

National  
**Family Planning**  
& Reproductive Health Association

December 5, 2017

**VIA ELECTRONIC SUBMISSION**

Acting Secretary Eric Hargan  
CMS Administrator Seema Verma  
Center for Medicare & Medicaid Services  
US Department of Health and Human Services  
Attention: CMS-9925-IFC  
P.O. Box 8016  
Baltimore, MD 21244-8016

**Re: Moral Exemptions and Accommodations for Coverage of Certain Preventive Services  
Under the Affordable Care Act (CMS-9925-IFC)**

Dear Acting Secretary Hargan and Administrator Verma:

The National Family Planning & Reproductive Health Association (NFPRHA) is committed to ensuring all individuals have access to affordable, high-quality family planning and sexual health services, including contraceptive services and supplies. As a result, NFPRHA has strongly supported the nation's efforts to ensure individuals have robust insurance coverage of contraception without cost-sharing and unequivocally opposes the Departments of Health and Human Services, Labor and Treasury's (the Departments') recent efforts that undermine the Affordable Care Act's (ACA) contraceptive coverage requirement through this interim final rule (IFR).

NFPRHA is a national membership organization representing providers and administrators committed to helping people get the family planning education and care they need to make the best choices for themselves and their loved ones. NFPRHA's members operate or fund a network of more than 3,500 health centers and service sites that provide high-quality family planning and other preventive health services to millions of low-income, uninsured, or underinsured individuals in all 50 states, the District of Columbia, as well as US territories. Services are provided through state, county, and local health departments as well as hospitals, family planning councils, Planned Parenthoods, federally qualified health centers, and other private nonprofit organizations.

The women's preventive services requirement of the ACA was designed to promote preventive health care, reduce future medical costs, and improve the health, equality, and economic security of women and families.<sup>1</sup> More than 62 million women with private insurance now have coverage of these vital health care services, including breast and cervical cancer screening, screening for sexually transmitted diseases, and contraception and contraceptive counseling.<sup>2</sup> By allowing virtually any employer or university to claim this moral exemption and deprive women of contraceptive coverage, this IFR will harm the health and well-being of women, their partners, and their families. Furthermore, the IFR is predicated upon a distorted picture of the federal programs that compose the family planning safety net, the Title X family planning program and Medicaid. **For these reasons, NFPRHA calls on the Departments to rescind the IFR and restore equal access to contraceptive coverage regardless of employer.**

### CONTRACEPTION IS CRITICAL TO HEALTH

Women face a unique set of health care challenges because they access more health services than men, yet earn less on average than men.<sup>3</sup> As a result, women face a high level of health care insecurity, which in turn leads many women to forgo necessary care due to prohibitive patient cost-sharing. Before the ACA, one in seven women with private health insurance and nearly one-third of women covered by Medicaid either postponed or went without needed services because they could not afford it.<sup>4</sup> Women were spending between 30% and 44% of their total out-of-pocket health costs on contraception alone.<sup>5</sup> As a result of the ACA and its contraceptive coverage benefit, women saved more than \$1.4 billion in out-of-pocket costs on oral contraceptives in 2013 alone.<sup>6</sup>

The goal of preventive health care is to help people control, track, and better manage their lifelong health, and the health of their families. Similarly, the goal of contraception is to prevent unintended pregnancy, control the timing of a desired pregnancy and spacing between pregnancies, in accordance with patient choice and to improve maternal, child, and family health.<sup>7</sup> In addition, contraception is particularly critical for women with underlying physical and

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<sup>1</sup> This comment uses the term "women" because women are targeted by the IFRs. We recognize, however, that the denial of reproductive health care and insurance coverage for such care also affects people who do not identify as women, including some gender non-conforming people and some transgender men.

<sup>2</sup> National Women's Law Center. New Data Estimates 62.4 Million Women Have Coverage of Birth Control Without Out-Of-Pocket Costs. September 2017. Available at <https://nwlc.org/wp-content/uploads/2017/09/New-Preventive-Services-Estimates-3.pdf>

<sup>3</sup> U.S. Census Bureau. Income, Poverty, and Health Insurance Coverage in the United States: 2008, Table A-2. 2009.

<sup>4</sup> Kaiser Family Foundation. Women's Health Care Chartbook. 2011.

<sup>5</sup> Ibid.

<sup>6</sup> Nora V. Becker and Daniel Polsky, Women Saw Large Decrease In Out-Of-Pocket Spending For Contraceptives After ACA Mandate Removed Cost Sharing, *Health Affairs*, 34, no.7 (2015):1204-1211. Available at <http://content.healthaffairs.org/content/34/7/1204.full.pdf+html>.

<sup>7</sup> Women's Preventive Services Initiative, *Recommendations for Preventive Services for Women* 83 (2016), available for download at <https://www.womenspreventivehealth.org/final-report/>.

psychological conditions, some of which can be exacerbated by pregnancy itself. These women may need to take particular care in planning their pregnancies to ensure that their health can support carrying a pregnancy to term.<sup>8</sup>

Unintended pregnancies have higher rates of long-term health complications for women and their infants. Women with unintended pregnancies are more likely to delay prenatal care, leaving their health complications unaddressed and increasing risk of infant mortality, birth defects, low birth weight, and preterm birth.<sup>9</sup> Women with unintended pregnancies are also at higher risk for maternal morbidity and mortality, maternal depression, and experiencing physical violence during pregnancy.<sup>10</sup>

Unintended pregnancy rates are higher in the US than in most other developed countries, with approximately 45% of pregnancies unintended.<sup>11</sup> In addition, the US has the highest rate of maternal mortality in the developed world.<sup>12</sup> Contraceptive efficacy in preventing unintended pregnancy is well established and supported in evidence.<sup>13</sup> Contraception is considered a major factor in reducing rates of maternal morbidity and mortality.

Beyond the well-established evidence that contraception is effective in the prevention of unintended pregnancy, non-contraceptive health benefits of contraception are recognized in evidence, including decreased bleeding and pain with menstrual periods and reduced risk of gynecologic disorders, including endometriosis, myoma, pelvic inflammatory disease, and a decreased risk of endometrial and ovarian cancer.<sup>14</sup> Non-contraceptive health benefits also include treatment for non-gynecologic conditions.<sup>15,16</sup>

The patient, in consultation with a trusted health care provider, should determine the right contraceptive method for her unique health care needs without interference from politicians. The IFR interferes with the patient-provider relationship, and conversations about if and when to become pregnant as well as which contraceptive method to use to avoid pregnancy.

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<sup>8</sup> *Id.* at 103–104.

<sup>9</sup> Conde-Agudelo A, Rosas-Bermudez A, Kafury-Goeta AC. Birth spacing and risk of adverse perinatal outcomes: a meta-analysis. *JAMA* 2006;295:1809–23.

<sup>10</sup> Tsui AO, McDonald-Mosley R, Burke AE. Family Planning and the Burden of Unintended Pregnancies. *Epidemiologic Reviews*. 2010;32(1):152–174. doi:10.1093/epirev/mxq012.

<sup>11</sup> Finer LB and Zolna MR, Declines in unintended pregnancy in the United States, 2008–2011, *New England Journal of Medicine*, 2016, 374(9):843–852,

<sup>12</sup> Murray, J.L., Wang, H., Kassebaum, N., “Sharp Decline in Maternal and Child Deaths Globally, New Data Show.” Institute for Health Metrics and Evaluation. University of Washington. 2016.

<sup>13</sup> Trussell J. Contraceptive failure in the United States. *Contraception*. 2011;83(5):397–404.

<sup>14</sup> Schindler AE. Non-contraceptive benefits of oral hormonal contraceptives. *Int J Endocrinol Metab*. 2013;11(1):41–7, and Access to contraception. Committee Opinion No. 615. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2015;125:250–5.

<sup>15</sup> Schindler AE. *supra*.

<sup>16</sup> Cortessis VK, Barrett M, Brown W, et. Al. Intrauterine Device Use and Cervical Cancer Risk; A Systematic Review and Meta-analysis *Obstet Gynecol*. 2017

## **OTHER GOVERNMENT PROGRAMS CANNOT MEET THE NEED FOR CONTRACEPTIVE COVERAGE**

In the accompanying IFR on religious exemptions (CMS-9940-IFC), the Department of Health and Human Services (HHS) asserts that existing government-sponsored programs, such as Medicaid and the Title X family planning program, can serve as alternatives or safeguards for individuals who will lose access to contraceptive coverage without cost-sharing under their employer-sponsored or student health plans.<sup>17</sup> As discussed below, this assertion fails to recognize that: 1) programs such as Medicaid and Title X are not designed to absorb the needs of higher income, privately insured individuals; 2) those programs do not have the capacity to meet the needs of current enrollees and those seeking care at Title X-funded health centers; and, 3) legislative and administrative proposals threaten the capacity and goals of these programs. Moreover, the claim that state coverage requirements are an alternative misconstrues the scope and protections provided by these requirements, which cannot fill in the gaps of coverage for many individuals who will lose contraceptive coverage.

### **Medicaid and Title X are not designed to meet the needs of individuals who lose access to contraceptive coverage under their employer-sponsored or student health plans.**

Safety-net programs like the Title X family planning program and Medicaid are not designed to absorb the unmet needs of higher-income, insured individuals. Enacted in 1970, Title X is the nation's only dedicated source of federal funding for family planning services.<sup>18</sup> While Title X-funded health centers provide care to all patients, federal law requires them to give priority to "persons from low-income families."<sup>19</sup> Low-income individuals receive services at low or no cost depending on their family income.<sup>20</sup> Congress did not design Title X as a substitute for employer-sponsored coverage. The Title X statute and regulations contemplate how Title X and third-party payers will work together to pay for care, directing Title X-funded agencies to seek payment from such third-party payers.<sup>21</sup>

Medicaid is a source of coverage designed to meet the unique health care needs of individuals who are low-income. Unlike Title X, which is required to subsidize low-income patients but must see all patients regardless of payor source, Medicaid has income and other eligibility requirements for individuals to participate. Many individuals enrolled in Medicaid have extremely low incomes and minimal savings at hand. These individuals also face severe health problems and lack any resources to address these issues on their own, unlike individuals with higher incomes and employer-sponsored coverage. Moreover, while 33 states have expanded

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<sup>17</sup> Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47803 (Oct. 13, 2017) (to be codified at 45 C.F.R. 147, pt. 147).

<sup>18</sup> See Fam. Plan. Servs. & Population Res. Act of 1970, Pub. L. No. 91-572, 84 Stat. 1504.

<sup>19</sup> 42 CFR § 59.5 (a)(6-9).

<sup>20</sup> 42 U.S.C. § 300a-4(c)(2); 42 C.F.R. § 59.5(a)(7)-(8).

<sup>21</sup> 42 U.S.C. § 300a-4(c)(2) (prohibiting charging persons from a "low-income family" for family planning services "except to the extent that payment will be made by a third party (including a government agency) which is authorized or is under legal obligation to pay such charge"); 42 CFR § 59.5(a)(7), (9).

coverage under the Medicaid expansion option of the ACA, many individuals remain ineligible for this coverage.<sup>22</sup> In states that have not expanded Medicaid, income eligibility for this program is quite limited. The median income limit for parents in these states was \$8,985 per year for a family of three in 2017.<sup>23</sup> In many of these states, childless adults remain ineligible for the program.<sup>24</sup> Due to this, many low-income women<sup>24</sup> who would be eligible to enroll in Medicaid under this option, depending on where they reside, are unable to do so. For many women who will lose access to the contraceptive coverage benefit, Title X and Medicaid will not be viable alternatives for securing contraceptive care and counseling.

### **Medicaid and Title X do not have capacity to meet the increased need.**

At a time when our nation's public health network is already burdened and under attack, it is critical to ensure that all women have access to contraceptive coverage and care. Medicaid is the nation's largest insurer, providing coverage to over 74 million people. Medicaid enrollees have robust coverage of comprehensive health care, and Medicaid already operates as a very lean program. Despite this, provider shortages have persisted. The majority (two-thirds) of state Medicaid programs face challenges in securing an adequate number of providers to furnish services to patients.<sup>25</sup> This is particularly true with respect to specialty providers, including OB/GYNs and other family planning and sexual health providers. A recent report from the HHS Office of the Inspector General found that many Medicaid managed care plans had provider shortages, with only 42% of in-network OB/GYN providers able to offer appointments to new patients.<sup>26</sup>

The IFR argues that Title X-funded health centers could fill the gap in contraceptive coverage caused by employer exemptions and would have to provide care to more patients than are currently served by the program. However, with current funding and resources, the Title X provider network cannot meet the existing need for publicly funded family planning, let alone absorb the increase in demand that would result from the IFR. Since 2010, the reported annual number of clients served at Title X-funded health centers has dropped from approximately 5.2 million patients to just over 4 million.<sup>27</sup> This decline corresponds with over \$30 million in cuts

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<sup>22</sup> The Henry J. Kaiser Family Foundation, Status of State Action on the Medicaid Expansion Decision, <https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D> (last updated Nov. 8, 2017).

<sup>23</sup> Rachel Garfield & Anthony Damico, The Henry J. Kaiser Family Foundation, The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid, (2017), <https://www.kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

<sup>24</sup> Ibid.

<sup>25</sup> U.S. Government Accountability Office. "States Made Multiple Program Changes, and Beneficiaries Generally Access Comparable to Private Insurance." (Nov. 2012). <http://www.gao.gov/assets/650/649788.pdf>; U.S. Department of Health and Human Services. Office of Inspector General. "Access to Care: Provider Availability in Medicaid Managed Care." (Dec. 2014). <http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf>.

<sup>26</sup> U.S. Department of Health and Human Services, supra at note 7.

<sup>27</sup> See Fowler, CI, Lloyd, SW, Gable, J, Wang, J, and Krieger, K, *Family Planning Annual Report: 2010 National Summary*, RTI International (Sept. 2011), available at <https://www.hhs.gov/opa/sites/default/files/fpar-2010-national->

to Title X's annual appropriated amount over the same period.<sup>28</sup> A recent study published in the *American Journal of Public Health* confirms that reductions in funding for Title X limit the number of patients Title X-funded providers are able to serve, concluding that Congress would have to increase federal funding for Title X by over \$450 million to adequately address the existing need for publicly funded family planning services.<sup>29</sup> Requiring otherwise higher-income, privately insured individuals to use Title X-funded health centers would deplete resources from an already overburdened and underfunded program. Thus, NFPRHA is unconvinced that Medicaid and Title X are plausible alternatives for the individuals affected by this IFR.

### **Political assault on Medicaid, Title X, and Planned Parenthood health centers have already compounded the threat to women's access to contraceptive care.**

Medicaid is a vital source of coverage for family planning and sexual health care in the United States, but political threats to the program may undermine its ability to provide the coverage that meets the needs of individuals and families. In 2010, Medicaid covered nearly 45% of all births in the US, and in many states Medicaid covers well over half of births.<sup>30</sup> Medicaid is also the single largest source of public funding for family planning services and supplies.<sup>31</sup>

Within the last year, policymakers have sought to radically alter the financial structure of Medicaid. The most recent legislative proposal sponsored by Senators Lindsey Graham and Bill Cassidy would have decimated the Medicaid program by cutting over one trillion dollars from the program over the next ten years.<sup>32</sup> The proposal would have repealed Medicaid expansion, converted Medicaid's financing structure to a per-capita cap, and permitted states to block

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[summary.pdf](#); Fowler, C.I, Gable, J., Wang, J., & Lasater, B, *Family Planning Annual Report: 2016 national summary*, RTI International (Aug. 2017), available at <https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf>.

<sup>28</sup> U.S. Dept. of Health and Human Servs., Funding History HHS.Gov (2017), available at <https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/funding-history/index.html> (last visited Nov 3, 2017).

<sup>29</sup> August, Euna M. et al., "Projecting the Unmet Need and Costs for Contraception Services After the Affordable Care Act," *American Journal of Public Health* (2016), available at <http://doi.org/10.2105/AJPH.2015.302928>.

<sup>30</sup> Kathy Gifford et al., The Henry J. Kaiser Family Found., Medicaid Coverage of Pregnancy and Perinatal Benefits: Results from a State Survey, (2017), <http://kff.org/womens-health-policy/report/medicaid-coverage-of-pregnancy-and-perinatal-benefits-results-from-a-state-survey/>; *Births Financed by Medicaid*, The Henry J. Kaiser Family Found., <http://kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Nov. 6, 2017).

<sup>31</sup> In 2010, Medicaid accounted for 75 percent of all public funds spent on contraceptive services and supplies. Kinsey Hasstedt et al., Guttmacher Institute, Public Funding for Family Planning and Abortion Services, FY 1980–2015 (2017), <https://www.guttmacher.org/report/public-funding-family-planning-abortion-services-fy-1980-2015>.

<sup>32</sup> Cong. Budget Office, Preliminary Analysis of Legislation That Would Replace Subsidies for Health Care with Block Grants, 6, (Sept. 2017), <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/53126-health.pdf>.

grant their Medicaid programs for certain communities, resulting in drastic cuts to coverage and services that individuals enrolled in Medicaid need and deserve.<sup>33</sup>

The administration has also made moves that could radically alter the Medicaid program. Earlier this year, then-Secretary Tom Price and CMS Administrator Seema Verma issued a letter to governors announcing HHS' intent to use existing Section 1115 waiver authority to approve changes to state Medicaid programs that could undermine the ability of individuals qualified to enroll in Medicaid—particularly non-disabled, working-age adults—to receive the coverage and health care they need.<sup>34</sup>

In addition to these legislative and administrative efforts to alter the Medicaid program, Congress and the administration have threatened access to trusted family planning and sexual health providers by attempting to block Planned Parenthood from participating in Medicaid despite the dominant role Planned Parenthood plays in delivering family planning care to people with Medicaid coverage. In fact, in 57% of counties with a Planned Parenthood health center, Planned Parenthood serves at least half of all safety-net family planning patients with Medicaid coverage.<sup>35</sup>

Unfortunately, Medicaid is not the only health care program that has faced administrative and congressional attacks. Title X has also been targeted. In addition to severe cuts to Title X's budget since 2011, political opponents of reproductive health have repeatedly sought to defund or interfere with patients' access to care under the program. In 2011, the House voted for the first time in the history of the Title X program to defund the program and the House has proposed to defund it once again for FY 2018.<sup>36</sup> The administration has not only signaled its support for these efforts, but has also put forth its own proposals to restrict access to publicly funded family planning under Title X.<sup>37</sup> For instance, the president's FY 2018 budget plan proposed blocking low-income and uninsured patients from obtaining federally-funded health care services, including Title X-funded care, at Planned Parenthood health centers, even

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<sup>33</sup> Mara Youdelman & Kim Lewis, Nat'l Health Law Program, Top 10 Changes to Medicaid Under the Graham-Cassidy Bill, (Sept. 14, 2017), <http://www.healthlaw.org/publications/browse-all-publications/top-10-changes-to-medicaid-under-graham-cassidy-bill#.Wft9mmhSzIV>.

<sup>34</sup> Letter from Secretary Tom E. Price and CMS Administrator, Seema Verma, to Governors (on file with NHLP-DC), <https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf>.

<sup>35</sup> Kinsey Hasstedt, Understanding Planned Parenthood's Critical Role in the Nation's Family Planning Safety Net, Guttmacher Policy Review, (2017), <https://www.guttmacher.org/gpr/2017/01/understanding-planned-parenthoods-critical-role-nations-family-planning-safety-net>.

<sup>36</sup> *Title X, Budget & Appropriations*, Nat'l Family Planning & Reprod. Health Ass'n, <https://www.nationalfamilyplanning.org/title-x-budget-appropriations>, (last updated visited Nov. 3, 2017); Make America Secure and Prosperous Appropriations Act, 2018, H.R. 3354, 115th Cong. (2017) ("None of the funds appropriated in this Act may be used to carry out title X of the PHS Act.").

<sup>37</sup> The White House, Statement Of Administration Policy: H.R. 3354 — Make America Secure and Prosperous Appropriations Act, 2018 (Rep. Frelinghuysen, R-NJ) (Sept. 5, 2017), available at <https://www.whitehouse.gov/the-press-office/2017/09/05/hr-3354-make-america-secure-and-prosperous-appropriations-act-2018>.

though Planned Parenthood health centers currently serve 41 percent of patients that access contraception through Title X nationwide.<sup>38 39</sup>

Needless to say, these dangerous proposals would severely limit access to high-quality family planning care for the populations that turn to Title X-funded providers and those enrolled in the Medicaid program, including low-income and uninsured women, LGBTQ+ individuals, communities of color, and young people.

**Most state coverage requirements fail to guarantee coverage of the full range of contraceptive methods, services, and counseling with no cost-sharing.**

Similarly, the IFR suggests that the existence of state-level contraceptive coverage requirements somehow diminish the need for a federal requirement. This suggestion ignores the fact that 22 states do not have contraceptive coverage laws at all, and that the federal contraceptive coverage requirement made several important advances over laws in the other 28 states.<sup>40</sup> Only four state laws currently match the federal requirement to cover contraception without copayments, deductibles, and other out-of-pocket costs.<sup>41</sup> Moreover, few state laws match the federal requirement in terms of the breadth and specificity of the contraceptive methods, services, and counseling that are included.<sup>42</sup> Additionally, no state has the authority to regulate plans offered by employers that self-insure, which cover 60% of covered workers nationwide.<sup>43</sup>

**The Departments' assertion that other programs and legal requirements can meet the need for contraceptive coverage created by this rule is inaccurate.**

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<sup>38</sup> Kinsey Hasstedt, *Beyond the Rhetoric: The Real-World Impact of Attacks on Planned Parenthood and Title X*, *Guttmacher Policy Review*, (Aug. 2017), available at <https://www.guttmacher.org/gpr/2017/08/beyond-rhetoric-real-world-impact-attacks-planned-parenthood-and-title-x>.

<sup>39</sup> White House, Office of Management and Budget, *The President's Fiscal Year 2018 Budget: Overview* (May 2017), available at [https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/budget/fy2018/fact\\_sheets/2018%20Budget%20Fact%20Sheet\\_Budget%20Overview.pdf](https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/budget/fy2018/fact_sheets/2018%20Budget%20Fact%20Sheet_Budget%20Overview.pdf) (last visited Nov 3, 2017).

<sup>40</sup> Guttmacher Institute, *Insurance coverage of contraceptives*, *State Laws and Policies (as of October 2017)*, 2017, <http://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives>.

<sup>41</sup> Several additional states have enacted new requirements that will take effect in 2018 or 2019. See Guttmacher Institute, *Insurance coverage of contraceptives*, *State Laws and Policies (as of October 2017)*, 2017, <http://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives>.

<sup>42</sup> For example, only three states currently require coverage of female sterilization, and only two states currently require coverage of methods sold over the counter (such as some types of emergency contraception). Several additional states have enacted new requirements that will take effect in 2018 or 2019. See Guttmacher Institute, *Insurance coverage of contraceptives*, *State Laws and Policies (as of October 2017)*, 2017, <http://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives>.

<sup>43</sup> Claxton G et al., *Employer Health Benefits: 2017 Annual Survey*, Menlo Park, CA: Kaiser Family Foundation; and Chicago: Health Research & Educational Trust, 2017, <https://www.kff.org/report-section/ehbs-2017-section-10-plan-funding/>.



## **JUSTIFICATIONS FOR THE IFR DO NOT MEET BASIC SCIENTIFIC STANDARDS**

As the nation’s health policy center, HHS must adopt policies and activities firmly based on scientifically valid and appropriate terms and evidence. The IFR does not meet the high standard of scientific evidence used by the IOM and the Women’s Preventive Services Initiative (WPSI), instead prioritizing moral objections over evidence-based medical recommendations. The Departments make several false and misleading statements in the IFR to undermine the contraceptive coverage benefit. NFPRHA fundamentally disagrees with the Departments’ decision to promulgate this IFR based on the moral beliefs of individuals and entities rather than science and medicine.

### **Contraception does not interfere with an existing pregnancy.**

The IFR takes issue with the IOM-recommended coverage of the full range of U.S. Food and Drug Administration (FDA)-approved contraceptive methods because it includes “certain drugs and devices...that many persons and organizations believe are abortifacient—that is, as causing early abortion.”<sup>44</sup> FDA-approved contraceptive methods do not function as abortifacients. Every FDA-approved contraceptive method acts before implantation, does not interfere with an existing pregnancy, and is not effective after a fertilized egg has implanted successfully in the uterus.<sup>45</sup>

### **Contraception is medication and carries risks like any medication.**

The IFR raises concerns about the “negative health effects” of contraception.<sup>46</sup> As with any medication, some contraceptive methods may be contraindicated for patients with certain medical conditions, including high blood pressure, lupus, or a history of breast cancer.<sup>47,48</sup> Specifically, the IFR suggests an increased risk of venous thromboembolism (VTE). In fact, VTE among oral contraceptive users is very low and is much lower than the risk of VTE during pregnancy or in the immediate postpartum period.<sup>49</sup> The IFR also suggests contraception increases the risk of breast cancer, but there is no scientifically-proven increased risk of breast cancer among contraceptive users, particularly those under 40.<sup>50</sup>

### **Contraception makes sex among adolescents healthier, not more likely to happen.**

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<sup>44</sup>82 Fed. Reg. 47,792, 47,749 (Oct. 13, 2017).

<sup>45</sup> Brief for Physicians for Reproductive Health, American College of Obstetricians and Gynecologists et al. as Amici Curiae Supporting Respondents, *Sebelius v. Hobby Lobby*, 573 U.S. XXX (2014) (No. 13–354). Available at: [acog.org/~media/Departments/Government%20Relations%20and%20Outreach/20131021AmicusHobby.pdf](http://acog.org/~media/Departments/Government%20Relations%20and%20Outreach/20131021AmicusHobby.pdf)

<sup>46</sup> 82 Fed. Reg. 47,792, 47,804 (Oct. 13, 2017).

<sup>47</sup> Progestin-only hormonal birth control: pill and injection. FAQ No. 86. American College of Obstetricians and Gynecologists. July 2014.

<sup>48</sup> Combined hormonal birth control: pill, patch, and ring. FAQ No. 185. American College of Obstetricians and Gynecologists. July 2014.

<sup>49</sup> Risk of venous thromboembolism among users of drospirenone-containing oral contraceptive pills. Committee Opinion No. 540. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2012;120:1239–42.

<sup>50</sup> Curtis KM, Jatlaoui TC, Tepper NK, et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. *MMWR Recomm Rep* 2016;65(No. RR-4):1–66. DOI: <http://dx.doi.org/10.15585/mmwr.rr6504a1>.

The IFR suggests the contraceptive coverage benefit could “affect risky sexual behavior in a negative way.”<sup>51</sup> Increased access to contraception is not associated with increased unsafe sexual behavior or increased sexual activity.<sup>52,53</sup> In fact, research has shown that school-based health centers that provide access to contraception are proven to increase use of contraception by already sexually active students, not to increase onset of sexual activity.<sup>54,55</sup> On the other hand, young women who did not use contraception at first sexual intercourse were twice as likely to become teen mothers.<sup>56</sup> Overall, increased access to and use of contraception has contributed to a dramatic decline in rates of adolescent pregnancy.<sup>57</sup>

**The Departments should rescind the IFR because it is not evidence-based and does not withstand basic scientific scrutiny.**

### THE IFR UNDERMINES CONGRESSIONAL INTENT

The Departments ignore Congress’ clear intent that contraception be covered as a preventive service under the ACA. When Congress passed the Women’s Health Amendment, it meant to “ensure that recommended preventive services for women are covered adequately by non-grandfathered group health plans and group health insurance coverage, recogniz[ing] that women have unique health care needs and burdens.”<sup>58</sup> Allowing more entities to deprive women of contraceptive coverage, as the IFR does, strikes at the very purpose of the contraceptive coverage requirement.

Indeed, Congress intended the Women’s Health Amendment, which includes the contraceptive coverage requirement, to help alleviate the “punitive practices of insurance companies that charge women more and give [them] less in a benefit” and to “end the punitive practices of the private insurance companies in their gender discrimination.”<sup>59</sup> In enacting the

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<sup>51</sup> 82 Fed. Reg. 47,792, 47,805 (Oct. 13, 2017).

<sup>52</sup> Kirby D. Emerging answers 2007: Research findings on programs to reduce teen pregnancy and sexually transmitted diseases. Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy. 2009.

<sup>53</sup> Meyer JL, Gold MA, Haggerty CL. Advance provision of emergency contraception among adolescent and young adult women: a systematic review of literature. *J Pediatr Adolesc Gynecol.* 2011;24(1):2-9).

<sup>54</sup> Minguez M, Santelli JS, Gibson E, Orr M, & Samant, S. Reproductive health impact of a school health center. *Journal of Adolescent health,* 2015;56(3), 338-344.

<sup>55</sup> Knopf JA, Finnie RKC, Peng Y, et al. Community Preventive Services Task Force. School-based health centers to advance health equity: a Community Guide systematic review. *American Journal of Preventive Medicine* 2016;51(1):114-26.

<sup>56</sup> *Ibid.*

<sup>57</sup> Lindberg L, Santelli J, Desai S. Understanding the Decline in Adolescent Fertility in the United States, 2007-2012. *J Adolesc health.* 2016;59(5):577-583. DOI: 10.1016/j.jadohealth.2016.06.024.

<sup>58</sup> Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8727 (Feb. 15, 2012).

<sup>59</sup> 155 Cong. Rec. S12,021, S12,026 (daily ed. Dec. 1, 2009) (statement of Sen. Mikulski); *see also id.* at S12,030 (statement of Sen. Dodd) (“I support the effort by Senator Mikulski on her efforts to see to it that women are treated equally, and particularly in preventive care[.]”).

amendment, Congress recognized that the failure to cover women’s preventive health services meant that women paid more in out-of-pocket costs than men for necessary preventive care and in some instances were unable to obtain this care at all because of cost barriers:

Women must shoulder the worst of the health care crisis, including *outrageous discriminatory practices in care and coverage*... In America today, too many women are delaying or skipping preventive care because of the costs of copays and limited access. In fact, more than half of women delay or avoid preventive care because of its cost. *This fundamental inequity in the current system is dangerous and discriminatory and we must act.*<sup>60</sup>

In considering the amendment, Congress expressed its expectation that the preventive services covered would include family planning services. For example, Senator Gillibrand stated, “With Senator Mikulski’s amendment, even more preventive screening will be covered, including for...family planning.”<sup>61</sup> Additional statements from Senators Boxer, Feinstein, Nelson, and Durbin prove that the intent to cover contraception was clear.<sup>62</sup>

To meet the amendment’s objectives, HHS commissioned the Institute of Medicine (IOM) to convene a diverse committee of experts in disease prevention, women’s health and adolescent health issues, and evidence-based guidelines to review existing guidelines, identify existing coverage gaps, and recommend services and screenings for HHS to consider in order to fill those gaps.<sup>63</sup> After conducting its analysis, the IOM panel recommended eight preventive services for women, including contraceptive coverage.<sup>64</sup> On August 1, 2011, HRSA adopted the recommendations set forth in the IOM report.<sup>65</sup> These were updated in 2016 based on recommendations from the Women’s Preventive Services Initiative (WPSI) as part of a five-year cooperative agreement between the American College of Obstetricians and Gynecologists and HRSA to coordinate the development, review, and update of recommendations. These, too, were adopted by HRSA.

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<sup>60</sup> *Id.* at S12,027 (statement of Sen. Gillibrand) (emphases added).

<sup>61</sup> 155 Cong. Rec. S12,021, S12,027 (daily ed. Dec. 1, 2009).

<sup>62</sup> *See also* 155 Cong. Rec. S12025 (Dec. 1, 2009) (Sen. Boxer) (preventative care “include[s] . . . family planning services”); 155 Cong. Rec. S12114 (Dec. 2, 2009) (Sen. Feinstein) (“The amendment . . . will require insurance plans to cover at no cost basic preventive services” including “family planning.”); *id.* at 12277 (Sen. Nelson) (“I strongly support the underlying goal of furthering preventive care for women, including . . . family planning.”); 155 Cong. Rec. S12671 (Dec. 8, 2009) (Sen. Durbin) (under the ACA “millions more women will have access to affordable birth control and other contraceptive services”).

<sup>63</sup> Inst. of Med., *Clinical Preventive Services for Women: Closing the Gaps* 20–21 (2011), available at <http://www.iom.edu/reports/2011/clinical-preventive-services-forwomen-closing-the-gaps.aspx>.

<sup>64</sup> *Id.* at 109–10.

<sup>65</sup> *See* Health Res. & Servs. Admin., U.S. Dep’t of Health & Human Servs., *Women’s Preventive Services Guidelines*, <http://www.hrsa.gov/womensguidelines> (last visited Feb. 15, 2016).

HHS, through the adoption of the IOM's recommendations and the subsequent adoption of the WPSI recommendations, carried out Congress' intent. **The Departments should rescind the IFR to continue reflecting that intent.**

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NFPRHA appreciates the opportunity to provide comment on the moral exemptions and accommodations for coverage of certain preventive services interim final rule. This IFR will cause people to lose contraceptive coverage and harm their health and well-being. It ignores congressional intent that contraception be covered by the ACA, and is based on a distorted picture of the science supporting contraception, and the federal programs supporting contraceptive access. **For all of these reasons, NFPRHA calls on the Departments to rescind the IFR.**

If you require additional information about the issues raised in this letter, please contact Mindy McGrath, NFPRHA Director, Advocacy & Communications, at 202-552-0144 or at [mmcgrath@nfprha.org](mailto:mmcgrath@nfprha.org).

Sincerely,



Clare Coleman  
President & CEO