulling out.
- Use it only once and then throw it away.

How do I get it?

- You do not need a prescription.
- You can buy it over-the-counter or online.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, 18 may get pregnant.
- The most important thing is that you use a condom every time you have sex.

Some Risks

- Irritation
- Allergic reactions (If you are allergic to latex, you can try condoms made of polyurethane).

Does it protect me from sexually transmitted infections (STIs)?

- Yes. Except for abstinence, latex condoms are the best protection against HIV/AIDS and other STIs.

Female Condom

What is it?

- A thin, lubricated pouch that is put into the vagina. It is created from man-made materials. It is not made with natural rubber latex.

How do I use it?

- Put the female condom into the vagina before sex.
- Follow the directions on the package to be sure the penis stays within the condom during sex and does not move alongside the condom.
- Use it only once and then throw it away.

How do I get it?

- You do not need a prescription.

- You can buy it over-the-counter or online.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, about 21 may get pregnant.
- The most important thing is that you use a condom every time you have sex.

Some Risks

- Irritation
- Allergic reactions

Does it protect me from sexually transmitted infections (STIs)?

- Yes.
- Natural rubber latex condoms for men are highly effective at preventing sexually transmitted infections, including HIV/AIDS, if used correctly. If you are not going to use a male condom, you can use the female condom to help protect yourself and your partner.

Diaphragm with Spermicide
Spermicides containing N9 can irritate the vagina and rectum. It may increase the risk of getting the AIDS virus (HIV) from an infected partner.

What is it?

- A dome-shaped flexible disk with a flexible rim.
- Made from latex rubber or silicone.
- It covers the cervix.

How do I use it?

- You need to put spermicidal jelly on the inside of the diaphragm before putting it into the vagina.
- You must put the diaphragm into the vagina before having sex.
- You must leave the diaphragm in place at least 6 hours after having sex.
- It can be left in place for up to 24 hours. You need to use more spermicide every time you have sex.

How do I get it?

- You need a prescription.
- A doctor or nurse will need to do an exam to find the right size diaphragm for you.
- You should have the diaphragm checked after childbirth or if you lose more than 15 pounds. You might need a different size.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, about 12 may get pregnant.

Some Risks

- Irritation, allergic reactions, and urinary tract infection.
- If you keep it in place longer than 24 hours, there is a risk of toxic shock syndrome. Toxic shock is a rare but serious infection.

Does it protect me from sexually transmitted infections (STIs)? No.

Sponge with spermide

Spermicides containing N9 can irritate the vagina and rectum. It may increase the risk of getting the AIDS virus (HIV) from an infected partner.

What is it?

- A disk-shaped polyurethane device with the spermicide nonoxynol-9.

How do I use it?

- Put it into the vagina before you have sex.
- Protects for up to 24 hours.
- You do not need to use more spermicide each time you have sex.
- You must leave the sponge in place for at least 6 hours after having sex.
- You must take the sponge out within 30 hours after you put it in. Throw it away after you use it.

How do I get it?

- You do not need a prescription.
- You can buy it over-the-counter.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)O

- Out of 100 women who use this method, 12 to 24 may get pregnant.
- It may not work as well for women who have given birth. Childbirth stretches the vagina and cervix and the sponge may not fit as well.

Some Risks

- Irritation
- Allergic reactions
- Some women may have a hard time taking the sponge out.
- If you keep it in place longer than 24-30 hours, there is a risk of toxic shock syndrome. Toxic shock is a rare but serious infection.

Does it protect me from sexually transmitted infections (STIs)? No.

Cervical Cap with Spermicide

Spermicides containing N9 can irritate the vagina and rectum. It may increase the risk of getting the AIDS virus (HIV) from an infected partner.

What is it?

- A soft latex or silicone cup with a round rim, which fits snugly around the cervix.

How do I use it?

- You need to put spermicidal jelly inside the cap before you use it.
- You must put the cap in the vagina before you have sex.

- You must leave the cap in place for at least 6 hours after having sex.
- You may leave the cap in for up to 48 hours.
- You do NOT need to use more spermicide each time you have sex.

How do I get it?

- You need a prescription.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, about 17 to 23 may get pregnant.
- It may not work as well for women who have given birth. Childbirth stretches the vagina and cervix and the cap may not fit as well.

Some Risks

- Irritation, allergic reactions, and abnormal Pap test.
- You may find it hard to put in.
- If you keep it in place longer than 48 hours, there is a risk of toxic shock syndrome. Toxic shock is a rare but serious infection.

Does it protect me from sexually transmitted infections (STIs)? No

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Spermicide Alone
Spermicides containing N9 can irritate the vagina and rectum. It may increase the risk of getting the AIDS virus (HIV) from an infected partner.

What is it?

- A foam, cream, jelly, film, or tablet that you put into the vagina.

How do I use it?

- You need to put spermicide into the vagina 5 to 90 minutes before you have sex.
- You usually need to leave it in place at least 6 to 8 hours after sex; do not douche or rinse the vagina for at least 6 hours after sex.
- Instructions can be different for each type of spermicide. Read the label before you use it.

How do I get it?

- You do not need a prescription.
- You can buy it over-the-counter.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, about 28 may get pregnant.
- Different studies show different rates of effectiveness.

Some Risks

- Irritation
- Allergic reactions
- Urinary tract infection

- If you are also using a medicine for a vaginal yeast infection, the spermicide might not work as well.

Does it protect me from sexually transmitted infections (STIs)? No.

HORMONAL METHODS: Prevent Pregnancy by interfering with ovulation and possibly fertilization of the egg

Oral Contraceptives (Combined Pill)
"The Pill"

What is it?

- A pill that has two hormones (estrogen and progestin) to stop the ovaries from releasing eggs
- It also thickens the cervical mucus, which keeps sperm from getting to the egg.

How do I use it?

- You should swallow the pill at the same time every day, whether or not you have sex.
- If you miss one or more pills, or start a pill pack too late, you may need to use another method of birth control, like a condom

How do I get it?

- You need a prescription.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, about 9 may get pregnant.

Some Side Effects

- Changes in your cycle (period)
- Nausea
- Breast tenderness
- Headache

Less Common Serious Side Effects

- It is not common, but some women who take the pill develop high blood pressure.
- It is rare, but some women will have blood clots, heart attacks, or strokes.

Does it protect me from sexually transmitted infections (STIs)? No.

Oral Contraceptives (Progestin-only)

"The Mini Pill"

What is it?

- A pill that has only one hormone, a progestin.
- It thickens the cervical mucus, which keeps sperm from getting to the egg.
- Less often, it stops the ovaries from releasing eggs.

How do I use it?

- You should swallow the pill at the same time every day, whether or not you have sex.

- If you miss one or more pills, or start a pill pack too late, you may need to use another method of birth control, like a condom.

How do I get it?

- You need a prescription.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, about 9 may get pregnant.

Some Side Effects

- Irregular bleeding
- Headache
- Breast tenderness
- Nausea
- Dizziness

Does it protect me from sexually transmitted infections (STIs)? No.

Oral Contraceptives (Extended/Continuous Use)
"Pill"

What is it?

- A pill that has two hormones (estrogen and progestin) to stop the ovaries from releasing eggs.
- It also thickens the cervical mucus, which keeps sperm from getting to the egg.
- These pills are designed so women have fewer or no periods.

How do I use it?

- You should swallow the pill at the same time every day, whether or not you have sex.
- If you miss one or more pills, or start a pill pack too late, you may need to use another method of birth control, like a condom.

How do I get it?

- You need a prescription.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, about 9 may get pregnant.

Some Side Effects and Risks

- Risks are similar to other oral contraceptives with estrogen and progestin.
- You may have more light bleeding and spotting between periods than with 21 or 24 day oral contraceptives.
- It may be harder to know if you become pregnant, since you will likely have fewer periods or no periods.

Does it protect me from sexually transmitted infections (STIs)? No.

Patch

What is it?

- This is a skin patch you can wear on the lower abdomen, buttocks, or upper arm or back.
- It has two hormones (estrogen and progestin) that stop the ovaries from releasing eggs
- It also thickens the cervical mucus, which keeps sperm from getting to the egg.

How do I use it?

- You put on a new patch and take off the old patch once a week for 3 weeks (21 total days).
- Don't put on a patch during the fourth week. Your menstrual period should start during this patch-free week.
- If the patch comes loose or falls off, you may need to use another method of birth control, like a condom.

How do I get it?

- You need a prescription.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, about 9 may get pregnant.

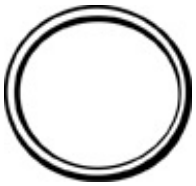
Some Risks

- It will expose you to higher levels of estrogen compared to most combined oral contraceptives.
- It is not known if serious risks, such as blood clots and strokes, are greater with the patch because of the greater exposure to estrogen.

Does it protect me from sexually transmitted infections (STIs)? No.

Vaginal Contraceptive Ring

What is it?



- It is a flexible ring that is about 2 inches around.
- It releases two hormones (progestin and estrogen) to stop the ovaries from releasing eggs.
- It also thickens the cervical mucus, which keeps sperm from getting to the egg.

How do I use it?

- You put the ring into your vagina.
- Keep the ring in your vagina for 3 weeks and then take it out for 1 week. Your menstrual period should start during this ring-free week.
- If the ring falls out and stays out for more than 3 hours, replace it but use another method of birth control, like a condom, until the ring has been in place for 7 days in a row.
- Read the directions and talk to your doctor, nurse or pharmacist about what to do.

How do I get it?

- You need a prescription.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

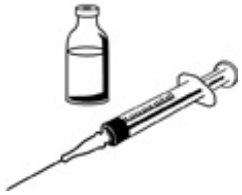
- Out of 100 women who use this method, about 9 may get pregnant.

- Vaginal discharge, discomfort in the vagina, and mild irritation.
- Other risks are similar to oral contraceptives (combined pill).

Does it protect me from sexually transmitted infections (STIs)? No.

Shot/Injection

What is it?



- A shot of the hormone progestin, either in the muscle or under the skin.

How does it work?

- The shot stops the ovaries from releasing eggs
- It also thickens the cervical mucus, which keeps the sperm from getting to the egg.

How do I get it?

- You need one shot every 3 months from a healthcare provider.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, including women who don't get the shot on time, 6 may get pregnant.

Some Risks

- You may lose bone density if you get the shot for more than 2 years in a row.
- Bleeding between periods
- Headaches
- Weight gain
- Nervousness
- Abdominal discomfort

Does it protect me from sexually transmitted infections (STIs)? No.

EMERGENCY CONTRACEPTION: May be used if you did not use birth control or if your regular birth control fails. It should not be used as a regular form of birth control

Plan B, Plan B One- Step and Next Choice (Levonorgestrel)

What is it?

- These are pills with the hormone progestin.
- They help prevent pregnancy after birth control failure or unprotected sex.

How does it work?

- It works mainly by stopping the release of an egg from the ovary. It may also work by preventing fertilization of an egg (the uniting of sperm with the egg) or by preventing attachment (implantation) to the womb (uterus).
- For the best chance for it to work, you should start taking the pill(s) as soon as possible after unprotected sex.
- You should take emergency contraception within three days after having unprotected sex.

How do I get it?

- You can buy **Plan B One-Step** over-the-counter. You do not need a prescription.
- You can buy Plan B and Next Choice over-the-counter if you are age 17 years or older. If you are younger than age 17, you need a prescription.

Chance of getting pregnant

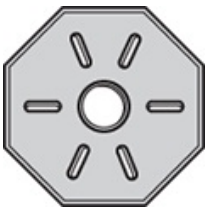
- Seven out of every 8 women who would have gotten pregnant will not become pregnant after taking Plan B, Plan B One-Step, or Next Choice.

Some Risks

- Nausea, vomiting, abdominal pain, fatigue and headache

Does it protect me from sexually transmitted infections (STIs)? No.

Ella (ulipristal acetate)



What is it?

- A pill that blocks the hormone progesterone.
- It helps prevent pregnancy after birth control failure or unprotected sex.
- It works mainly by stopping or delaying the ovaries from releasing an egg. It may also work by changing the lining of the womb (uterus) that may prevent attachment (implantation).

How do I use it?

- For the best chance for it to work, you should take the pill as soon as possible after unprotected sex.
- You should take Ella within five days after unprotected sex.

How do I get it?

- You need a prescription.

Chance of getting pregnant

- Six or 7 out of every 10 women who would have gotten pregnant will not become pregnant after taking ella.

Some Risks

- Headache
- Nausea
- Abdominal pain
- Menstrual pain
- Tiredness
- Dizziness

Does it protect me from sexually transmitted infections (STIs)? No.

IMPLANTED DEVICES: Inserted/implanted into the body and can be kept in place for several years

Copper IUD

What is it?

- A T-shaped device containing copper that is put into the uterus by a healthcare provider.

How does it work?

- The IUD prevents sperm from reaching the egg, from fertilizing the egg, and may prevent the egg from attaching (implanting) in the womb (uterus).
- It does not stop the ovaries from making an egg each month.
- The Copper IUD can be used for up to 10 years.
- After the IUD is taken out, it is possible to get pregnant.

How do I get it?

- A doctor or other healthcare provider needs to put in the IUD.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, less than 1 may get pregnant.

Some Side Effects

- Cramps
- Irregular bleeding

Uncommon Risks

- Pelvic inflammatory disease
- Infertility

Rare Risk

- IUD is stuck in the uterus or found outside the uterus.
- Life-threatening infection.

Does it protect me from sexually transmitted infections (STIs)? No.

IUD with progestin

What is it?

- A T-shaped device containing a progestin that is put into the uterus by a healthcare provider.

How does it work?

- It may thicken the mucus of your cervix, which makes it harder for sperm to get to the egg, and also thins the lining of your uterus.
- After a doctor or other healthcare provider puts in the IUD, it can be used for up to 3 to 5 years, depending on the type.
- After the IUD is taken out, it is possible to get pregnant.

How do I get it?

- A doctor or other healthcare provider needs to put in the IUD.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, less than 1 may get pregnant.

Some Side Effects

- Irregular bleeding
- No periods
- Abdominal/pelvic pain
- Ovarian cysts

Uncommon Risks

- Pelvic inflammatory disease
- Infertility

Rare Risk

- IUD is stuck in the uterus or found outside the uterus
- Life-threatening infection.

Does it protect me from sexually transmitted infections (STIs)? No.

Implantable Rod

What is it?

- A thin, matchstick-sized rod that contains the hormone progestin.
- It is put under the skin on the inside of your upper arm.

How does it work?

- It stops the ovaries from releasing eggs.
- It thickens the cervical mucus, which keeps sperm from getting to the egg.
- It can be used for up to 3 years.

How do I get it?

- After giving you local anesthesia, a doctor or nurse will put it under the skin of your arm with a special needle.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, less than 1 may get pregnant.

Some Side Effects

- changes in bleeding patterns
- weight gain
- breast and abdominal pain

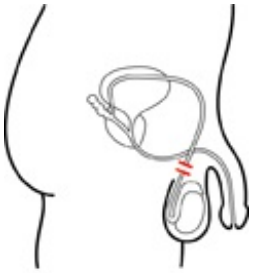
Does it protect me from sexually transmitted infections (STIs)? No.

PERMANENT METHODS: For people who are sure they never want to have a child or do not want any more children.

Sterilization Surgery for Men (Vasectomy)

This method is for men who are sure they never want to have a child or do not want any more children. If you are thinking about reversal, vasectomy may not be right for you. Sometimes it is possible to reverse the operation, but there are no guarantees. Reversal involves complicated surgery that might not work.

What is it?



- This is a surgery a man has only once.
- It is permanent

How does it work?

- A surgery blocks a man's vas deferens (the tubes that carry sperm from the testes to other glands).
- Semen (the fluid that comes out of a man's penis) never has any sperm in it.
- It takes about three months to clear sperm out of a man's system. You need to use another form of birth control until a test shows there are no longer any sperm in the seminal fluid.

How do I get it?

- A man needs to have surgery.
- Local anesthesia is used.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women whose partner has had a vasectomy, less than 1 may get pregnant.

Some Risks

- Pain
- Bleeding
- Infection

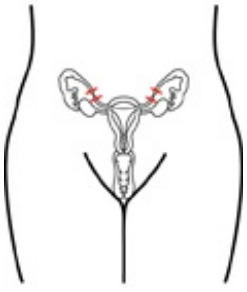
Does it protect me from sexually transmitted infections (STIs)? No.

The success of reversal surgery depends on:

- The length of time since the vasectomy was performed.
- Whether or not antibodies to sperm have developed.
- The method used for vasectomy
- Length and location of the segments of vas deferens that were removed or blocked.

Sterilization Surgery for Women
Surgical Implant (also called trans-abdominal surgical sterilization)

What is it?



- A device is placed on the outside of each fallopian tube.

How does it work?

- One way is by tying and cutting the tubes — this is called tubal ligation. The fallopian tubes also can be sealed using an instrument with an electrical current. They also can be closed with clips, clamps, or rings. Sometimes, a small piece of the tube is removed.
- The woman's fallopian tubes are blocked so the egg and sperm can't meet in the fallopian

tube. This stops you from getting pregnant.

- This is a surgery a woman has only once.
- It is permanent.

How do I get it?

- This is a surgery you ask for.
- You will need general anesthesia.

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, less than 1 may get pregnant.

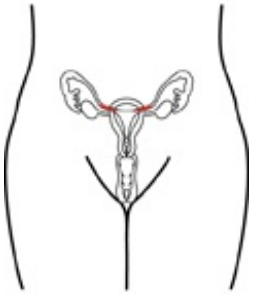
Some Risks

- Pain
- Bleeding
- Infection or other complications after surgery
- Ectopic (tubal) pregnancy

Does it protect me from sexually transmitted infections (STIs)? No.

Sterilization Implant for Women (Transcervical Surgical Sterilization Implant)

What is it?



- Small flexible, metal coil that is put into the fallopian tubes through the vagina.
- The device works by causing scar tissue to form around the coil. This blocks the fallopian tubes and stops you from getting pregnant.

How does it work?

- The device is put inside the fallopian tube with a special catheter.
- You need to use another birth control method during the first 3 months. You will need an X-ray to make sure the device is in the right place.
- It is permanent.

How do I get it?

- The devices are placed into the tubes using a camera placed in the uterus.
- Once the tubes are found, the devices are inserted. No skin cutting (incision) is needed.
- You may need local anesthesia.
- Since it is inserted through the vagina, you do not need an incision (cutting).

Chance of getting pregnant with typical use (Number of pregnancies expected per 100 women who use this method for one year)

- Out of 100 women who use this method, less than 1 may get pregnant.

Some Risks

- Mild to moderate pain after insertion

- Ectopic (tubal) pregnancy

Does it protect me from sexually transmitted infections (STIs)? No.

To Learn More:
This guide should not be used in place of talking to your doctor or reading the label for your product. The product and risk information may change.

To get the most recent information for your birth control go to:

Drugs:
http://www.accessdata.fda.gov/scripts/cder/drugsatfda (type in the name of your drug)

Devices:
http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfRL/LSTSimpleSearch.cfm
(type in the name of your device)

Updated May 2013

Exhibit C

Women's Preventive Services Guidelines

Affordable Care Act Expands Prevention Coverage for Women's Health and Well-Being

The Affordable Care Act – the health insurance reform legislation passed by Congress and signed into law by President Obama on March 23, 2010 – helps make prevention affordable and accessible for all Americans by requiring health plans to cover preventive services and by eliminating cost sharing for those services. Preventive services that have strong scientific evidence of their health benefits must be covered and plans can no longer charge a patient a copayment, coinsurance or deductible for these services when they are delivered by a network provider.

Women's Preventive Services Guidelines Supported by the Health Resources and Services Administration

Under the Affordable Care Act, women's preventive health care – such as mammograms, screenings for cervical cancer, prenatal care, and other services – generally must be covered by health plans with no cost sharing. However, the law recognizes and HHS understands the need to take into account the unique health needs of women throughout their lifespan.

The HRSA-supported health plan coverage guidelines, developed by the Institute of Medicine (IOM), will help ensure that women receive a comprehensive set of preventive services without having to pay a co-payment, co-insurance or a deductible. HHS commissioned an IOM study to review what preventive services are necessary for women's health and well-being and therefore should be considered in the development of comprehensive guidelines for preventive services for women. HRSA is supporting the IOM's recommendations on preventive services that address health needs specific to women and fill gaps in existing guidelines.

Health Resources and Services Administration Women's Preventive Services Guidelines

Non-grandfathered plans (plans or policies created or sold after March 23, 2010, or older plans or policies that have been changed in certain ways since that date) generally are required to provide coverage without cost sharing consistent with these guidelines in the first plan year (in the individual market, policy year) that begins on or after August 1, 2012.

Type of Preventive Service	HHS Guideline for Health Insurance Coverage	Frequency
Well-woman visits.	Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception care and many services necessary for prenatal care. This well-woman visit should, where appropriate, include other preventive services listed in this set of guidelines, as well as others referenced in	Annual, although HHS recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors.* (see note)

Learn More

Clinical Preventive Services for Women: Closing the Gaps Institute of Medicine report

HealthCare.gov

Prevention

	section 2713.	
Screening for gestational diabetes.	Screening for gestational diabetes.	In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
Human papillomavirus testing.	High-risk human papillomavirus DNA testing in women with normal cytology results.	Screening should begin at 30 years of age and should occur no more frequently than every 3 years.
Counseling for sexually transmitted infections.	Counseling on sexually transmitted infections for all sexually active women.	Annual.
Counseling and screening for human immune-deficiency virus.	Counseling and screening for human immune-deficiency virus infection for all sexually active women.	Annual.
Contraceptive methods and counseling. ** (see note)	All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.	As prescribed.
Breastfeeding support, supplies, and counseling.	Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.	In conjunction with each birth.
Screening and counseling for interpersonal and domestic violence.	Screening and counseling for interpersonal and domestic violence.	

** Refer to guidance issued by the Center for Consumer Information and Insurance Oversight entitled Affordable Care Act Implementation FAQs, Set 12, Q10. In addition, refer to recommendations in the July 2011 IOM report entitled Clinical Preventive Services for Women: Closing the Gaps concerning distinct preventive services that may be obtained during a well-woman preventive services visit.*

*** The guidelines concerning contraceptive methods and counseling described above do not apply to women who are participants or beneficiaries in group health plans sponsored by religious employers. Effective August 1, 2013, a religious employer is defined as an employer that is organized and operates as a non-profit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code. HRSA notes that, as of August 1, 2013, group health plans established or maintained by religious employers (and group health insurance coverage provided in connection with such plans) are exempt from the requirement to cover contraceptive services under section 2713 of the Public Health Service Act, as incorporated into the Employee Retirement Income Security Act and the Internal Revenue Code. HRSA also notes that, as of January 1, 2014, accommodations are available to group health plans established or maintained by certain eligible organizations (and group health insurance coverage provided in connection with such plans), as well as student health insurance coverage arranged by eligible organizations, with respect to the contraceptive coverage requirement. See Federal Register Notice: Coverage of Certain Preventive Services Under the Affordable Care Act (PDF - 327 KB)*

Exhibit D

News Release

FOR IMMEDIATE RELEASE
January 20, 2012

Contact: HHS Press Office
(202) 690-6343

A statement by U.S. Department of Health and Human Services Secretary Kathleen Sebelius

In August 2011, the Department of Health and Human Services issued an interim final rule that will require most health insurance plans to cover preventive services for women including recommended contraceptive services without charging a co-pay, co-insurance or a deductible. The rule allows certain non-profit religious employers that offer insurance to their employees the choice of whether or not to cover contraceptive services. Today the department is announcing that the final rule on preventive health services will ensure that women with health insurance coverage will have access to the full range of the Institute of Medicine's recommended preventive services, including all FDA -approved forms of contraception. Women will not have to forego these services because of expensive co-pays or deductibles, or because an insurance plan doesn't include contraceptive services. This rule is consistent with the laws in a majority of states which already require contraception coverage in health plans, and includes the exemption in the interim final rule allowing certain religious organizations not to provide contraception coverage. Beginning August 1, 2012, most new and renewed health plans will be required to cover these services without cost sharing for women across the country.

After evaluating comments, we have decided to add an additional element to the final rule. Nonprofit employers who, based on religious beliefs, do not currently provide contraceptive coverage in their insurance plan, will be provided an additional year, until August 1, 2013, to comply with the new law. Employers wishing to take advantage of the additional year must certify that they qualify for the delayed implementation. This additional year will allow these organizations more time and flexibility to adapt to this new rule. We intend to require employers that do not offer coverage of contraceptive services to provide notice to employees, which will also state that contraceptive services are available at sites such as community health centers, public clinics, and hospitals with income-based support. We will continue to work closely with religious groups during this transitional period to discuss their concerns.

Scientists have abundant evidence that birth control has significant health benefits for women and their families, is documented to significantly reduce health costs, and is the most commonly taken drug in America by young and middle-aged women. This rule will provide women with greater access to contraception by requiring coverage and by prohibiting cost sharing.

This decision was made after very careful consideration, including the important concerns some have raised about religious liberty. I believe this proposal strikes the appropriate balance between respecting religious freedom and increasing access to important preventive services. The administration remains fully committed to its partnerships with faith-based organizations, which promote healthy communities and serve the common good. And this final rule will have no impact on the protections that existing conscience laws and regulations give to health care providers.

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Note: All HHS news releases, fact sheets and other press materials are available at *http://www.hhs.gov/news*.

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Follow HHS Secretary Kathleen Sebelius on Twitter @Sebelius.

Last revised: February 2, 2012

Exhibit E

Wheaton College
For Christ and His Kingdom

Office of the President
630} 752-5002
630} 752-5003 fax

April 8, 2013

Submitted Electronically

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-9968-P
P.O. Box 8013
Baltimore, MD 21244-1850

Dear Secretary Sebelius:

I write to express concern about the February 1, 2013 Notice of Proposed Rulemaking (NPRM) to the regulations entitled Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventative Services Under the Patient Protection and Affordable Care Act (78 Fed. Reg. 8456).

I have several concerns about the NPRM. First, I am concerned that the exemption created in this proposed change still does not exempt Wheaton College as a distinctively Christian institution. Second, the NPRM does not offer a concrete proposal for self-insured entities like Wheaton College, thus leaving us to face uncertainty about what precisely we will be asked to do and how the process will work. Wheaton cannot either directly provide health insurance coverage for abortion-causing drugs and devices or facilitate access to those drugs and devices. Without concrete and fully fleshed-out proposals, it is impossible to evaluate what Wheaton is being asked to do. Finally, the NPRM's refusal to protect religious liberty for individuals and institutions in the business world concerns us insofar as we, as an institution of Christian higher education, prepare our students to be witnesses to Christ in all facets of their life, including in the operation of for-profit businesses.

The "religious employer" exemption

Our mission is "to help build the church and improve society worldwide by promoting the development of whole and effective Christians through excellence in programs of Christian higher education." As a systemically religious institution, we incorporate our Christian faith into every facet of our work. Yet the NPRM's religious employer exemption defines "religious employer" in a way that makes clear that Wheaton does not qualify and will not be exempt from the contraceptive mandate.

The exemption defines "religious employer" as a "nonprofit organization described in section 6033(a)(1) and (a)(3)(A)(i) or (iii) of the Code. Section 6033(a)(3)(A)(i) and (iii) of the Code refers to churches, their integrated auxiliaries, and conventions or associations of churches, as well as to the exclusively religious activities of any religious order." These

501 College Avenue
Wheaton, Illinois 60187
www.wheaton.edu

categories from the IRS Tax Code govern certain reporting requirements, but they bear no relationship to the legitimate religious nature of our institution. Despite this irrelevance of the categories to our religious nature, they disqualify us from being considered a "religious employer."

Moreover, the NPRM's definition of "religious employer" serves to distinguish between the constitutional rights of churches and other religious organizations. Wheaton College is not affiliated with a larger church organizational or denominational structure. By denying Wheaton the exemption other religious groups receive, the NPRM treats Wheaton as a second-class religious organization. Wheaton has the right to be religious without being pressured by the government to affiliate with a larger church organization in order to protect its rights.

No concrete guidance for self-insured non-profits

The NPRM also fails to articulate a concrete proposed rule with respect to self-insured organizations like Wheaton. Instead of a concrete proposal that we can fully evaluate, the NPRM merely offers broad outlines for several possible alternative schemes. Without a concrete proposed rule, we have no clarity on what we will be asked to do and how the process will work. Accordingly, we cannot fully consider whether the government will be trying to force us to facilitate access to abortion-causing drugs and devices—which we cannot do—or not.

No protection for for-profit businesses

Finally, the NPRM specifically rejects any accommodation for the religious objections of business owners. As explained earlier, our mission at Wheaton is "to help build the church and improve society worldwide by promoting the development of whole and effective Christians through excellence in programs of Christian higher education." We seek to develop student-leaders who will be witnesses to Christ in all areas of life and are concerned by the lack of protection the NPRM offers for the religious liberty of individuals and institutions in the business world, as it will hinder the ability of our students to fully live out their faith. Wheaton graduates exercise their religion in many different facets of life, and their religious liberty should be protected broadly.

In light of these considerations, we ask the Department to eliminate the mandate altogether. If the Department chooses to keep the mandate in place, we ask the Department to expand the scope of the exemption to include all religious individuals and institutions who cannot comply with the mandate without violating their religious beliefs.

I appreciate your attention to this crucially important matter and am happy to speak with you or your department's representatives if that would be helpful.

Sincerely,

Philip G. Ryken
President

PGR:mp

Exhibit F

CMS.gov
Centers for Medicare & Medicaid Services

The Center for Consumer Information & Insurance Oversight

Amendment to Regulation on "Grandfathered" Health Plans under the Affordable Care Act

On June 17, 2010, the Departments of Health and Human Services, Labor, and the Treasury (the Departments) issued the "grandfather" regulation which, by addressing how health plans can retain a "grandfathered" exemption from certain new requirements, helps protect Americans' ability to keep their current plan if they like it. At the same time, Americans in grandfathered plans will receive many of the added benefits that the new law provides. The regulation also minimizes market disruption and helps put us on a path toward the competitive, patient-centered market of the future.

The grandfather regulation includes a number of rules for determining when changes to a health plan cause the plan to lose its grandfathered status. For example, plans could lose their grandfathered status if they choose to make certain significant changes that reduce benefits or increase costs to consumers. This amendment modifies one aspect of the original regulation.

Previously, one of the ways an employer group health plan could lose its grandfathered status was if the employer changed issuers – switching from one insurance company to another. The original regulation only allowed self-funded plans to change third-party administrators without necessarily losing their grandfathered plan status. Today's amendment allows all group health plans to switch insurance companies and shop for the same coverage at a lower cost while maintaining their grandfathered status, so long as the structure of the coverage doesn't violate one of the other rules for maintaining grandfathered plan status..

What does this mean for you?

The purpose of the grandfather regulation is to help people keep existing health plans that are working for them. This amendment furthers that goal by allowing employers to offer the same level of coverage through a new issuer and remain grandfathered, as long as the change in issuer does not result in significant cost increases, a reduction in benefits, or other changes described in the original grandfather rule.

Why did HHS, Labor and Treasury make this change?

The Departments received many comments on the provision in the original grandfather rule stating that a group health plan would relinquish grandfathered status if it changed issuers or policies. This change was made in response to those comments for the following reasons:

1. There are circumstances where a group health plan may need to make administrative changes that don't affect the benefits or costs of a plan. For example, an insurer may stop offering coverage in a market. Or a company may change hands. In those cases, the employer can maintain grandfathered status for their employee plan under this amendment.
2. Comments expressed concern that the original provision could have the inadvertent effect of interfering with health care cost containment. If an employer has to stay with the same insurance company to keep the benefits of having a grandfathered plan, the insurance company has undue and unfair leverage in negotiating the price of coverage renewals. Allowing employers to shop around can help keep costs down while ensuring individuals can keep the coverage they have.
3. Some employers buy coverage from insurance companies; others "self-insure," meaning that they pay claims themselves but usually hire a third-party administrator (TPA) to handle the paperwork. Usually only large companies can self-insure. Before this amendment, self-insured plans could change the company hired to handle the paperwork without losing grandfathered status as long as the benefits and costs of the plan stayed the same, while an employer that just changed insurance companies while maintaining the same benefits under their plan could not do so. Under this amendment, all employers have the flexibility to keep their grandfathered plan but change insurance company or third-party administrator.

What types of plans does this affect?

The amendment affects insured group health plans.

A change of issuers in the individual market would still result in the loss of grandfathered status.

How many plans will this affect?

The Departments expect that this amendment will result in a small increase in the number of plans retaining their grandfathered status relative to the estimates made in the grandfathering regulation.

The Departments did not produce a range of estimates for the number of affected entities given considerable uncertainty about the response to this amendment.

Exhibit G

HEALTH REFORM FOR SMALL BUSINESSES

The Affordable Care Act Increases Choice and Saving Money for Small Businesses

WHITEHOUSE.GOV/HEALTHREFORM

HEALTH REFORM FOR SMALL BUSINESSES

The Affordable Care Act Increases Choice and Saving Money for Small Businesses.

Small businesses are the backbone of our economy, but high health care costs and declining coverage have hindered small business owners and their employees. Over the past decade, average annual family premiums for workers at small firms increased by 123 percent, from $5,700 in 1999 to $12,700 in 2009, while the percentage of small firms offering coverage fell from 65 to 59 percent. The Affordable Care Act will provide enormous benefits to the millions of small business owners and the tens of millions of small business employees by expanding coverage options, increasing purchasing power, lowering costs and giving consumers, not insurance companies, control over their own health care.

No Employer Mandate, Exempts Small Firms from Employer Responsibility Requirement

The Affordable Care Act does not include an employer mandate. In 2014, as a matter of fairness, the Affordable Care Act requires large employers to pay a shared responsibility fee only if they don't provide affordable coverage and taxpayers are supporting the cost of health insurance for their workers through premium tax credits for middle to low income families.

- The law specifically exempts all firms that have fewer than 50 employees – 96 percent of all firms in the United States or 5.8 million out of 6 million total firms – from any employer responsibility requirements. These 5.8 million firms employ nearly 34 million workers. More than 96 percent of firms with 50 or more employees already offer health insurance to their workers. Less than 0.2 percent of all firms (about 10,000 out of 6 million) may face employer responsibility requirements. Many firms that do not currently offer coverage will be more likely to do so because of lower premiums and wider choices in the Exchange.

> For more information, please visit: **www.healthreform.gov/about/answers.html**.

Small Business Health Care Affordability Tax Credits

Under the Affordable Care Act, an estimated 4 million small businesses nationwide could qualify for a small business tax credit this year, which will provide a total of $40 billion in relief for small firms over the next 10 years.

- Small employers with fewer than 25 full-time equivalent employees and average annual wages of less than $50,000 that purchase health insurance for employees are eligible for the tax credit. The maximum credit will be available to employers with 10 or fewer full-time equivalent employees and average annual wages of less than $25,000. To be eligible for a tax credit, the employer must contribute at least 50 percent of the total premium cost.
- Businesses that receive state health care tax credits may also qualify for the federal tax credit. Dental and vision care qualify for the credit as well.
- For 2010 through 2013, eligible employers will receive a small business credit for up to 35 percent of their contribution toward the employee's health insurance premium. Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 25 percent of their contribution.
- For 2014 and beyond, small employers who purchase coverage through the new Health Insurance Exchanges can receive a tax credit for two years of up to 50 percent of their contribution. Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 35 percent of their contribution.

> For more information on tax credits, please visit: **www.irs.gov/newsroom/article/0,,id=223666,00.html**.

HEALTH REFORM FOR SMALL BUSINESSES

The Affordable Care Act Increases Choice and Saving Money for Small Businesses.

Better Information on Affordable Health Care Options

In July 2010, the Department of Health and Human Services will establish a new consumer website with easy to understand information about affordable and comprehensive coverage choices. The website will also provide information to small businesses about available health coverage options, including information on reinsurance for early retirees, small business tax credits, and how to shop for insurance in the Exchanges that will increase the purchasing power of small businesses.

Administrative Simplification

The Affordable Care Act accelerates adoption of standard "operating rules" for health insurance plan administration. Operating rules are the business rules and guidelines for electronic transactions with health insurance plans, and the current non-standard environment is a source of waste, unnecessary cost, and frustration for small business owners and others. Under administrative simplification, there will be one format and one set of codes for claims, remittance advice, service authorization, eligibility verification, and claims status inquiry.

By establishing uniform operating rules, the Affordable Care Act ensures that small businesses, health plans, physicians, hospitals, and patients are all speaking the same language. Benefits include:

- Improved coordination of care for the patient
- Increased payment accuracy and timeliness
- Reduced administrative cost and hassle factor for small businesses
- Payment transparency

The Affordable Care Act requires standard operating rules for eligibility and claims status to be adopted by July1, 2011 and fully implemented by January 1, 2013.

Increases Quality, Affordable Options for Small Businesses

Currently, small businesses face not only premiums that are 18 percent higher than large businesses pay, but also face higher administrative costs to set up and maintain a health plan. The premiums they pay have up to three times as much administrative cost built into them as plans in the large group market. They are also at a disadvantage in negotiating with insurance companies because they lack bargaining power. The Affordable Care Act will change this dynamic. Starting in 2014, small businesses with up to 100 employees will have access to state-based Small Business Health Options Program (SHOP) Exchanges, which will expand their purchasing power. The Congressional Budget Office (CBO) stated that the Exchanges will reduce costs and increase competitive pressure on insurers, driving down premiums by up to 4 percent for small businesses.

- These Exchanges would include web portals that provide standardized, easy-to-understand information that make comparing and purchasing health care coverage easier for small business employees, and reduce the administrative hassle that small businesses currently face in offering plans.
- Starting in 2017, the Affordable Care Act also provides states flexibility to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange.
- If businesses don't offer coverage, workers at small firms and their families would be eligible for their own tax credits to purchase coverage through the Exchange.
- The Affordable Care Act streamlines health plans to keep premiums lower by instituting a premium rate review process and setting standards for how much insurance companies can spend on administrative costs, also known as the medical loss ratio.

> To learn more, visit: **www.healthreform.gov/newsroom/naicletter.html**.

The Affordable Care Act Increases Choice and Saving Money for Small Businesses.

Security and Stability that Promotes Entrepreneurship

In 2014, the Affordable Care Act ends the discriminatory insurance industry practices of jacking up premiums by up to 200 percent because an employee got sick or older, or because the business hired a woman. In many cases, women can be charged higher premiums than men, simply because of their gender. It will also reduce "job lock" – the fear of switching jobs or starting a small business due to concerns over losing health coverage – by guaranteeing access to coverage for all Americans. This will encourage more people to launch their own small businesses, or join existing small employers.

Reviews the Impact of Reform on Small Businesses

The Affordable Care Act requires the Government Accountability Office (GAO) to specifically review the impact of Exchanges on increasing access to affordable health care for small businesses to ensure that Exchanges are indeed making a difference for small business owners.

Exhibit H

online.wsj.com http://online.wsj.com/news/articles/SB10001424052970203518404577094631979925326#printMode

The Church of Kathleen Sebelius

In the church of Kathleen Sebelius, there is little room for dissent. "We are in a war," the Health and Human Services Secretary declared to cheers at a recent NARAL Pro-Choice America fund-raiser. Give the lady her due: Her actions mostly match her words.

Mrs. Sebelius's militancy explains the shock her allies are now feeling after last Wednesday's decision to overrule the Food and Drug Administration on Plan B, a morning-after pill. The FDA had proposed allowing over-the-counter sales, which would give girls as young as 11 or 12 access without either a prescription or a parent. Now the secretary's allies are howling about her "caving in" to the Catholic bishops.

On this score they needn't worry. Notwithstanding the unexpected burst of common sense on Plan B, the great untold story remains the intolerance so beloved of self-styled progressives. In this Mrs. Sebelius has proved herself one of the administration's most faithful practitioners: here watering down conscience protections for nurses and doctors who don't want to participate in abortions; there yanking funding for a top-rated program for victims of sexual trafficking run by the Catholic bishops, because they will not sign on to the NARAL agenda; soon to impose a new HHS mandate that will require health-insurance plans to cover contraception, sterilization and drugs known to induce abortion.

Alas for her president, her zeal for this agenda has yielded two unintended consequences. Within her party, it is creating a rift between the Planned Parenthood wing and the president's Catholic and religious supporters. Outside her party, it is illuminating the danger of equating bigger government with a more just society.

Thus far, attention has mostly focused on the politics. One reason is that even Catholics who supported President Obama on his signature health bill recognize the contraceptive mandate as a bridge too far. These include the Catholic Health Association's Sr. Carol Keehan, whose well-publicized embrace of the Affordable Care Act gave the president critical cover when he needed it. Others simply question whether forcing Catholic hospitals to drop health insurance for their employees rather than submit to Madam Sebelius's bull is really the image the president wants during a tough re-election year.

Then there are the Catholic bishops. Just two years ago, many seemed to regard ObamaCare as a compassionate piece of legislation if only a few provisions (e.g., conscience rights and abortion funding) could be tweaked. Now they are learning the real problem is the whole thing is built on force—from the individual mandate and doctors' fees to the panels deciding what treatment grandma is entitled to. The awakening has led to a new bishops' committee on religious liberty, and tough, unprecedented criticism.

Predictably the press has been treating all this as a purely Catholic battle. If the church looms large here, that is because Catholic institutions have always been at the fore of social service. Still, it would be nice to come across a story that recognized that even if HHS were to widen the religious exemption (it's so narrow Jesus Christ wouldn't qualify) the new contraceptive mandate would still be imposed on non-Catholic as well as Catholic individuals and insurers.

Whether you approve or disapprove of contraception or sterilization is beside the point. Today nine out of 10 employer plans offer what Mrs. Sebelius wants them to. The point is whether it is right or necessary for Mrs. Sebelius to use the federal government to bring the other 10% to heel.

There was a day when liberals and libertarians appreciated the importance of upholding the freedoms of people and groups with unpopular views. No longer. As government expands, religious liberty is reduced to a special "exemption" and concerns about government coercion are dismissed, in the memorable words of Nancy Pelosi, as "this conscience thing."

"Religious liberty is better seen as more a liberty issue than a religion issue," says Bill Mumma of the Becket Fund for Religious Liberty. "The more we drive religious and private associations off the public square, the more that space will be occupied by government."

Of course, some might answer that they object to lots of things their money underwrites—say, the war in Iraq. Mrs. Sebelius's HHS rule, however, doesn't involve tax dollars: It involves forcing Americans to spend their private dollars on things they deem unconscionable. How far this is from the understanding in 1776 that the way to uphold liberty and keep these conflicts to a minimum was to keep government small and limited.

A new TV ad from CatholicVote.org features a little girl. "Dear President Obama," she says. "Can I ask you a question? Why are you trying to force my church and my school to pay for things that we don't even believe in?"

It's a good question. Apparently it's not enough that contraception be legal, cheap and available. As Mrs. Sebelius illustrates, modern American liberalism cannot rest until those who object are forced to underwrite it.

Write to MainStreet@wsj.com.

Exhibit I

104th NAACP Annual Conference

As prepared for delivery

Orlando, Florida
July 16, 2013

Thank you, Hilary, for that introduction. Thank you, President Jealous, Chairwoman Brock, and the Board of Directors, for inviting me. And thank you all for being here and for your service with one of the most important civil rights organizations in America.

Before I begin, I'd like to take a moment and thank our Surgeon General, Dr. Regina Benjamin, whose last day as America's doctor is today. Dr. Benjamin served with distinction – leading our first-of-its-kind National Prevention Strategy that helps move our country from one focused on sickness and disease to one based on wellness. She's also led our Public Health Service Commissioned Corps during public health emergencies. I'm grateful for her service, and pleased she will be here tomorrow.

I want to also thank Secretary Donovan and Attorney General Holder for their leadership and collaboration in President Obama's Cabinet. We know that housing, health, and a just society are key elements in the President's opportunity agenda to strengthen the middle class and help more people join the middle class.

Creating more possibilities for everyone to reach his or her full potential is why we all get up and go to work every day. That's how we bridge the meaning of our inalienable rights of life, liberty, and the pursuit of happiness to the realities of our time – as President Obama discussed in his second inaugural address.

And today, I'd like to talk about how our Department – the Department of Health and Human Services – is moving forward on the unfinished work of securing those rights. The rights may be self-evident, but they are not self-executing, as the President reminded us after a historic re-election that all of you helped make happen.

One critical step we're taking is expanding quality early education for our children.

We know that when children aren't safe and secure and in a learning environment, they can fall far behind their peers. But when they have social, emotional, and educational support in their earliest years, the benefits can last a lifetime.

Like with many of you and your children, I've seen the importance of early childhood development with my own sons, who were 2 and 5 when I was first elected to the Kansas legislature. I see it now as a grandmother of an 11-month-old grandson, with two working parents.

That's why we're working so closely with our great partners in the Department of Education, led by my good friend, Arne Duncan, to strengthen and expand early learning programs, especially for low-income families.

We're expanding home-visiting programs to support new parents and caregivers. We're strengthening Early Head Start and Head Start to help more children develop critical social and emotional skills that make a lifetime difference. Our babies and toddlers can become lifelong learners if their parents and caregivers can help them make a great start.

The President's historic plan for birth to age 5 also includes providing every child in America access to affordable preschool, which helps our children perform better in school and saves hard-working families hard-earned dollars in daycare costs.

We know early learning is a child's gateway to a better life. And it benefits us all. We all benefit from our young people going to school, starting a career, and achieving their dreams.

But we need your help reinforcing that message with policymakers and the public, and highlighting what's at stake.

If we shortchange our children, we shortchange our future. We can't let that happen.

And that brings me to another area of unfinished work that does right by our children and keeps the doors of opportunity open to them. We do our children and country no justice if we do nothing to stop the violence that plagues our communities.

I know that's been on our minds too often recently, but especially over the last couple of days. The death of Trayvon Martin was a tragedy for his family, but also for our country. And so are the tragedies of all the children we have lost because of gun violence before and since Trayvon was killed.

We pray for his family and respect their call for calm reflection. And we follow the President in asking ourselves if we're doing all we can to prevent future tragedies – from mass school shootings to the daily violence on street corners – from happening again.

That is a job for all of us. We can all widen the circle of compassion and understanding in our own communities.

At our Department we're asking how public health agencies like the CDC and NIH can better research and monitor gun violence-related injuries and deaths. We want to better determine risk factors and help state and local partners develop effective violence prevention programs.

And while we know that the majority of Americans who struggle with a mental illness are not violent, we're working to make it easier for young people, adults, and families struggling with mental illness to seek help. I encourage all of you to engage in our community conversations that are part of our effort to let people know that treatment works and that recovery is real.

The President hasn't given up on pushing forward on commonsense gun violence prevention efforts. You shouldn't either. We need your voices. We need your action. Now is the time.

And now is also the time to fulfill a promise of equality for tens of millions of Americans denied a basic freedom and opportunity to live a healthy life. From day one of this presidency, we've worked with all of our assets to reduce the health inequality that Dr. King called the most shocking and inhumane form of injustice of all.

We're investing in community health centers and workforce programs to bring thousands more doctors and nurses to the neighborhoods where they are most needed. We're recruiting public and private sector partners to help promote active lifestyles and healthy eating through the First Lady's Let's Move initiative.

I was at the White House with Valerie Jarrett yesterday to observe the third anniversary of the President's National HIV/AIDS Strategy. It has given us a new sense of direction to our fight against the epidemic, focusing more resources on the communities that are hardest hit – many of which are communities of color.

But there's probably no bigger step toward improving the health of communities of color than expanding access to affordable health coverage – and that's what the Affordable Care Act does.

Now, no matter what you're hearing out there, let's remember some facts. The debate in Washington is over. The Supreme Court has issued its decision. The people have spoken. President Obama was re-elected.

And to paraphrase Stevie Wonder, the Affordable Care Act is signed, sealed, and it's delivering.

More than 7 million African Americans with private insurance can now get preventive services for free – including blood pressure and cholesterol checks, cancer screenings and flu shots. All of this helps reduce the incidence of diseases – many of them preventable – which disproportionately affect communities of color.

Four and a half million elderly and disabled African Americans on Medicare – your grandmothers and grandfathers – now have access to free wellness visits and more affordable prescription drugs.

More than 500,000 young African American adults – your sons and daughters – who were previously uninsured are now covered by their parents' plan.

For all the women in the audience, this is a new day! Being a woman will no longer be a pre-existing condition for insurance companies! No longer will women have to worry about being denied care or charged more because of a pregnancy or breast cancer. Millions more women will have new options for coverage – already women now have access to critical services like contraception and cancer screenings with no extra out-of-pocket costs.

When we talk about health insurance, it's not just a card in a wallet. It's security. It's peace of mind. And it's not just about "insurance." It's also about "health."

So the first thing that people should know is that the health law is making that health coverage stronger for the majority of Americans who have it already – and that's about 85% of all Americans.

And the second thing to know is that for the 15% percent of Americans who don't have coverage at all, or for Americans who buy their own insurance right now and aren't happy with it, they'll have better options come this fall.

Beginning October 1, a new Health Insurance Marketplace will open for enrollment in every state, with benefits starting in January 2014.

All plans in the Marketplace must cover an essential set of benefits, including doctor visits, prescription drugs, and mental health services. Discrimination based on gender or pre-existing conditions, like diabetes or cancer, will be outlawed. And many individuals, families and small businesses will qualify for a break on the costs of their monthly premiums.

For the first time in history, insurance companies will have to compete for business based on price and service – not lock out, dump out, or price out of the market anyone who might get sick. Those days are over!

To enroll in the Marketplace, all you have to do is visit HealthCare.gov, where you'll find simple information that helps you find a plan that fits your budget.

HealthCare.gov will also help people find out about Medicaid coverage in their state – and this is another critical piece of the puzzle to ensure more Americans get the care they need.

Some of you live in states where the Governor and legislature have already decided to expand Medicaid. The door is open and we will keep working until all states sign up.

That's because if Medicaid isn't expanded in more states, millions of working people and some of our most vulnerable families could be left with no source of affordable health coverage. And speaking as a former governor, since the federal government will pay 100 percent of the costs for the first three years, and at least 90 percent thereafter, this deal is too good to pass up.

But here's the key point. Just because people have the opportunity to get new coverage – whether through the Marketplace or Medicaid expansion – doesn't mean they know about it.

A big share of the uninsured is young and healthy. If you have young adult children like I do, you know that getting health insurance is not always their first priority. I sometimes don't know what their first priority is, but it certainly isn't insurance.

But we also know there are people who have been uninsured or underinsured for so long that they simply don't believe that affordable coverage will ever be within reach.

They are busy working hard or going to school. They worry about the health of the ones they care for instead of their own. Each of you probably knows someone who wants that weight off their shoulders – who wants that new coverage so they can live, work, and reach their dreams.

And in less than three months, we have the chance to help our family, friends, and neighbors finally find that security and peace of mind. But we can't do it alone. We need your help.

To get ready for October 1 when the Marketplace opens for enrollment, you can visit HealthCare.gov today to sign up for information and updates.

It's not your typical government website – it's much easier to use and understand. And it's the best way to find out about those benefits that will be available as early as January 1, 2014. There's a web chat feature to help answer your questions – just like what you see when you're shopping online. And if you don't have access to a computer, there's a 24/7 customer call center ready to answer your questions in 150 languages.

And know that we're doing everything we can to help spread the word. We're partnering with local libraries and community health centers to help people sign up and enroll in October. We're supporting efforts to hire people who will work in many of your communities to educate your friends and neighbors about their options. Anton Gunn from our Department spoke at your Health Leaders Luncheon yesterday on ways your local branches can get involved.

And I've been traveling the country along with other senior health officials, visiting churches and holding town halls with African American community leaders to reach as many people as we can.

We know lots of people need information. They just want to know where to go to find it. And you can make all the difference!

In this room are educators, community leaders, parents, and grandparents. We need your voices and your help with outreach and education. So start spreading the word.

Download toolkits and customize flyers to hang up in local businesses like restaurants, barbershops, and beauty salons. Share them with your fraternities and sororities.

Some of you are health leaders: doctors, nurses, and counselors: Educate your patients about their rights and new coverage options. If you're a pastor or first lady, a deacon or a health ministry leader, few voices are more powerful than those from the ones we trust – use your voice to educate and motivate.

After 100 years of conversation about health reform, change is finally coming. And we only get this chance once in a lifetime. We need the NAACP to continue to be a champion for coverage to help remove one of the most persistent forms of inequality once and for all.

The Affordable Care Act is the most powerful law for reducing health disparities since Medicare and Medicaid were created in 1965, the same year the Voting Rights Act was also enacted.

That significance hits especially close to home. My father was a Congressman from Cincinnati who voted for each of those critical civil rights laws, and who represented a district near where the late Reverend Fred Shuttlesworth lived and preached.

The same arguments against change, the same fear and misinformation that opponents used then are the same ones opponents are spreading now. "*This won't work*," "*slow down*," "*let's wait*" – they say.

But history shows that upholding our founding principles demands continuous work toward a more perfect union. Bridging the meaning our inalienable rights to the realities of our time requires speaking up and standing up for them. And it requires the kind of work that the NAACP has done for more than a century to move us forward.

You showed it in the fight against lynching and the fight for desegregation. You showed it by ensuring inalienable rights are secured in the courtroom and at the ballot box. And you showed it by supporting a health law 100 years in the making.

With each step forward, you said to forces of the status quo, "*This will work*," "*we can't slow down" We can't wait*," "*we won't turn back*."

And those voices of progress form the echo we hear and honor this year.

They echo from church bells rung at midnight 150 years ago to educate our nation of a people's emancipation. They echo from a speech on our nation's mall 50 years ago next month about the promise of our nation's dream. And they still echo and guide us today in a second term of a historic presidency.

So let us seize this moment. We can't slow down. We can't wait. We won't turn back.

We move forward.

Thank you.

Exhibit J

Weldon Amendment, Consolidated Appropriations Act, 2009, Pub. L. No. 111-117, 123 Stat 3034

United States Public Laws
111th Congress – First Session
PL 111-117, December 16, 2009, 123 Stat 3034
Consolidated Appropriations Act, 2009

. . .

TITLE V
GENERAL PROVISIONS

. . .

SEC. 508.
. . .

(d)(1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(2) In this subsection, the term "health care entity" includes 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.