FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9899-P, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted via Regulations.gov

RE: CMS-9903-P: Coverage of Certain Preventive Services Under the Affordable Care Act Proposed Rule

Dear Administrator Brooks-LaSure,

Families USA (FUSA) is a leading national voice for health care consumers, dedicated to the achievement of high quality, affordable health care and improved health for all. We seek to make concrete and tangible improvements in health care that make a real difference in people's lives. We appreciate the opportunity to comment on proposed regulation amendments under the Patient Protection and Affordable Care Act (ACA).

Achieving improved health for all requires that all birthing people have the ability to choose whether and when they become pregnant and have a child. Nearly all women rely on contraception at some point during their lifetimes to realize this result.[i] Ninety-nine percent of sexually experienced women have used at least one method of contraception.[ii] Religious affiliation plays little role in contraceptive use among women. Ninety-nine percent of women who identify as mainline Protestant, evangelical Protestant, or Catholic, and 96% of all women who identify as religious have used contraception at some point during their lifetime.[iii]

Given the critical importance of contraceptives for women's health and well-being, access to contraceptive services should not rely on a patient's ability to pay. The data is clear that the availability of no-cost sharing coverage for contraceptive services is essential for women with limited resources or who live in poverty. After implementation of the ACA, insured women's out-of-pocket costs for contraceptives dropped dramatically, making those services more accessible and increasing the use of long-term services like IUDs and implants.[iv],[v] Between 2014 and 2016, 86% of sexually-active women with incomes below the federal poverty level used a method of contraception- 91% of those women with an income of 300% of the poverty level did so.[vi] In the wake of the *Dobbs v. Jackson Women's Health Organization,* the availability and affordability of preventive, contraceptive services is even more crucial. This proposed rule is particularly significant in protecting women's access to that care.[vii]

Overall, FUSA supports the proposed rule to establish Individual Contraceptive Arrangements, specifically as it ensures access to essential health care services. Below FUSA offers suggestions for further adjustments to the proposed regulation.

II.D.2: Individual Contraceptive Arrangement for Eligible Individuals

The rule proposes to establish an Individual Contraceptive Arrangement (ICA) to provide no cost sharing contraceptive services to individuals who have lost access to those services due to a religious exemption of their insurance sponsor. A religious exemption is available to for-profit and nonprofit employers -- including ERISA plans -- some colleges and universities, and church-provided health plans. The organizations taking advantage of the exemption are known as the objecting entity. The ICA would allow individuals to obtain contraceptives from participating providers and participating issuers, as a pathway to no cost sharing contraceptive care separate from the objecting entity. **We strongly support the establishment of this program but have concerns about its implementation. To make this program more viable, we recommend that CMS take additional steps to reduce the individual and provider burden in accessing the program.**

We believe that the proposed rule creates an unnecessary burden on the person seeking services, as the objecting entity is not required to provide information to employees/health plan enrollees about the religious exemption and the existence of an ICA. Without this notice, qualifying individuals may not receive timely, preventive, contraceptive care solely because they do not know it is available to them. Additionally, putting the burden on the individual to find a participating provider, without a system-wide registry or established network of providers, may limit who is able to access participating providers and to ultimately receive the care they need.

Providing educational materials and informing individuals of the existence of a coverage option is different than directly arranging the care. **We encourage the Department to require objecting entities to promptly provide educational materials about the ICA to individuals. We also strongly encourage the Department to establish a system-wide registry, published on Healthcare.gov and cross-referenced on State-based exchange sites and the Department of Labor website.** We recommend publicizing the availability of the registry through social and traditional media as well as encouraging navigators and assisters to add this to the list of topics on which they provide community education. Since provider directories can quickly go out-of-date, we recommend that the Departments update such a registry on a quarterly basis.

The proposed rule seeks comment on whether those who have access to the existing optional accommodation should be considered eligible for the ICA. Objecting entities currently can opt-in to an accommodation that establishes external coverage of contraceptive services for the employees and dependents enrolled in their health plans. The ICA would create a new pathway only for those health plan enrollees without access to the optional accommodation. We believe that this distinction may cause provider confusion in determining which individual is eligible for the ICA and which is not. This might lead to eligible individuals being deemed ineligible, leaving them with no pathway to affordable contraceptive care. **We recommend that the definition of "eligible individuals" include both those covered under an optional accommodation and those not covered, simplifying access to the program for individuals and potentially reducing eligibility determination errors.**

As it relates to the viability of the program, we are concerned that because the ICA is optional and in addition to established patient-provider relationships, providers might not be inclined to participate. The Department estimated that approximately 2,180 participating providers of contraceptive services would participate across the country; however the country overall is experiencing a health care workforce shortage and low-income people and people of color are already more likely to live in

contraception deserts.[viii,ix,x] In order for this program to be effective, there must be a low administrative barrier to entry for providers and a substantial number of providers participating.

In the proposed rule, providers are required to establish new contracts with participating issuers on the Federally Facilitated Exchange (FFE) or State Exchange on the Federal Platform (SBE-FP) to receive reimbursement for care they provide through the ICA. The FFE and SBE-FP would then apply for a user fee adjustment. We are supportive of the inclusion of administrative fees in the Department's assessment of the total cost of participating in the program. However, the administrative effort required in establishing new contracts, even when one already exists, could be a limiting factor to participation. Understanding the program processes and confirming beneficiary eligibility may also limit a provider's willingness to participate. **We suggest that all licensed providers of contraceptive services who have a current contractual relationship with any FFE or SBE-FP issuer, be listed as a participating provider and their existing contract be valid as their ICA reimbursement contract. Making these providers automatically a participant in the arrangement could cut down on administrative burden for them and issuers, limit the time spent establishing those arrangements, and increase the number of doctors available in the program.**

II.C.2: Moral Exemptions

The current regulation allows both religious and moral exemption for objecting entities. Families USA strongly supports the proposal to remove the non-religious, moral exemption for objecting entities. Interim Final rules in 2017 proposed exemptions for entities based on moral convictions and 2018 final rules solidified the new moral exemption.[xi],[xii] We agree with the Department that neither the RFRA nor other laws require a moral exemption.

The cases that have come before the Supreme Court on contraceptive coverage do not address non-religious, moral exemption but rather only the religious ones.[xiii] Review of other relevant litigation has led the Department to understand that there is no ruling preventing them from removing the moral exemption. Additionally, the Department notes that there is little reasoning to believe that there would be successful Religious Freedom Restoration Act (RFRA) claims for non-religious, moral entities. Further, an employer with a non-religious objection should not be allowed to burden employees that do not share that objection with additional procedural hurdles to obtain contraceptive care. As pointed out in the preamble, from the Supreme Court's decision of *Corp. of Presiding Bishop v. Amos*, where "government acts with the proper purpose of lifting a regulation that burdens the exercise of religion, we see no reason to require that the exemption come packaged with benefits to secular entities."[xiv] This ruling, while not specific to contraceptive coverage, supports the Department's position for considering moral objections in a different manner to religious ones. We strongly support the Department in their analysis of past litigation and their movement to remove the non-religious moral exemption.

Families USA greatly appreciates the opportunity to provide comments on this proposed rule. If finalized, the proposed rule could make a significant difference for women across the country. Specifically for those low-income and people of color who are disproportionately affected by inaccessibility of contraceptive coverage and reproductive care through their employer-sponsored coverage, medical disenfranchisement, and heightened financial barriers. We look forward to continuing to work with the Department on these critical access and affordability issues. For additional information please contact Hazel Law at hlaw@familiesusa.org.

Sincerely,

Frederick Isasi

Executive Director, Families USA

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[i] For the purpose of this comment: "birthing people" refers to people who can get pregnant and give birth. We understand that people other than "women" can get pregnant and rely on contraceptive services, but for the purpose of this comment we will use "women" as the predominant demographic impacted by the proposed rule and policies.

[ii] *Contraceptive Use in the United States,* The Guttmacher Institute, 2021, https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states

[iii] *Contraceptive Use in the United States,* The Guttmacher Institute, 2021, https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states

[iv] *Kaiser Family Foundation analysis of Truven Health Analytics MarketScan Commerical Claims and Encounters Database*, Kaiser Family Foundation, 2004-2016, https://www.kff.org/wp-content/uploads/2018/11/9093-02-jan-figure-2.png

[v] Birgisson, N., Zhao, Q., Secura, G., et al, *Preventing Unintended Pregnancy: The Contraceptive CHOICE Project in Review,* Journal of Women's Health, 2015, https://pubmed.ncbi.nlm.nih.gov/25825986/

[vi] Kavanaugh, M., Pliskin, E., *Use of contraception among reproductive-aged women in the United States, 2014 and 2016*, F&S Reports, 2020, https://www.fertstertreports.org/article/S2666-3341(20)30038-6/fulltext.

[vii] *Dobbs v Jackson Women's Health Organization, 597 U.S.,* Supreme Court of the United States, 2022, https://supreme.justia.com/cases/federal/us/597/19-1392/#tab-opinion-4600822

[viii] CMS, *Coverage of Certain Preventive Services Under the Affordable Care Act,* IRS, EBSA, HHS, 2023, https://www.federalregister.gov/documents/2023/02/02/2023-01981/coverage-of-certain-preventive-services-under-the-affordable-care-act

[ix] *Health Workforce Shortage Areas,* HRSA, 2023, https://data.hrsa.gov/topics/health-workforce/shortage-areas

[x] Kreitzer, R., Smith, C., et al, *Affordable but Inaccessible? Contraception Deserts in the US States,* Journal of Health, Politics, Policy, and Law, 2021, https://pubmed.ncbi.nlm.nih.gov/32955562/

[xi] CMS, *Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act,* IRS, EBSA, DOL, HHS, 2017, https://www.federalregister.gov/documents/2017/10/13/2017-21852/moral-exemptions-and-accommodations-for-coverage-of-certain-preventive-services-under-the-affordable

[xii] CMS, *Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act,* IRS, EBSA, DOL, HHS, 2018, https://www.federalregister.gov/documents/2018/11/15/2018-24514/moral-exemptions-and-accommodations-for-coverage-of-certain-preventive-services-under-the-affordable

[xiii] Three cases on this subject have come before the Supreme Court of the United States:
Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014), https://supreme.justia.com/cases/federal/us/573/682/
Zubik v. Burwell, 578 U.S. ___ (2016), https://supreme.justia.com/cases/federal/us/578/14-1418/
Little Sisters of the Poor Saints Peter and Paul Home v. Pennsylvania, 140 S. Ct. 2367 (2020), https://casetext.com/case/little-sisters-of-the-poor-saints-peter-and-paul-home-v-pennsylvania

[xiv] *Corporation of Presiding Bishop of Jesus Christ of Latter-Day Saints v. Amos*, 483 U.S. 327, 339, 107 S. Ct. 2862 (1987), https://supreme.justia.com/cases/federal/us/483/327/