April 3, 2023

**VIA ELECTRONIC SUBMISSION**

Secretary Xavier Becerra
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Secretary Martin J. Walsh
Department of Labor
200 Constitution Ave NW
Washington, DC 20210

Secretary Janet L. Yellen
Department of the Treasury
1500 Pennsylvania Ave. NW
Washington, DC 20220

**Re: Coverage of Certain Preventive Services Under the Affordable Care Act; RIN 1545-BQ35, RIN 1210-AC13, & RIN 0938-AU94**

Dear Secretaries Becerra, Walsh, and Yellen:

The National Health Law Program (NHeLP) appreciates the opportunity to comment on the proposed rulemaking, *Coverage of Certain Preventive Services Under the Affordable Care Act*, from the Departments of the Treasury, Labor, and Health and Human Services (HHS) (collectively "Departments"), published February 2, 2023.[1] NHeLP protects and advances the health rights of low-income and underserved individuals. Founded in 1969, NHeLP advocates, litigates, and educates at the federal and state levels. Consistent with this mission, NHeLP works to

ensure that all people in the United States have access to comprehensive preventive health services, including contraception.

NHeLP supports the rescission of an exemption to requirements to cover contraception based on moral objections, and believes the Departments should also reconsider the existing religious exemption in light of its impact on people who need contraception. We dedicate much of this comment to the Departments' proposed individual contraceptive arrangement (ICA). We understand why the Departments have elected this arrangement when someone's coverage excludes contraception, and raise a number of considerations for planning and implementation. We also address the need for oversight and enforcement of the Affordable Care Act (ACA) contraceptive coverage requirement, which is ongoing. We encourage the Departments to integrate these recommendations into the final rule and to finalize the rule as soon as possible.

## I. We support the rescission of the moral exemption in the proposed rules

In the 2017 Interim Final Rule, Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act (hereinafter "2017 IFR"), the Departments exercised discretion to create an exemption to the Affordable Care Act's requirement for contraceptive coverage based on non-religious moral objections (pre-existing regulations permitted an exemption based on religious objections).[2] In our public comments in response to the IFR, NHeLP urged the Departments to strike the moral exemption in its entirety. Our position remains that the moral exemption was unconstitutionally vague and ambiguous. In addition, we agree with the Departments' reasoning that the Religious Freedom Restoration Act (RFRA) does not require any exemption for non-religious moral objections and there is no other statute that requires such an exemption. We appreciate the Departments' reconsideration and support its decision to rescind the moral exemption.

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[1] Coverage of Certain Preventive Services Under the Affordable Care Act, 88 Fed. Reg. 7236 (Feb. 2, 2023), https://www.govinfo.gov/content/pkg/FR-2023-02-02/pdf/2023-01981.pdf (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pts. 147 & 156).

[2] Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47,838 (Oct. 13, 2017), https://www.gpo.gov/fdsys/pkg/FR-2017-10-13/pdf/2017-21852.pdf (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 147).

## II. We oppose the proposed rules' retention of a sweeping religious exemption

We continue to oppose the sweeping religious exemption in the 2018 Final Rule Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act (hereinafter "2018 Final Rule"), which unjustifiably expanded the exemption to apply to *all* nonprofit and for-profit employers and private colleges and universities.[3] In NHeLP's public comments in response to the NPRM for that rule, we strongly objected to such a broad exemption for nearly all employers. We reiterate that Congress expressly intended for contraception to covered as a preventive service under the ACA, and did not add any exemption to the Women's Health Amendment.[4] We are also concerned that in interfering with access to a benefit intended to address longstanding discrimination and ensure women equal access to the preventive services that allow them to be full participants in society, the broad religious exemption may constitute unconstitutional discrimination as well as violate § 1557 of the ACA, which prohibits discrimination on the basis of sex in "any health program or activity, any part of which is receiving Federal financial assistance . . . or under any program or activity that is administered by an Executive Agency."[5]

The Departments should reconsider the religious exemption, and at minimum, limit its sweeping scope. As one example, the Departments should strike the exemption for not-closely-held for-profits and reissue a definition of closely-held for-profits that was eliminated in the 2018 Final Rule.

## III. We generally support the ICA, with the understanding that the administration is obligated to take affirmative steps to make the ICA as functional as possible

We appreciate the goals underlying the ICA, to create an alternative pathway to obtaining contraceptive services at no cost for those enrolled in a health plan excluding that coverage. It is worth noting, however, that the ICA is only necessary because of the various exceptions that

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[3] Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57536 (Nov. 15, 2018), https://www.federalregister.gov/documents/2018/11/15/2018-24512/religious-exemptions-and-accommodations-for-coverage-of-certain-preventive-services-under-the.

[4] 155 CONG. REC. S12,033, S12,052 (daily ed. Dec. 1, 2009); *See also,* 155 CONG. REC. S12,106, S12,114 (daily ed. Dec. 2, 2009) (statement of Sen. Feinstein) ("[The Amendment] will require insurance plans to cover at no cost basic preventive services and screenings for women. This may include . . . family planning . . .").

[5] 42 U.S.C. § 18116.

the Departments and courts have permitted, and those who will potentially use the ICA would otherwise be entitled to access all contraceptive services through their health plan. Indeed, it is unfortunate that there are so many opportunities to deny employees and students critical health care. Contraceptive care is preventive care, and yet it is consistently treated differently from other preventive services, particularly with regard to health care refusals. Were it treated as the health care service that it is, an ICA would be redundant.

We support the Departments' proposal to create the ICA and many of the specific details included in the proposed rule. However, for the ICA to be an effective substitute for seamless contraceptive coverage, the Departments will need to take proactive steps to ensure that the ICA fulfills the goals of the ACA. While we recognize that the ICA by its nature will never be perfectly seamless, there are a myriad of opportunities for the Departments to ensure that financial, logistical, and administrative obstacles are curtailed. Among other steps, the Departments should ensure that:

- a robust network of providers participate in the ICA;
- the ICA is proactively and broadly publicized;
- there is broad eligibility for the ICA;
- a patient attestation is sufficient to receive services;
- consumers never have cost sharing for contraception; and
- consumers, providers, and issuers are held harmless for unintentional errors.

We also propose presumptive eligibility in the Medicaid program as a model for the ICA.

*a. The Departments must build a robust network of ICA providers*

We believe it is the responsibility of the Departments to build a robust network of contraceptive care providers that elect to participate in the proposed ICA. The Departments must look beyond those who typically provide contraceptive services, like Title X clinics and independent obstetrics and gynecology practices, to build a diverse network of providers. This might include, but is not limited to, pharmacies, hospitals, Federally-Qualified Health Centers, local departments of health, and independent primary care practices, including those operated by nurse practitioners and other qualified providers.

In developing this network, the Departments should aim to include providers that have the capacity to accept new patients, are geographically widespread, and that routinely offer the full

range of contraceptive care, including immediately postpartum, in an evidence-informed and patient-centered manner. This is critically important, as individuals should be able to access the contraceptive method of their choice, on their schedule.

We also encourage the Departments to consider ways that they might internally track the number of providers participating in the ICA and the frequency with which they will revisit the number of participating providers. Assessing the provider data will enable the Departments to focus recruitment efforts in areas with the lowest access.

*b. The ICA must be proactively and broadly publicized*

The Departments have a responsibility to take a leadership role in the ICA rollout, including broadly publicizing and disseminating information about the ICA to potential participants, both through its own platforms as well as in collaboration with community-based organizations. The current proposed rule only discusses participating providers as a source of information to consumers about the existence of the ICA, which is wholly insufficient.

i. Consumer-focused outreach

The Departments should create and disseminate public education materials informing consumers of the existence of the ICA as a means to obtain no-cost contraception when their insurance does not cover it. These materials should be available in multiple languages and formats available for individuals with limited English proficiency and people with disabilities. Further, it should be written at an elementary reading level to ensure broad understanding, and provide consumers with resources such as a hotline or FAQs to help address ongoing questions. A prime location for this information, among others, will be reproductiverights.gov.

We appreciate the invitation to comment on whether or not to publish the names of providers participating in the individual contraceptive arrangement. The concern for provider safety is valid, as is the concern that publishing a directory will disincentivize providers from participating. However, the process of seeking contraceptive care is already unduly burdensome for consumers, and will be almost entirely untenable if they are unable to determine which providers they can visit for contraceptive care. Moreover, there must be a system by which providers who do not elect to participate in ICAs can help their patients find a provider that does. The Departments should make accessible and regularly update an online resource that contains the contact information for providers that participate in the ICA. The

Departments should ensure that this list includes not only prescribers, but also pharmacies that dispense contraception. In addition to consumers, prescribing providers will also have to know which pharmacies are participating in an ICA when writing prescriptions for eligible patients. To address concerns around provider safety, the Departments could consider including an "opt out" option for providers of contraceptive services that elect to participate in an ICA but would prefer that their information not be shared in this way.

Finally, we encourage the Departments to consider whether it would be feasible to integrate screening for the ICA into the federal exchange. This would be a prime place to add information about the ICA for those with plans excluding contraceptive coverage.

ii. Provider-focused outreach

We support the proposal to make available to providers a list of participating issuers that have previously participated in the third-party administrator optional contraceptive user fee adjustment process under current 45 C.F.R. § 156.50(d), as a means of easing the administrative burden on providers seeking to participate in the ICA. Nonetheless, we anticipate confusion for providers on who to enter into an ICA with and what plans to seek reimbursement from. For example, do they have to enter into an agreement with the same issuer that is already insuring the patient or will any plan participating in the federal marketplace suffice? We urge the Departments to make this process as seamless as possible by allowing providers to enter into agreements with any issuer participating in the federal marketplace and not limit it to the same issuer that is covering the patient.

Furthermore, the Departments could take on a match-making role between issuers and providers that want to participate in the ICA. The Departments are well-aware of the issuers that already participate in the accommodation, and could connect providers willing to participate in the ICA with issuers that are already participating in the accommodation or who express interest in participating in the ICA.

The Departments might also consider developing a model agreement for providers and issuers to complete in order to establish an ICA. While the proposed rule clarifies that the individual details of the agreement are up to the discretion of the provider and the issuer to negotiate (including the period of time over which the agreement is effective), the model agreement could at least outline the required components.

*c. Eligibility for the ICA should be broad*

As detailed in the proposed rule, the ICA is meant to be a solution for people whose health coverage excludes no-cost contraceptive care. To fulfill that role, the ICA must broadly define eligibility for consumers and providers. Extending broad eligibility for the ICA would be in line with the purpose of the ACA and would also help to ensure that there are enough people using the ICA to make participation a worthwhile investment of time and resources for issuers and providers. Without a sufficient number of users and providers, the ICA is unlikely to be a viable solution for individuals who would otherwise be denied the ACA's contraceptive coverage guarantee.

In describing the ICA, the Departments describe two sets of individuals who are excluded from the ICA under the NPRM: 1) enrollees in plans that are eligible to use the optional accommodation; and 2) enrollees in grandfathered plans. We strongly recommend that the Departments reverse course in the final regulations and make both sets of enrollees eligible to use of the ICA. In addition, the ICA should include any person whose contraceptive coverage is impacted by an injunction or settlement agreement obtained by an employer, university, or individual that claims or claimed a moral objection to contraception.

i. <u>Individuals eligible to use the optional accommodation</u>

For enrollees in plans that are using the optional accommodation, we agree with the Departments' assessment that few such individuals would purposefully use the ICA, because using the optional accommodation should be seamless for them. However, we also agree with the Departments that there may be confusion among individuals and providers between the optional accommodation and the ICA. Moreover, there is little public information about whether the optional accommodation has indeed been operating as intended (*e.g.,* do enrollees in the accommodation know they have the benefit? Do they understand how to use it?), and it is possible that it has not been working for some individuals.

We recommend making this group of individuals eligible for the ICA. This would help ensure that they have access to the contraceptive coverage that is guaranteed to them under the ACA. It would also comport with the principle of holding individuals, providers, and issuers harmless for unintended errors, which the Departments have emphasized elsewhere in the proposed rule (see also § f below).

ii. Individuals enrolled in grandfathered plans

The Departments briefly comment that they have not made enrollees in grandfathered plans eligible for the ICA. The stated argument is that there are relatively few grandfathered plans still in existence, and these plans and may voluntarily, or as required by State law, provide contraceptive coverage. However, as the Departments acknowledge, there are still millions of enrollees in grandfathered plans, 13 years after the enactment of the ACA. The Departments estimate that there were 23.7 million such participants and beneficiaries in 2020, including those in private-sector and state and local government plans. Although that number may be somewhat lower now in 2023, it is notable that the proportion of covered workers in grandfathered plans has not fallen as quickly or as consistently as originally expected by the Departments or outside experts. In fact, according to data from the Kaiser Family Foundation, that proportion appeared to have plateaued by 2017 among small employers.[6] The ICA presents a small but significant way that the Departments can mitigate the ongoing harm of grandfathered plans, by ensuring that enrollees in these plans have guaranteed access to no-cost contraception.

*d. The Departments should require that a patient attestation is sufficient to receive services*

The proposed rule states that an individual can confirm that their eligibility for the ICA by providing an attestation or documentation of their lack of contraceptive coverage, such as a summary of benefits and coverage, and that providers have discretion in choosing what confirmation method to accept. We urge the Departments to require providers to accept an attestation. Because objecting employers are not required to provide specific notice to employees that the employer-sponsored health plan does not provide contraceptive coverage, people may not know until they are visiting a provider that they lack coverage, and may be unable to access documentation of their lack of coverage. Another option could be for issuers to include the phrase “No BC” in relevant plan names, which could then appear on an individual’s insurance card; this would make it seamless to present a regular insurance card to a provider, who could easily verify eligibility.

[6] Kaiser Fam. Found., 2019 Employer Health Benefits Survey: Grandfathered Health Plans https://www.kff.org/report-section/ehbs-2019-section-13-grandfathered-health-plans/ (last visited Mar. 22, 2023).

We appreciate that the Departments provide example attestation language at 45 C.F.R. § 147.131(d)(2). However, we are concerned that this example language would be challenging for most patients to comprehend and encourage the Departments to revise the language to be more health literate.

*e. The Departments must ensure that care under the ICA is always free for the consumer*

The Departments recognize the public health interest in ensuring access to reproductive health care and contraceptive services without cost sharing, particularly in light of the Supreme Court's opinion in *Dobbs v. Jackson Women's Health Organization*. We reiterate the compelling public health research demonstrating the impact of removing cost-sharing on health care utilization, and emphasize that the success of the ICA is contingent on ensuring that consumers can get contraception at no cost directly at the point of service.[7]

A large body of literature concludes that cost-sharing reduces use of medically necessary, valuable services, as opposed to merely discouraging overuse of unnecessary services.[8] According to the Institute of Medicine ("IOM"), a division of the National Academies of Sciences, Engineering, and Medicine, "[s]tudies have . . . shown that even moderate copayments for preventive services . . . deter patients from receiving those services."[9] The IOM has recognized that the "elimination of cost-sharing for contraception therefore could greatly increase its use, including use of the more effective and longer-acting methods."[10] In

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[7] Emmett B. Keeler, RAND Corp., *Effects of Cost Sharing on Use of Medical Services and Health*, 8 MED. PRAC. MGMT 317, 318–19 (1992), https://www.rand.org/pubs/reprints/RP1114.html.

[8] *See generally* Katherine Swartz, Robert Wood Johnson Found., *Cost-Sharing: Effects on Spending and Outcomes* (2010), http://www.statecoverage.org/files/RWJF_Cost_Sharing_Effects_on_spending_and_outcomes.pdf; Robert H. Brook et al., RAND Corp., *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate* 3 (2006), http://www.rand.org/pubs/research_briefs/RB9174.html; Niteesh K. Choudhry et al., *Full Coverage for Preventive Medications after Myocardial Infarction*, 365 NEW ENG. J. MED. 2088, 2091-96 (2011); Niteesh K. Choudhry et al., *At Pitney Bowes, Value-Based Insurance Design Cut Copayments and Increased Drug Adherence*, 29 HEALTH AFF. 1995, 1995 (2010); Michael T. Eaddy et al., *How Patient Cost-Sharing Trends Affect Adherence and Outcomes: A Literature Review*, 37 PHARMACY & THERAPEUTICS 45, 47 (2012).

[9] INST. OF MED. OF THE NAT'L ACADS., CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS 19 (2011), https://www.nap.edu/read/13181/chapter/1.

[10] *Id.* at 109.

this regard, the California Kaiser Foundation Health Plan's experience is informative. In 2002, the California Kaiser Foundation Health Plan eliminated copayments for the most effective contraceptive methods (intrauterine devices, injectables, and implants).[11] Prior to the change, users paid up to $300 for a five-year contraceptive method; after elimination of the copayment, use of these methods increased by 137%.[12] Similarly, the Contraceptive CHOICE Project—a large prospective cohort study of nearly 10,000 adolescents and women in the St. Louis, Missouri area—provided participants a choice of no-cost contraception and followed them for two to three years.[13] The researchers concluded that providing access to no-cost contraception greatly increased the ability of adolescents and women in the St. Louis region to select the most effective methods of contraception.[14]

Prior to enactment of the ACA, individuals used preventive services at about half the rate recommended by medical standards of care.[15] Low-income individuals and people of color used fewer preventive care services than non-Hispanic whites.[16] Compared to men, women were "more likely to forgo needed care because of cost and to have problems paying their medical bills, accrue medical debt, or both."[17] The ACA reflects the well-documented body of research that out-of-pocket costs for health care services are a problematic barrier to medication adherence.[18] By removing cost barriers, the ACA is proving to be effective at

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[11] Kelly Cleland et al., *Family Planning as Cost-Saving Preventive Health Service*, 364 NEW ENG. J. MED. e.37(1), e.37(2) (2011).
[12] *Id.*
[13] Jeffrey F. Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120(6) OBSTETRICS & GYNECOLOGY 1291, 1291–92 (2012).
[14] *Id.* at 1295–96.
[15] P'ship for Prevention, Preventive Care: A National Profile on Use, Disparities, and Health Benefits 8 (2007), http://www.rwjf.org/content/dam/farm/reports/reports/2007/rwjf13325; *see also* Elizabeth A. McGlynn et al., *The Quality of Health Care Delivered to Adults in the United States*, 348 NEW ENG. J. MED. 2635, 2641 (2003).
[16] Lawrence O. Gostin, *Securing Health or Just Health Care? The Effect of the Health Care System on the Health of America*, 39 ST. LOUIS U. L. J. 7, 32 (1994); P'ship for Prevention, *supra* note 13, at 7.
[17] Sheila D. Rustgi et al., The Commonwealth Fund, Women at Risk: Why Many Women Are Forgoing Needed Health Care 1–2 (2009), https://www.commonwealthfund.org/publications/issue-briefs/2009/may/women-risk-why-many-women-are-forgoing-needed-health-care.
[18] *See*, *e.g.*, Michael E. Chernew et al., *Impact of Decreasing Copayments on Medication Adherence Within a Disease Management Environment*, 27 HEALTH AFF. 103, 111 (2008) (finding that "increased cost sharing leads to decreased adherence to potentially life-saving medications, with likely serious deleterious health effects"); Niteesh K. Choudhry et al., *Should Patients Receive Secondary Prevention Medications for Free After a Myocardial Infarction? An Economic Analysis*, 26 HEALTH AFF. 186, 186 (2007) (finding that cost-sharing can cause medication underuse).

achieving this compelling governmental interest in increasing access to contraception, and in impacting people's ability to decide if and when to become pregnant. In the Guttmacher Institute's Continuity and Change in Contraceptive Use study, researchers surveyed women aged 18 to 39 years about their contraceptive use before and after the contraceptive coverage requirement went into wide-scale effect.[19] The results show that the proportion of privately insured women with no out-of-pocket cost for their oral contraceptives increased from fifteen percent to sixty-seven percent; for injectable contraception, from twenty-seven percent to fifty-nine percent; for the vaginal ring, from twenty percent to seventy-four percent; and for the intrauterine device, from forty-five percent to sixty-two percent.[20] As rates of contraceptive coverage without cost-sharing increased, so did contraceptive access.[21] A report from the IMS Institute for Healthcare Informatics found that 24.4 million more prescriptions for oral contraceptives with no copayment were filled in 2013 than in 2012.[22] According to that report, oral contraceptives accounted for the largest increases in prescriptions dispensed without a copayment.[23]

Reducing the cost barrier to contraception is resulting in greater access to contraception, just as the ACA intended. Any ICA process that veers away from this policy and requires cost-sharing, even if the out-of-pocket costs could be reimbursed later, will not be successful. Furthermore, in publicization and dissemination of ICA information it should be very clear that providers must agree to provide contraceptive care at no cost to ICA users at point of service as the basic threshold for participation, and any provider agreements with issuers should reiterate this requirement.

*f. The Departments should hold ICA participants harmless*

The ICA is an exciting, but untested, access policy that is going to require flexibility and some experimentation. However, no ICA participants should fear repercussions for good faith participation. The proposed rule states that if a provider or issuer relies on good faith representation of eligibility, for either the ICA or the accommodation, then they can still meet

[19] Adam Sonfield et al., *Impact of the Federal Contraceptive Coverage Guarantee on Out-of-Pocket Payments for Contraceptives: 2014 Update*, 91 CONTRACEPTION 44, 44–45 (2014).
[20] *Id.* at 45–47.
[21] *See* IMS Inst. for Healthcare Informatics, *Medicine Use and Shifting Costs of Healthcare: A Review of the Use of Medicines in the United States in 2013* (2014).
[22] *Id.* at 16.
[23] *Id.* at 13.

the documentation requirements if the eligibility is later determined to be incorrect. We strongly support these provisions, and recommend the Departments continue to make clear that they will not pursue any retaliatory action against providers or issuers for any aspect of the ICA if they are participating in good faith. In addition, we recommend communicating to contraceptive users that they will not be penalized at any point in the ICA process if they have misunderstood a requirement during a good faith attempt to access the contraceptive care to which they believed they were entitled.

*g. The Departments should look to presumptive eligibility (PE) in the Medicaid program as a model for the ICA*

Presumptive eligibility (PE) allows certain groups to temporarily enroll in Medicaid while their eligibility is being determined for ongoing coverage; this means they can receive services immediately if they are likely to be found eligible based on income, household size, domicile, immigration status, and if applicable, pregnancy status.[24] The ICA should function similarly, where individuals can attest to their eligibility and then immediately receive contraceptive care.

In order to receive immediate PE services, a "qualified entity" must certify that, based on its calculation, someone likely qualifies for coverage. Qualified entities who make a determination that a patient is eligible for PE will be reimbursed for services provided during the PE period, even if the individual is later found not eligible for full-scope Medicaid. Applying this principle to the ICA, contraceptive providers should be reimbursed for the contraceptive care they provide, even if it is later found that the individual was not actually eligible to use the ICA.

The determination of who can be considered a qualified entity for PE purposes is generally based on existing participation in certain safety net programs, like Medicaid, WIC, Head Start, Title V, and more. We recommend a similar framework for the ICA, where providers who have existing relationships with participating issuers are automatically considered qualified to participate in the ICA. Providers who do not have existing relationships with participating issuers should still be able to easily become ICA providers, bypassing the issuer's existing contracting and credentialing process, which can be arduous and lengthy.

[24] *See* CMS, *Medicaid and CHIP FAQs: Implementing Hospital Presumptive Eligibility Programs* (Jan. 2014), https://www.medicaid.gov/state-resource-center/faq-medicaid-and-chip-affordablecare-act-implementation/downloads/faqs-by-topic-hospital-pe-01-23-14.pdf.

The PE application process varies by state and qualified entity, but almost always uses a simplified method of determining income as compared to traditional eligibility calculations.[25] As a best practice, only the minimum amount of information necessary for input into the Medicaid Management Information System is required for the PE application, such as name, address, and birthdate. The ICA should follow course and use the simplest method possible for determining that an individual likely qualifies for contraceptive care: patient attestation.

As part of PE, states must provide qualified entities with adequate training, forms, and other information necessary to assist with completion and submission of the PE application. States use a range of training strategies including online programs, regional group sessions, and on-site trainings that qualified entities must complete before they are certified to make PE determinations.[26] In fact, many states have staff specifically dedicated to administering PE, demonstrating the complexity in operationalizing such a program. Additionally, some states support PE sites through outreach grants or application processing fees.[27] In the case of the ICA, we recommend that the Departments and issuers work together to recruit providers, train them on required processes, provide them with easy-to-use template forms that meet the ICA documentation requirements, and otherwise troubleshoot any issues that arise during implementation. They could also work together on outreach and education to individuals who might be eligible for the ICA.

While we propose PE as a potential model, we acknowledge that it is not perfectly analogous to the ICA. PE is time limited, intended as a stop gap while individuals await their full Medicaid determination. The ICA, on the other hand, is not a precursor to any broader coverage, unless an individual changes employers or their employer elects to cover contraception in the future. For this reason, an individual's attestation should not be required every time they seek contraceptive care from the same provider. Under PE, a qualified entity provides eligible individuals with a temporary card or form confirming eligibility; ICA providers and issuers could consider a similar system whereby an eligible individual receives (and the provider retains) a confirmation that they are eligible to use the ICA with the determining provider for a designated period of time, ideally at least one year.

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[25] *Id.* at Q12 ("[F]ull MAGI-based eligibility determinations cannot be used to determine [presumptive eligibility].").
[26] Tricia Brooks, Georgetown Ctr. for Child. & Fams., *Presumptive Eligibility: Providing Access to Health Care Without Delay and Connecting Children to Coverage* 3–6, https://ccf.georgetown.edu/wp-content/uploads/2012/03/Presumptive_eligibility_20111.pdf.
[27] *Id.* at 6.

We are also aware of documented issues with PE, where individuals were denied coverage because they were determined to be eligible for marketplace coverage or had previously applied for other coverage but chose not to enroll.[28] We fear that a strict eligibility process for the ICA could have a similar result if providers are required to cross-check applicants with third-party coverage data. Given the reasons for the ICA, it is very likely that those seeking to use it would come up as otherwise insured in a data match process, because they do have coverage for non-contraceptive care. We recommend that issuers be prohibited from requiring providers to engage in such a process before certifying individuals as likely eligible for the ICA.

## IV. The Departments must take immediate enforcement action to bring the insurance industry into compliance with the ACA contraceptive coverage requirement

We are pleased that the Departments make note of the accounts of health plan noncompliance with the ACA in the preamble to the proposed rule. There are clear, industry-wide, on-going violations of the ACA contraceptive coverage requirement currently happening.[29] This non-compliance is occurring despite the Departments' sub-regulatory guidance, including two Frequently Asked Questions documents in 2022 alone.[30] Health plans are flagrantly violating

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[28] Nat'l Health L. Prog., Lessons from California: Hospital Presumptive Eligibility (Mar. 2015), https://healthlaw.org/wp-content/uploads/2015/03/Lessons-from-California_HPE-March-2015-FINAL.pdf.

[29] Nat'l Women's L. Ctr., The Biden Administration Must Ensure the Affordable Care Act Contraceptive Coverage Requirement Is Working for All (Oct. 14, 2021), https://nwlc.org/resource/the-biden-administration-must-ensure-the-affordable-care-act-contraceptive-coverage-requirement-is-working-for-all/; Power to Decide, When Your Birth Control Isn't Covered: Health Plan Non-Compliance with the Federal Contraceptive Coverage Requirement (Apr. 2022), https://powertodecide.org/sites/default/files/2022-04/ACA%20Contraception%20Exception%20Report.pdf; Comm. on Oversight & Reform. U.S. House of Representatives, Barriers to Birth Control: An Analysis of Contraceptive Coverage and Costs for Patients with Private Insurance (Oct. 25, 2022), https://oversightdemocrats.house.gov/sites/democrats.oversight.house.gov/files/2022-10-25.COR%20PBM-Insurer%20Report.pdf.

[30] Dept's of Labor, Health and Hum. Servs., and Treasury, *FAQs About Affordable Care Act Implementation Part 51, Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation* (Jan. 10, 2022), https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-51.pdf; CCIIO, *FAQs About Affordable Care Act Implementation Part 54* (July 28, 2022), https://www.cms.gov/files/document/faqs-part-54.pdf.

the ACA contraceptive coverage requirement and the Departments must take appropriate enforcement action to stop this from going any further.

In 2021, NHeLP dedicated dozens of hours to assisting a young student who was illegally charged over $4,000 for contraceptive care; although her plan was subject to the ACA, they denied coverage initially as well as through all internal appeals because the student did not have a primary care provider's referral, even though a referral is explicitly prohibited under the ACA. Only after multiple conversations with the DC Ombudsman, and numerous collections notices sent to the student, did the plan agree to reverse course and follow the law.

Since the beginning of 2023, NHeLP has received complaints of wanton non-compliance in multiple states. In Pennsylvania, for example, we are aware of private insurance companies telling enrollees that they need to meet the plan's deductible before contraceptive care will be covered, which is not permitted under the ACA. We are also aware of a state employee plan in Kentucky which refused to cover LARC removal under the ACA, improperly stating the removal was no longer part of the preventive services coverage.

We share this nonexhaustive list of real-life cases to illustrate how commonplace it is for plans to ignore the Departments' comprehensive guidance, as well as demonstrate how resource-intensive it can be to get illegal denials reversed. For this reason, we renew our request for a centralized enforcement entity within the Departments that can conduct any audits necessary to ensure that processes are operating as intended under the law, serve as a repository for consumer complaints, and ultimately ensure people receive the contraceptive care they are entitled to without barrier or delay.[31]

## V. Conclusion

Section 2713(a)(4) of the Public Health Service Act, and its implementing regulations, make access to contraception possible by ensuring that health plans in the individual and small group market adequately cover contraception without cost-sharing—cost-sharing that would otherwise reduce use of this necessary service. We strongly support rescission of the moral exemption, as it furthers the law's goal of contraceptive access. We object to the sweeping religious exemption, particularly the breadth, because it drastically interferes with contraceptive

[31] Although states are responsible for enforcing plan coverage, HHS has authority to enforce PHSA, and the Internal Revenue Service (IRS) is responsible for penalizing plans that do not comply with PHSA § 2713 (and other ACA requirements).

access. While we generally support both the ICA and the Departments' ongoing enforcement, we urge them to consider the important details highlighted in our comments, and to put significant energy and resources into all aspects of implementation.

Thank you for your attention to our comments and recommendations. If you have any questions or need any further information, please contact me at mccaman@healthlaw.org.

Sincerely,

Liz McCaman Taylor
Senior Attorney