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Via Email (HHSPPlan@hhs.gov)

October 25, 2017

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
Strategic Planning Team
Attn: Strategic Plan Comments
200 Independence Avenue, SW
Room 415F
Washington, DC 20201

Dear Sir or Madam:

On behalf of the United States Conference of Catholic Bishops (“Conference” or “USCCB”), we offer the following comments on HHS’s Draft Strategic Plan FY 2018-2022 (“the Plan”).

We support and commend HHS for the Plan’s treatment of three issues of special concern to the Conference. We also have constructive suggestions on a fourth special concern relating to people in poverty.

First, the Plan helpfully recognizes and endorses the need to promote the health of human beings at every stage of life, beginning at conception.

Second, the Plan helpfully recognizes the need to reduce burdens on the free exercise of religion, and to promote the equal participation of individuals and organizations of faith in the delivery of health care and other services and in HHS programs.

Third, the Plan helpfully supports the implementation of programs to protect and strengthen marriage and family.

These are commendable and important goals. We support them and encourage their adoption in the final version of HHS’s Strategic Plan.

The *fourth* area of special concern relates to aspects of the plan that impact the poor. The Plan presents some positive components that should be adopted in the final version of the Strategic Plan on these matters. However, other sections of the Plan need revision or further context to merit inclusion.

I. Promoting the Health of Unborn Children

In several sections, the Plan recognizes the need to promote the health of human beings at every stage of life, beginning at conception. Lines 60 to 61 of the Plan state that “HHS accomplishes its mission through programs and initiatives that cover a wide spectrum of activities, serving and protecting Americans at every stage of life, beginning at conception.” *See also* lines 846-48 (stating as a core component of HHS’s missions its dedication “to serve all Americans from conception to natural death”). Lines 114-15 state that the Department’s “ultimate goal is to improve healthcare outcomes for all people, including the unborn, across healthcare settings.” Lines 149-50 speak to the need to reduce avoidable medical costs by “increasing use of timely prenatal, maternal, and postpartum care.” Lines 540-41 likewise promote expanded access to prenatal and pregnancy care. Lines 830-31 discuss medical and community mitigation measures that will advance global health by “respecting the inherent dignity of persons from conception to natural death.”

Lines 975-76 speak of the need to “[p]rotect women and their unborn children from harm and harmful exposures during pregnancy, and promote recommended protective prenatal and postpartum behaviors...” Lines 1143-44, 1286-89, and 1341-44 support the protection of human subjects in research “from conception to natural death,” and the enforcement of regulations and other laws concerning research involving human embryos and embryonic stem cells/tissue and fetal tissue.

These are praiseworthy objectives and they should be adopted in the final version of the Strategic Plan. Adequate prenatal care, especially early prenatal care (in the first trimester of pregnancy), is essential to maintain the health of the developing baby and mother. Prenatal health care allows detection of preexisting medical conditions in pregnant women which, left untreated, could be exacerbated by the pregnancy and harm the woman or pose a threat to the health of her unborn child. As HHS noted at the turn of the millennium, “[i]ncreasing the percentage of women who receive prenatal care, and who do so early in their pregnancies, can improve birth outcomes and lower health care costs by reducing the likelihood of complications during pregnancy and childbirth.” HHS, *Trends in the Well-being of America’s Children & Youth 2000*, § HC 3.2, Prenatal Care (2000), <https://aspe.hhs.gov/report/trends-well-being-americas-children-and-youth-2000>.

There are still too many women in the United States who receive no or less-than-adequate health care when pregnant. In 2011, among 36 states and the District of Columbia, over 25 percent of women giving birth did not receive early prenatal care in the first trimester of their pregnancy, and the number goes up for women whose highest educational degree is a high school education or less. HHS, Health Resources and Services Administration, *Child Health*

USA 2013, p. 32 (Oct. 2013), <https://mchb.hrsa.gov/chusa13/dl/pdf/chusa13.pdf>. Yet women who receive early prenatal care are more likely to give birth to healthy babies – and much less likely to deliver babies with low birth weights.

The Conference believes that every human being has the right to quality health services, regardless of age, income, illness, or condition of life, and has long supported access to prenatal care for pregnant women and their babies. As the Conference wrote in *Putting Children and Families First*: “Beginning with our children and their mothers, we must extend access to quality health care to all our people. Quality and accessible prenatal care is essential for healthy children. There can be no excuse for the failure to ensure adequate health care and nutrition for pregnant women. Nothing would make a greater contribution to reducing infant mortality than progress in this area.” USCCB, *Putting Children and Families First: A Challenge for Our Church, Nation, and World* (Nov. 1991).

Because prenatal care is essential for the health of both the child and the mother, we support these objectives.

The Plan’s recognition of the unborn child is amply supported by the scientific and medical literature. This literature, and modern medical practice, recognize that the life of a human being begins at conception and continues until adulthood. Embryology textbooks, for example, overwhelmingly recognize that human life begins at conception:

Human development begins after the union of male and female gametes or germ cells during a process known as fertilization (conception)... This fertilized ovum, known as a zygote, is a large diploid cell that is the beginning, or primordium, of a human being.

Keith L. Moore, *Essentials of Human Embryology*, p. 2 (1988).

The development of a human begins with fertilization, a process by which the spermatozoon from the male and the oocyte from the female unite to give rise to a new organism, the zygote.

T.W. Sadler, *Langman’s Medical Embryology*, p. 3 (7th ed. 1995).

Almost all higher animals start their lives from a single cell, the fertilized ovum (zygote)... The time of fertilization represents the starting point in the life history, or ontogeny, of the individual.

Bruce M. Carlson, *Patten’s Foundations of Embryology*, p. 3 (6th ed. 1996).

The biological fact that human life begins at conception is also acknowledged by current medical practice. In particular, the American Academy of Pediatrics, which is dedicated to providing health care to children, has long recognized the unborn child as a patient of the pediatrician. The Academy states:

The purview of pediatrics includes the physical and psychosocial growth, development, and health of the individual. This commitment begins prior to birth when conception is apparent and continues throughout infancy, childhood, adolescence and early adulthood, when the growth and developmental processes are generally completed.

American Academy of Pediatrics, *Policy Statement: Age Limits of Pediatrics*, 81 PEDIATRICS 736 (May 1988).

Indeed, the unborn child's status as a patient in need of health care has long enjoyed international recognition. The United Nations Declaration on the Rights of the Child, and the 1990 Convention implementing its principles which has been ratified by 196 nations, declare that "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth." See Preamble to the U.N. Convention on the Rights of the Child.

The care of the child in his or her mother's womb also constitutes a distinct medical specialty, that of maternal-fetal medicine. Moreover, as technology has increased and understanding of unborn life has expanded, subspecialties have developed within this field. For example, at the University of Pennsylvania School of Medicine there is a Fetal Echocardiography Project that is dedicated to assisting physicians in the diagnosis of heart problems in the unborn child. The Society for Fetal Urology is dedicated "to improv[ing] the care of patients with fetal or perinatal urological problems." Society for Fetal Urology, *Bylaws*, art. 2, ¶ 1. Across the country, public health and community organizations are dedicated to protecting unborn children from exposure to alcohol. See National Organization on Fetal Alcohol Syndrome (providing database of national and state programs and services).

An overwhelming scientific and medical consensus recognizes that the life of a child begins before birth at conception, and that the unborn child is a distinct patient with his or her own health needs. It is therefore entirely appropriate for HHS to formulate policies that serve the health and well-being of the unborn child.

There is precedent for doing so. In 1980, during the Carter Administration, HHS reviewed conditions throughout the human life cycle that may warrant the federal government's concern and support. Noting that "life is a constantly evolving process that begins with conception and continues until death," the report stated:

With the passage of time, the human organism grows from a single cell to a fully developed adult.... In relation to the total life span of the individual, the early developmental years are short and serve as the foundation for the remainder of one's life span. The needs of a child in the support of this growth and development begin before birth and continue throughout the growth years until maturity is reached.... The stage of the family's life cycle in which the developing fetus grows influences the emotional, physical, and economic resources that will be available for supporting and protecting the growing child.

HHS, Office of Human Development Services, *The Status of Children, Youth and Families 1979*, DHHS Publication No. (OHDS) 80-30274 (Aug. 1980), pp. 29, 30 (citation omitted).

This report acknowledged the reality of human life from conception onward, recognized the special needs and vulnerability of the unborn child, and called for care and concern directed specifically to the healthy development of this child in the womb.

The treatment of unborn children is also consistent with legal precedent. Outside the abortion context, unborn children are often recognized as persons who warrant the law's protection. Most states, for example, allow recovery in one form or another for prenatal injuries. *Roe v. Wade*, 410 U.S. 113, 161-62 (1973). More than two-thirds of states criminalize fetal homicide. Paul Benjamin Linton, *The Legal Status of the Unborn Child Under State Law*, 6 U. ST. THOMAS J. L. & PUB. POL'Y 141, 143-44 (Fall 2011). Unborn children have long been recognized as persons for purposes of inheritance, *Roe*, 410 U.S. at 162, and a child unborn at the time of his or her father's wrongful death has been held to be among the children for whose benefit a wrongful death action may be brought. Federal law similarly recognizes the unborn child as a human subject deserving protection from harmful research as soon as pregnancy is confirmed. 42 U.S.C. § 289g(b); 45 C.F.R. §§ 46.203 et seq. It is therefore no innovation to treat an unborn child as a human individual for the purpose of providing quality prenatal care to the child and his or her mother.

We support provisions in the Plan that recognize the need to promote the health of human beings at every stage of life, beginning at conception, and we encourage HHS to adopt those provisions in the final version of the Strategic Plan.

II. Reducing Burdens on Religious Liberty and Promoting the Equal Participation of Persons and Organizations of Faith in HHS Programs

In several sections, the Plan proposes reducing burdens on religious liberty and promoting the equal participation of persons and organizations of faith in HHS programs.

Lines 316, 390-91, and 447-53 of the Plan encourage and facilitate the participation of faith-based and other community organizations as a means of improving public health and access to health care.

Lines 359-74 call for vigorous enforcement of laws, regulations, and other authorities, particularly Executive Order 13798 ("Promoting Free Speech and Religious Liberty"), to reduce burdens on the exercise of religious and moral convictions, promote equal and nondiscriminatory participation by faith-based organizations in HHS-funded or -conducted activities, remove barriers to the full and active engagement of faith-based organizations in HHS programs, and affirmatively accommodate religious beliefs and moral convictions "to ensure full and active engagement of persons of faith or moral conviction and of faith-based organizations in the work of HHS."

Numerous other provisions of the Plan (lines 169-70, 189-90, 333-34, 350-51, 353-54, 375-76, 399-403, 435-36, 469, 474-76, 489-92, 507-08, 542-44, 548-51 644, 659, 675, 694-95, 703, 747-48, 763, 790-91, 875-76, 880-81, 902, 941, 949, 952-53, 992, 998, 1008, 1020, 1033-34, 1057, 1070, 1080, 1113, and 1133-34) recognize the value in the participation of faith-based and other community organizations in contributing to the achievement of health-related objectives, and the critical need to protect religious and moral convictions.

These are praiseworthy goals and we encourage their adoption in the final version of the Strategic Plan.

Encouraging and facilitating the participation of faith-based organizations in the delivery of health care and human services is especially important given the size, scope, and quality of services such organizations provide. Millions of persons are served by faith-based organizations in the health care sector alone, and the ramifications of losing those services, which are often life-saving, is sobering to contemplate. No one benefits from rules or practices that have the effect of excluding faith-based organizations from the public sphere, or that make it impossible for such organizations, in good conscience, to serve the public.

The range and quality of services offered by faith-based organizations cannot be easily or at all replicated by government and secular organizations. With respect to acute care, for example, nonprofit religious hospitals “save more lives, release patients from the hospital sooner, and have better overall patient satisfaction ratings” than their secular counterparts. David Foster, et al., *Hospital Performance Differences by Ownership*, p. 1 (June 2013), http://www.nonprofithealthcare.org/uploads/Hospital_Performance_Differences_by_Ownership.pdf. Religious hospitals “demonstrated significantly better results than for-profit and government hospitals on inpatient and 30-day mortality, patient safety, length of stay, and patient satisfaction....” *Id.* at 2. And religious hospitals often provide services that other hospitals do not offer. Catholic hospitals, for example, which care for one of six hospital patients in the United States, “often provide more public health and specialty services than other health care providers,” including “some traditionally ‘unprofitable’ services.” Catholic Health Association, *Catholic Health Care in the United States*, p. 1 (Jan. 2015).

Likewise, faith-based organizations are among the largest and most critically needed U.S.-based deliverers of human services in the world measured by the scope of services provided and the number of persons served. In 2014, for example, Catholic Charities agencies in the United States served over 8.7 million people, with total expenditures exceeding \$4.3 billion. Catholic Charities USA, *2014 Annual Survey: Summary*, pp. 1-2, <https://files.catholiccharitiesusa.org/files/publications/2014-Annual-Network-Impact-Report-Summary.pdf?mtime=20160223154235>. Their impact in just one major metropolitan area is illustrative. In 2013, Catholic Charities agencies in New York City and the lower Hudson Valley alone provided over \$735 million in services to over 370,000 people. Catholic Charities, Archdiocese of New York, *Annual Report 2013*, p. 5, <http://catholiccharitiesny.org/about-us/annual-report>. Services included day care, foster care, adoption, community centers, emergency meals, emergency shelters, temporary and transitional residences, permanent affordable housing, counseling, financial assistance, maternity services, supportive housing for

the mentally ill, residences for those with special needs and disabilities, and services for immigrants and refugees. *Id.*

And the Catholic Church is not alone. Other faith groups make similarly large and irreplaceable contributions to persons in need.¹ The Salvation Army, to take one example, reports that it offers services in virtually every zip code in the nation, and serves more than 30 million Americans every year. The Salvation Army, 2015 Annual Report, p. 4, <http://2015.salvationarmyannualreport.org/assets/2015/2015%20Annual%20Report.pdf>. That includes, on an annual basis, 58.4 million meals, nightly shelter for 10.8 million people, treatment for 200,000 people in 142 rehabilitation facilities, more than 400 after-school programs, and immediate and long-term assistance following disasters to 382,000 people. *Id.*

In light of the high volume, broad sweep, and quality of the services that faith-based organizations provide, there is everything to be gained by enhancing their ability to participate in the provision of health care and other human services and everything to be lost by restricting or impeding their participation. The modern trend has seen greater reliance upon the services offered by such organizations. Since nearly the last half century, the federal government has relied increasingly upon nonprofit (including religious) organizations and local authorities in providing health and social services. Ram A. Cnaan, *The Newer Deal*, pp. x, xi, 4, 10-14 (1999). The modern movement toward local and private providers is illustrated by the charitable choice provisions of federal welfare reform that expanded the role of faith-based organizations, provisions that have been replicated in subsequent legislation. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 104 (Aug. 22, 1996); *see, e.g.*, Children’s Health Act of 2000, Pub. L. No. 106-310, tit. XXXIII, § 3305 (Oct. 17, 2000) (codified at 42 U.S.C. § 300x-65). As HHS reiterated just two weeks ago, the United States has a long history of protecting and accommodating the religious and moral convictions of faith-based organizations to ensure their continued participation in the delivery of health care and other services. 82 Fed. Reg. 47792 (Oct. 13, 2017) (interim final rules providing religious exemptions and accommodations for faith-based organizations and other stakeholders under the Affordable Care Act); 82 Fed. Reg. 47838 (Oct. 13, 2017) (interim final rules providing moral exemptions and accommodations for faith-based and other stakeholders under the Affordable Care Act); *see* <http://www.usccb.org/issues-and-action/religious-liberty/conscience-protection/upload/Federal-Conscience-Laws.pdf> (listing federal statutes protecting conscience).

The Plan’s proposal to reduce burdens on religious liberty and to promote the equal participation of persons and organizations of faith in HHS programs is consistent with these trends, and we encourage their incorporation into the final version of the Strategic Plan.

III. Strengthening Families

The Plan (lines 1020-23) laudably calls for the provision of human services to promote “strong, healthy family formation and maintenance through programs that combine marriage and

¹ *See, e.g.*, Brian J. Grim & Melissa E. Grim, *The Socio-Economic Contributions of Religion to American Society: An Empirical Analysis*, 12 INTERDISC. J. RES. RELIGION (2016) (cataloguing contributions of faith-based groups, including charitable organizations, to American economy).

relationship education services” with other efforts. The Plan (lines 1024-27) also calls for developing and implementing “local and national dissemination strategies to communicate the value of healthy marriages and relationships....” Other provisions of the Plan speak to the need to promote “healthy marriage and relationship education” (lines 887-88, 1002-03), to promote strong families (line 967), and to improve “marital and family stability” (line 1007).

Marriage and family “constitute one of the most precious of human values,” Pope John Paul II, Apostolic Exhortation *Familiaris Consortio*, no. 1 (1981), and these institutions play an essential role in the nurturing, education, and care of the human person. As noted by a member of Parliament just a few years ago:

Children lucky enough to be born into strong families are advantaged in almost every area for the rest of their lives: school attendance, educational achievement, getting and keeping a job. They will earn more. They will be healthier. They will be more likely to form strong families of their own.

Remarks of Chief Rabbi (of the UK) Lord Jonathan Sacks, quoted in Lynn D. Wardle, “*As the Family Goes*”: *Reconciling Moral and Legal Pluralism by Prioritizing Marriage*, Selections from the Recife Congress, International Society of Family Law (Margaret F. Brinig, ed., Univ. of Notre Dame), p. 223, at <http://s3-ap-southeast-2.amazonaws.com/resources.farm1.mycms.me/isflhome-org/Resources/PDF/Recife%20Congress%20Selected%20Papers.pdf>.

An “overwhelmingly large majority” of “more than 50 published, empirical studies on the correlation between marital status and health” indicate that married couples are “happier, healthier, and live longer than those who are not married.” Susan Martinuk, *Marriage is Good for Your Health* (Sept. 29, 2016), <https://www.cardus.ca/research/family/publications/4957/marriage-is-good-for-your-health/>. Studies indicate (*see id.*) that couples with good marriages tend to have:

- Higher likelihood of recovering from cancer
- Lower risk of suffering a heart attack
- Better odds of surviving a heart attack
- Quicker recovery from illness
- Healthier habits and lifestyles
- Better responses to psychological stress.

Conversely, “a considerable body of research indicates a low-quality marriage has several harmful effects on couples’ health”:

- Increased blood pressure
- Increased risk of heart disease
- Increased depression
- Increased time needed for healing of physical wounds
- Increased levels of stress hormones
- Decreased immune function.

Id.

Marriage can have a positive impact not only on the health of the married couple, but on that of their children. A large body of data from the Centers for Disease Control show that “[c]hildren living with two married parents are more likely to be healthy than children from other types of families.” Anna Sutherland, *Family Structure and Children’s Health* (July 3, 2014), <https://ifstudies.org/blog/family-structure-and-childrens-health>. The dissolution of a healthy marriage is associated with poor health outcomes for children. *See, e.g.*, Anna Sutherland, *Parental Divorce Can Have a Lasting Effect on Children’s Health* (Dec. 31, 2015) (Experiencing parental divorce in childhood is “positively associated with worse self-reported health at age 50,” and the outcomes are worse when the divorce is experienced before age seven), <https://ifstudies.org/blog/parental-divorce-can-have-a-lasting-effect-on-childrens-health>, citing Jason Thomas & Robin Hognas, *The Effect of Parental Divorce on the Health of Adult Children*, 6 LONGITUDINAL AND LIFE COURSE STUDIES, pp. 279-302 (2015), <https://www.ncbi.nlm.nih.gov/pubmed/26594245>. Fractured marriages can also have other ill effects on children. *See, e.g.*, Harry Benson, *Divorce is Hardest on Already Disadvantaged Children* (May 15, 2014) (“[F]ollowing parental divorce, children tend to become worse at reading, at math, in their approach to learning, in their interpersonal skills, in their self-control, and in the way they internalize and externalize problems.”), <https://ifstudies.org/blog/divorce-is-hardest-on-already-disadvantaged-children>, citing Paul R. Amato & Christopher J. Anthony, *Estimating the Effects of Parental Divorce and Death with Fixed Effects Models*, 76 J. OF MARRIAGE AND FAMILY, pp. 370-86 (Mar. 4, 2014), <https://www.ncbi.nlm.nih.gov/pubmed/26594245>. *See also* Jane Anderson, *The Impact of Family Structure on the Health of Children: Effects of Divorce*, 81 LINACRE Q. 378 (Nov. 2014) (“Nearly three decades of research evaluating the impact of family structure on the health and well-being of children demonstrates that children living with their married, biological parents consistently have better physical, emotional, and academic well-being.”), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4240051/>.

Proposals that promote and strengthen marriages and families can only have a salutary impact and will redound to the benefit of the broader society.

IV. Concern for Those Living in Poverty

The Plan includes many features intended to extend the reach of health services to underserved populations. This focus by HHS is praiseworthy. The Plan attempts to achieve this aim in a number of ways—through improving access to physical and behavioral health care options (lines 335-36), expanding the number and type of health care workers that can reach areas with fewer providers (lines 397-444), promoting lifestyle changes for better health (lines 466-551), and expanding communication approaches for the underserved (lines 489-96). Commendably, the Plan seeks to improve quality of life for older adults and those with disabilities, among others (lines 290-96).

The Plan also seeks to address some of the most difficult challenges to poor and vulnerable people, including in the areas of mental and substance abuse disorders (lines 654-744). The country is in a crisis state with regard to mental health care and substance abuse,

including opioid addiction. HHS's intention to focus on this reality and devote time and resources to it is laudable.

Lines 297-98 emphasize the "social determinants of health." HHS is right to stress the importance of housing, education and training, child care, social services, and economic supports as key factors in the health and well-being of individuals and families, and to integrate those factors into its overall approach.

Along with these positive features, the Plan includes some vague, incomplete and/or troubling sections as well. While not comprehensive, the following list provides examples that are indicative:

- Building out and broadening models that allow the option of more control over health care dollars without clear indication of safeguards for the poor and vulnerable and programs that currently serve them (lines 162-63).
- Streamlining eligibility and enrollment processes for Medicare and Medicaid, without the stated aim of ensuring the integrity and reach of the underlying programs (lines 178-80).
- Improving "return on investment" of federal and state spending by encouraging new payment models, while not coupling the concept with maintenance or expansion of coverage (lines 191-92).
- Enhancing the use of health information technology among safety net providers and community-based organizations to inform decision-making and improve outcomes, without expressing the need to balance the pace of these advances with sensitivity to capacity and resources of the target organizations (lines 284-86).
- Allowing consumers to purchase customizable health insurance plans, with cost-sharing and out-of-pocket costs commensurate with benefits chosen, with no indication that such plans will be subject to adequate standards concerning even minimal coverage or that steps will be taken to protect against confusing or illusory promises (lines 357-58).
- "Reform [of] safety net programs" through innovation to help individuals and families in need become self-sufficient, without a corresponding commitment to ensure program integrity and at least current reach (lines 874-77).
- Significant discussion of improving TANF-related work requirement outcomes, while not recognizing the current state of the program relative to actual need. Additionally, there is no suggestion of an assessment regarding the availability of suitable work for those served by the program (lines 890-95).

The Plan provides some innovative approaches to addressing underserved populations. Even so, the Plan would benefit from additional clarity on care for those in poverty, especially in

ensuring the integrity and reach of existing poverty-related programs, especially Medicaid and Medicare. Currently 75.3 million people are covered by Medicaid and the Children's Health Insurance Program alone. The Plan would also be strengthened by coupling flexibility goals with a commitment to adequate safeguards.

* * *

Thank you for the opportunity to comment on the Plan, and for your consideration of these comments.

Sincerely,

Anthony R. Picarello, Jr.
Associate General Secretary &
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Michael F. Moses
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