NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

June 19, 2012

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9968-ANPRM
P.O. Box 8016
Baltimore, MD 21244-185

Submitted electronically at www.regulations.gov

Subject: ANPRM: Certain Preventive Services Under the Affordable Care Act, CMS-9968-ANPRM, Docket ID: CMS-2012-0031

The National Women's Law Center (the Center) is a non-profit organization dedicated to expanding the possibilities for women and girls. Since its founding in 1972, the Center has worked to improve women's health and to eliminate the discrimination and barriers women experience in the health care system. The Center is writing in response to the request for comments in the Advance Notice of Proposed Rulemaking (ANPRM) on "Certain Preventive Services Under the Affordable Care Act," published in the Federal Register on March 21, 2012 by the Department of the Treasury, Department of Labor, and Department of Health and Human Services (Departments).[1] The ANPRM announces the Departments' intention to provide an "accommodation" to "religious organizations" that object to coverage of contraceptive services without cost-sharing – as required by the Affordable Care Act (ACA) – for religious reasons.

The National Women's Law Center strongly opposed inclusion of a provision allowing certain religious employers to exclude contraceptive services from their employees' health plans.[2] The exemption undermines the intention of both the ACA and the Women's Health Amendment. Nothing in the ACA allows for any limitations regarding contraceptive coverage. Moreover, Sections 1554 and 1557 of the ACA actually prohibit the exemption of religious employers from covering preventive services.[3] Nonetheless, the Departments finalized the religious employer exemption,[4] leaving women who work for those employers without access to this critical preventive health care service. The Departments have also proposed an "accommodation" for "religious organizations" that object for religious reasons to providing coverage of contraceptive services to their employees. For the same reasons, there is no legal authority for such an

[1] Certain Preventative Services Under the Affordable Care Act, 77 Fed. Reg. 16,501 (proposed Mar. 21, 2012) (to be codified at 45 C.F.R. pt. 147).
[2] Letter from National Women's Law Center, to Centers for Medicare & Medicaid Services (Sept. 30, 2011) re: Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act; CMS-9992-IFC2.
[3] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 1554, 1557 (2010) (to be codified at 42 U.S.C. §§ 18114, 18116).
[4] Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8,725, 8,727 (Feb. 15, 2012) (to be codified at 45 C.F.R. pt. 147).

accommodation and depending on its contours, such an accommodation could cause real harm to women. Therefore, in proceeding with any such accommodation, it is essential that women receive the benefits of contraceptive coverage without cost-sharing in a seamless way. To that end, the Center provides the following comments on the specific questions raised in the ANPRM.

A. Who Qualifies for the Accommodation?

The Departments should define "religious organization" as "a non-profit institution or organization owned or controlled by a church, association of churches, or religious order." In so doing, the Departments should make clear, for example, that for-profit enterprises, health insurance issuers, and third party administrators are excluded.

The Center recommends that the Departments define "religious organization" for purposes of the accommodation as "a non-profit institution or organization owned or controlled by a church, association of churches, or religious order." This language is drawn from the Hawaii state contraceptive equity law.[5]

This definition excludes for-profit enterprises. For-profit businesses exist to make money through commercial activity. Their purpose is profit, not religious exercise. As such, tax-exempt status is commonly dispositive as to whether an organization falls within an exception for religious institutions.[6] Indeed, for decades, the Supreme Court has held that entering into commercial activity means accepting your faith cannot be superimposed on those in your employ.[7] The accommodation similarly should not be extended to health insurance issuers or third party administrators (TPAs).

The Departments should not in any way expand the religious employer exemption.

The Center is very concerned that the ANPRM seeks comment on whether an *exemption* should be made for "certain religious health insurance issuers or third-party administrators."[8] Given that the Center does not believe that the religious employer exemption is warranted, certainly it should not be expanded beyond the current definition adopted in final regulations on February 15, 2012.[9] Expanding the religious exemption in any way would only serve to further undermine the important women's health goals of the ACA and the Women's Health Amendment.

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[5] HAW. REV. STAT. § 431:10A-116.7(a) (2010) ("For purposes of this definition, any educational, health care, or other nonprofit institution or organization owned or controlled by the religious employer is included in this exemption.").

[6] *See e.g.*, 26 U.S.C. § 3121(w)(3)(B) (2008); Treas. Reg. § 1.414(e)-1(a) (1960); 29 U.S.C. § 1002(33)(C)(iii) (2008); HAW. REV. STAT. § 431:10A-116.7(a) (2010).

[7] United States v. Lee, 455 U.S. 252, 261 (1982).

[8] Certain Preventative Services Under the Affordable Care Act, 77 Fed. Reg. 16,501, 16,507 (proposed Mar. 21, 2012) (to be codified at 45 C.F.R. pt. 147).

[9] A "religious employer" is defined as an employer that:

(1) Has the inculcation of religious values as its purpose;

(2) primarily employs persons who share its religious tenets;

(3) primarily serves persons who share its religious tenets; and

The question of whether the religious exemption should be expanded has already been extensively evaluated through the comment process, and should not be reopened here. As the Departments have noted, they "received over 200,000 responses to the request for comments on the amended interim final regulations" issued on August 1, 2011, which included the religious employer exemption.[10] After assessing these comments, the Departments concluded that "A broader exemption, as urged by some commenters, would lead to more employees having to pay out of pocket for contraceptive services, thus making it less likely that they would use contraceptives, which would undermine the benefits described [in the final rule]."[11] These benefits include a healthier population, reduced health care costs, medical benefits to women, health benefits to infants, cost savings to employers, and allowing women to be healthy and productive members of the workforce.[12]

Expanding the exemption conflicts with the "determination by Congress that coverage of recommended preventive services by non-grandfathered group health plans and health insurance issuers without cost-sharing is necessary to achieve basic health care coverage for more Americans."[13] Additionally, as recognized by the Departments, 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."[14] Allowing more entities to opt-out of the contraceptive coverage requirement would strike at the very purpose of the Women's Health Amendment.

Requiring that contraception be covered with no cost-sharing is a tremendous step forward in improving the health status of women and their families. Expanding the exemption would cause harm to employees of "religious organizations," undermining the employees' access to the significant benefits of contraception.[15]

Accordingly, for all of these reasons, the religious exemption should not be expanded any further.

> (4) is a non-profit organization under section 6033(a)(1) and section 6033(a)(3)(A)(i) or (iii) of the Code. Section 6033(a)(3)(A)(i) and (iii) refer to churches, their integrated auxiliaries, and conventions or associations of churches, as well as to the exclusively religious activities of any religious order.

Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, Interim Final Rules, 76 Fed. Reg. 46,621, 46,623 (Aug. 3, 2011). This definition was finalized without change. Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8,725, 8,727 (Feb. 15, 2012) (to be codified at 45 C.F.R. pt. 147).

[10] Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. at 8,726.

[11] *Id.* at 8,728.

[12] *Id.* at 8,727-28.

[13] *Id.* at 8,727.

[14] *Id.*

[15] *See* Letter from National Women's Law Center, to Centers for Medicare & Medicaid Services (Sept. 30, 2011) re: Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act; CMS-9992-IFC2.

The Center is also concerned that the Departments appear to have already expanded the religious employer exemption by allowing entities that do not meet the religious employer definition to "piggyback" on the exemption granted to those who do. The ANPRM provides an example of a Catholic elementary school, which seems to suggest that an organization that would not qualify on its own for the religious employer exemption can simply enroll its employees in a qualified religious employer's health plan and thereby deny its employees contraceptive coverage.[16] The Center opposes this expansion of the religious employer exemption; if an organization would not independently meet all four criteria to qualify for the religious employer exception on its own, its employees must not be denied contraceptive coverage. Permitting this kind of back-door denial is all the more inappropriate if the Departments move forward with an accommodation since the accommodation would provide a way for religious organizations that do not qualify for the religious employer exemption to avoid providing coverage of contraceptive services. The accommodation ensures that the participants and beneficiaries still receive the preventive services benefit to which they are entitled; a back-door denial sacrifices women's health and the health of their families, undermines gender equality, and imposes the religious beliefs of a non-exempt organization on participants and beneficiaries who might not share them.

The Departments should clarify that existing legal obligations continue to apply to those organizations that meet the religious employer or religious organization definitions.

The Center strongly urges the Departments to clarify that qualifying for either the religious employer exemption or the religious organization accommodation does not relieve those organizations of complying with other existing federal legal obligations to provide coverage of contraception, such as those arising from Title VII of the Civil Rights Act of 1964[17] or Title IX of the Education Amendments of 1972.[18]

The Departments should take whatever steps are necessary to ensure that the definition of "religious organization" does not set a precedent for any other health service required under the Affordable Care Act or for any other purpose.

The Center strongly supports the Departments' statement that "whatever definition of religious organization is adopted will not be applied with respect to any other provision of the PHS Act, ERISA, or the [Internal Revenue] Code, nor is it intended to set a precedent for any other

[16] There is some confusion about what the Departments actually intend based on the language in the ANPRM. The Departments say that the religious employer exemption "is available to religious employers in a variety of arrangements." It then provides the example of a Catholic elementary school that qualifies for the religious exemption with its own plan and contrasts that with an example of the "same school" that is on the diocese's plan. In both cases, according to the Departments, the Catholic elementary school is exempt. It is unclear if by using the term "the same school" the Departments mean that the Catholic elementary school would independently qualify for the religious exemption in either case, or if it would not independently qualify in the second case, but would receive the exemption by providing coverage to its employees through the plan of an exempt religious employer. Certain Preventative Services Under the Affordable Care Act, 77 Fed. Reg. 16,501, 16,502 (proposed Mar. 21, 2012) (to be codified at 45 C.F.R. pt. 147).

[17] Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241 (codified as amended in scattered sections of 2 U.S.C., 28 U.S.C., & 42 U.S.C.).

[18] 20 U.S.C. 1681 (1972).

purpose."[19] As noted above, an accommodation is not legally grounded, let alone required, and is not necessary; therefore this should not be used for any other purpose. The Departments should take whatever steps are necessary to guard against creating a demand by some individuals and institutions for similar exemptions or accommodations from other ACA requirements to cover preventive services or essential health benefits, given that some individuals and institutions have expressed religious objections to other services included under the Section 2713 requirements (e.g., vaccinations) or that will be included under the Section 1302 essential health benefits requirements (e.g., blood transfusions and mental health services).

Providing accommodations for only some forms of contraceptives would be impractical and undermine the goal of the contraceptive coverage requirement.

The Departments seek comment on whether religious organizations should be allowed to qualify for the accommodation with respect to some forms of contraception, while providing other forms of contraceptives without cost-sharing. The Center strongly urges the Departments not to permit such a bifurcation of contraceptive coverage without cost-sharing. Allowing a split in coverage of contraception would create administrative complexity, potentially requiring health insurance issuers and TPAs working with multiple religious organizations to design numerous different plans with various permutations of contraceptive coverage. It would also increase the potential for confusion among participants and beneficiaries, which could lead to gaps in access to and use of the contraceptive method most appropriate for a woman's needs.

Because of the great administrative complexity and the potential for confusion for women, the accommodation should apply to all forms of contraception – for even those employers who only partially cover contraception. This would cause the least harm to women and best furthers the Departments' goal of providing contraceptive coverage "in the simplest way possible"[20] to the women working for employers given the accommodation.

B. Who Administers the Accommodation?

No matter the method of accommodation, there are some important principles that must be met to ensure that employees of religious organizations have seamless access to contraceptive coverage to the same extent as employees of other organizations. Indeed, as described below, these principles are required by Sections 1554 and 1557 of the ACA, as well as other federal laws prohibiting discrimination in health benefits.

[19] Certain Preventative Services Under the Affordable Care Act, 77 Fed. Reg. at 16,504.
[20] *Id.* at 16,503. Moreover, if an organization is opposed to a form of contraception because of a misunderstanding of the contraceptive's mechanism of action, that is not an objection based on religious beliefs, and should not be eligible for the accommodation.

Whatever the method of accommodation, participants and beneficiaries must receive contraceptive coverage without cost-sharing and without paying a separate premium charge for it.

It is very important the Departments made clear in the ANPRM that "there be no premium charge for the separate contraceptive coverage" when participants and beneficiaries receive coverage through the accommodation.[21] Similarly, it is critical that the ANPRM makes clear that health insurance issuers providing contraceptive coverage through the accommodation must provide that coverage without any cost-sharing to participants and beneficiaries.[22] Any other result would undermine Congress's determination that coverage of recommended preventive services without cost-sharing is necessary to achieve basic health coverage for more Americans, and, in particular, to remedy discrimination against women in health care. Moreover, not doing so would undermine the guarantee that President Obama made in his remarks announcing the accommodation, that "women who work at . . . institutions [that qualify for the accommodation] will have access to free contraceptive services, just like other women, and they'll no longer have to pay hundreds of dollars a year that could go towards paying the rent or buying groceries."[23]

Whatever the method of accommodation, contraceptive coverage must be provided automatically and directly, without special enrollment or delay, and the privacy of participants and beneficiaries who use the coverage must be protected.

The Center strongly supports the Departments' statement that contraceptive coverage through the accommodation must be provided "automatically to participants and beneficiaries covered under the organization's plan (for example, without an application or enrollment process)."[24] Section 2713 of the ACA intends to broaden access to coverage of contraceptive services and supplies, and participants and beneficiaries must not face any additional barrier or burden when accessing their birth control coverage.[25] In particular, the Departments should structure the accommodation so that participants and beneficiaries subject to the accommodation have unfettered access to their contraceptive coverage and their coverage of contraception is not a separate or additional policy that requires separate or additional enrollment and approval processes. Additionally, the Center strongly supports the goal of ensuring that any accommodation "protect[s] the privacy of participants and beneficiaries covered under the plan who use contraceptive services," as stated in the ANPRM.[26]

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[21] *Id.*
[22] *Id.*
[23] Press Release, The White House, Remarks by the President on Preventative Care (Feb. 10, 2012), http://www.whitehouse.gov/the-press-office/2012/02/10/remarks-president-preventive-care.
[24] Certain Preventative Services Under the Affordable Care Act, 77 Fed. Reg. at 16,505.
[25] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1001 (2010) (to be codified at 42 U.S.C. § 300gg-13).
[26] Certain Preventative Services Under the Affordable Care Act, 77 Fed. Reg. at 16,505.

The Departments should ensure through this rulemaking that participants and beneficiaries subject to the accommodation receive timely, accurate, and clear information about their contraceptive coverage without cost-sharing.

The Center appreciates that the Departments recognize the importance of providing plan participants and beneficiaries with notice about the contraceptive coverage without cost-sharing. The Center agrees with the Departments that health insurance issuers and TPAs should provide such notice. The Departments should require health insurance issuers and TPAs to use multiple methods so that every participant and beneficiary receives notice.

For example, the health insurance issuer or TPA can provide notice when it provides an insurance card to the participants and beneficiaries. When an individual enrolls in a new health plan, the health insurance issuer or TPA sends an insurance card directly to the participants and beneficiaries of the plan. The Departments should require that the health insurance issuer or TPA includes a clear, obvious notice with this card indicating that the individual has contraceptive coverage without cost-sharing. The notice could take the form of a paragraph in the letter informing the individual of their coverage or a statement accompanying the card. For existing participants and beneficiaries who already have an insurance card, a separate notice containing the same information should be delivered to the participants and beneficiaries. No matter the form of the notice, the statement should indicate how the participant or beneficiary can access more information about the coverage, by contacting the issuer or TPA to request more information or through information included on the issuer's or TPA's website.

Health insurance issuers and TPAs can also provide information on contraceptive coverage to participants and beneficiaries through their websites. Participants and beneficiaries often rely on a health insurance issuer's website for information on their coverage, such as current provider networks and prescription formularies. Offering information on contraceptive coverage on the health insurance issuer's website would put such information in the same place as other information about insurance coverage the individual can access. However, providing information about contraceptive coverage on a website without specifically directing participants and beneficiaries to the webpage including the information should not be considered adequate notice of coverage.

Furthermore, the Departments should require that participants and beneficiaries receive accurate information about their contraceptive coverage in any communications from the health insurance issuer, employer, plan sponsor, or TPA. The Departments should guarantee that all applicable state and federal notice or communication requirements accurately reflect the coverage to which an individual is entitled and do not convey conflicting information.

For example, under the ACA, all group health plans and health insurance issuers offering group or individual health insurance coverage must comply with the requirement to provide a summary of benefits and coverage (SBC) to all applicants, enrollees, and policyholders or certificate holders.[27] The SBC is required by statute to "accurately describ[e] the benefits and coverage

[27] Patient Protection and Affordable Care Act § 1001.

under the applicable plan or coverage."[28] To that end, the Departments should ensure that the SBC does not state or imply that an individual in a plan receiving an accommodation does not have contraceptive coverage. For example, contraceptive coverage should *not* be included in the "Limitations & Exceptions" column of the chart that begins on page two of the SBC. Similarly, contraceptive coverage should *not* be listed in the box "Services Your Plan Does NOT Cover." If it were included in these sections of the SBC, the SBC would not comply with Section 2715, frustrating the goal of helping consumers better understand their coverage and compare coverage options, and rectifying the "current patchwork of non-uniform consumer disclosure requirements."[29] Additionally, the Departments should make clear in this rulemaking, or through future guidance, that contraceptive coverage without cost-sharing provided by health insurance issuers or TPAs in accordance with the accommodation does not necessitate providing an additional SBC reflecting that coverage.[30]

Requiring notice and communication to participants and beneficiaries in this way does not restrict a religious organization's freedom of speech regarding contraception. The religious organization is free to communicate its views about contraception to employees or students through other, more appropriate venues.

Whatever the method of accommodation, participants and beneficiaries must not lose out on critical protections, like continuation coverage, appeals and external review, and the right to see an OB/GYN provider without a referral. If there is a need to make the contraceptive coverage an excepted benefit, there should be close attention paid to make sure women have full access to the contraceptive coverage required under the law.

The Departments explain in the ANRPM that they are considering adding contraceptive coverage to the types of excepted benefits in the individual market and seek comment on whether and how to structure such a change and what Public Health Service (PHS) Act protections should apply.[31] Any provisions of the PHS Act that are designed to protect enrollees' access to benefits that are covered by a plan should apply to contraceptive coverage provided through the accommodation.

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[28] *Id.*

[29] Summary of Benefits and Coverage and Uniform Glossary, 77 Fed. Reg. 8,668, 8,668 (Feb. 14, 2012) (to be codified at 26 C.F.R. pt. 54).

[30] The final rule on the SBC was not drafted with the proposed accommodation in mind. As a result, a misinterpretation of the final rule could result in participants and beneficiaries receiving two SBCs, one reflecting coverage under the employer or university plan and one reflecting contraceptive coverage provided by the health insurance issuer. Receiving two SBCs would clearly thwart the statutory and regulatory intent of the SBC to allow consumers to understand their coverage and compare coverage options, and would perpetuate the problem of non-uniform disclosure documents by necessitating two documents to convey the full scope of coverage rather than one simple document.

[31] Certain Preventative Services Under the Affordable Care Act, 77 Fed. Reg. at 16,506.

For example:

- The Section 2711 requirement that there should be no annual or lifetime dollar value maximums on essential health benefits should apply.[32]
- Individuals should retain their Section 2719 right to internal appeals and external review, including all accompanying notice requirements, for contraceptive coverage.
- Women seeking contraception services should be allowed direct access to any primary care provider in the network as required by Section 2719A, including any OB-GYN provider, and without a referral.
- The contraceptive coverage should be incorporated into the Section 2715 Summary of Benefits and Coverage, as explained above.

At the same time, if a provision is specific to a set of services that are not included in the accommodation, it need not apply to contraceptive coverage provided through an accommodation. For example, a product or package providing contraceptive coverage through the accommodation should not have to provide all essential health benefits.

However the accommodation is structured, the benefits should automatically be included in COBRA continuation coverage.[33] If an individual is eligible for and enrolls in continuation coverage, then that coverage must include the contraceptive coverage either as part of the plan or through the accommodation. There should be no additional steps required, including no requirement to actively choose to have contraceptive coverage included, and no additional premium.

These recommendations represent a minimum starting point, not an exclusive list. The Center urges the Departments to be very careful in crafting any definition of the contraceptive coverage as excepted benefits to ensure women do not lose any protections they would receive without an accommodation.

The Departments should ensure that any accommodation offered to universities and colleges for their student health plans takes into account and resolves the barriers and challenges facing students seeking contraception.

The same reasons that the Center outlined regarding the inappropriateness of providing exclusions or accommodations for employers apply to student plans. Nonetheless, if the Departments move forward with the proposal to extend the accommodation to student health plans, students should have the same seamless access to contraceptive coverage without cost-sharing that other participants and beneficiaries receive. Additionally, any such accommodation must take into account the unique barriers and challenges facing students who seek contraception. For example, most students likely have had little experience with health

[32] The preventive services required by Section 2713 are included as part of the essential health benefit package. U.S. Dep't Health & Human Services, *Frequently Asked Questions on Essential Health Benefits Bulletin*, http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf, (last visited June 4, 2012).
[33] 29 U.S.C. § 1161.

insurance, leading to low insurance literacy. For this reason, the Departments should ensure that health insurance issuers provide timely, accurate, and clear information about the students' contraceptive coverage without cost-sharing. Additionally, students can face especially significant difficulties in accessing contraception, particularly if they attend a college or university that does not provide contraception through its student health center for religious reasons. For students without cars or reliable public transportation to get to an off-campus provider, their ability to access contraception is significantly compromised. And because student health plans often only include student health centers and university hospitals in the plan network, reaching an off-campus provider for contraception might result in burdensome additional costs. For these reasons, the Center urges the Departments to clarify that when students are unable to obtain preventive services at an in-network provider, students will be able to access care, including contraceptive services, through an out-of-network provider with no cost-sharing.[34]

Seamless coverage is required by various laws prohibiting barriers to or discrimination in benefits and access to care.

That any accommodation must be structured in such a way to provide seamless access to contraceptive coverage is not just necessary to fulfill the goals of the preventive services provision, but is also required by other provisions of the ACA and other federal laws prohibiting discrimination in benefits.

Section 1554 of the ACA, entitled Access to Therapies, prohibits the Secretary from promulgating "any regulation that—

(1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care;
(2) impedes timely access to health care services."[35]

A separate premium charge, enrollment period or delay in access to coverage, lack of accurate notice, loss of critical protections, or any other impediment built into the structure of the accommodation would create an unreasonable barrier and impede timely access to contraception.

Additionally, if the accommodation were structured in such a way as to erect additional hurdles or burdens on women's access to contraceptive coverage, it would allow the continuation of discriminatory health care policies and practices that place an unfair burden on women, contrary to various prohibitions on sex discrimination in the provision of health care programs and benefits, including Section 1557 of the ACA,[36] Title VII,[37] and Title IX.[38]

[34] We urge the Departments to clarify that the Section 2713 coverage and no cost-sharing requirements apply to services obtained from any provider when in-network providers are unwilling or unable to provide the services, for both students and any other individual enrolled in a non-grandfathered plan.
[35] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1554 (2010) (to be codified at 42 U.S.C. § 18114).
[36] *Id.* at § 1557.

C. Additional Questions

The Center strongly supports the Departments' application of preemption principles that both allow the continued enforcement of state contraceptive coverage laws that are more protective of consumer access to contraceptive coverage, and preempt those that undermine the federal contraceptive coverage requirement. The Departments should make clear that these preemption principles will apply beyond the temporary enforcement safe harbor period. The Departments also should clarify that grandfathered plans must continue to comply with applicable state contraceptive coverage requirements.

As the Departments recognized in the ANPRM, twenty-eight states have existing legal requirements mandating coverage of contraception in health insurance plans.[39] Like the additional women's preventive health services required by Section 2713 of the PHS Act, these state laws were enacted to remedy disparities in women's access to critical health care. These laws have gone a long way toward meeting women's unique health care needs and ensuring health benefits for both women and infants. Now, the federal contraceptive coverage requirement will help to fill in gaps in coverage and further reduce disparities by providing women broad access to contraceptive coverage without cost-sharing.

Some of the state contraceptive coverage laws have religious employer exemptions that are broader than the federal contraceptive coverage requirement's exemption, allowing more employers to refuse this critical coverage. The Departments appropriately recognize that broader religious employer exemptions must be "narrowed to align with that in the final regulations."[40] Such a result is required by the preemption provisions of the ACA, which dictate that state insurance laws that "prevent[] the application of a requirement" of the ACA are preempted.[41] Allowing more employers to refuse contraceptive coverage would leave more individuals without coverage of this critical service, force them to pay out-of-pocket, and put them at risk for unintended pregnancies, with the concomitant risks of poor maternal and infant health outcomes.[42] These state laws prevent the application of the federal contraceptive coverage requirement and are therefore preempted by it.

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[37] Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241 (codified as amended in scattered sections of 2 U.S.C., 28 U.S.C., & 42 U.S.C.).
[38] 20 U.S.C. 1681 (1972).
[39] Certain Preventative Services Under the Affordable Care Act, 77 Fed. Reg. 16,501, 16,507-08 (proposed Mar. 21, 2012) (to be codified at 45 C.F.R. pt. 147).
[40] *Id.* at 16,508.
[41] *See* Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, Interim Final Rules, 75 Fed. Reg. 41,726, 41,739 (July 19, 2010) (referring to "the preemption provisions of section 731 of ERISA and PHS Act section 2724 (implemented in 29 C.F.R. § 2590.731(a) (2011) and 45 C.F.R. § 146.143(a) (2010))").
[42] *See* Letter from National Women's Law Center, to Centers for Medicare & Medicaid Services (Sept. 30, 2011) re: Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act; CMS-9992-IFC2 (for a longer discussion).

At the same time, a state law that does more to ensure women's access to contraceptive coverage – for example, by not exempting any religious employers – is not preempted by the contraceptive coverage requirement. Because such a law is more protective of women's health than the federal requirement and helps more consumers, it does not prevent, but in fact furthers, the application of the ACA.[43] The Departments appropriately recognize that these state laws "will continue."[44] However, the Center is concerned that the Departments appear to unnecessarily limit the continuation of more protective state laws to a "transition period,"[45] which presumably refers to the temporary enforcement safe harbor period. The preemption principles of the ACA are not limited to any particular time period. For this reason, the Departments should clarify that the preemption principles it recognizes – that those laws that protect more consumers will not be preempted while those that protect fewer will be – will continue to apply beyond the transition period.

Finally, the Departments should address the interaction of state contraceptive coverage laws and the federal contraceptive coverage requirement with respect to grandfathered plans. Grandfathered plans are not required to comply with Section 2713 of the PHS Act, including the contraceptive coverage requirement. However, grandfathered plans are, for the most part, subject to state contraceptive coverage laws. The Departments should clarify that grandfathered plans must continue to comply with the applicable state contraceptive coverage laws even though they are not required to comply with the federal contraceptive coverage requirement.

The Departments should issue further guidance on the preventive services provisions as soon as possible.

The Departments indicate in the ANPRM that they "plan to issue further guidance on section 2713 of the PHS Act generally."[46] The Center applauds the Departments' decision to issue further guidance. Furthermore, the Center urges the Departments to issue further guidance as soon as possible given that the Section 2713 requirements go into effect for plan years beginning on or after August 1, 2012.

The Departments should provide enforcement and oversight of the preventive services requirement overall, and of the religious employer exemption and religious organization accommodation in particular.

The ANPRM, the religious employer final regulations, and the Section 2713 regulations overall are silent as to oversight and enforcement. The Departments should clearly adopt mechanisms for oversight and enforcement of all of the preventive services coverage provisions, including the religious employer exemption and any accommodation adopted for religious organizations.

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[43] Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, Interim Final Rules, 75 Fed. Reg. at 41,739 ("State insurance laws that are more stringent than the Federal requirements are unlikely to 'prevent the application of' the Affordable Care Act, and be preempted.").

[44] Certain Preventative Services Under the Affordable Care Act, 77 Fed. Reg. at 16,508.

[45] *Id.*

[46] *Id.* at 16,504.

Those processes should allow consumers to issue complaints and make appeals when they are inappropriately denied access to or required to absorb some of the cost of protected services and supplies. To encourage compliance, the Departments should provide technical assistance and education to health plans, health care providers, pharmacies, and the general public. Moreover, with respect to the exemption and accommodation from contraceptive coverage, the Center recommends that any entity seeking to avail itself of the exemption or accommodation send a written statement certifying its eligibility to an appropriately designated enforcement body. The enforcement body should maintain a file of all entities invoking the exemption or accommodation and make that information available to the public. These procedural requirements formalize the process and provide transparency to the public about which entities have invoked the exemption or accommodation.

In summary, in order to fulfill the promise of the preventive services provision of the health care law, participants and beneficiaries subject to the accommodation must have the same seamless access to no-cost contraceptive coverage as employees of other organizations, companies, and institutions.

Thank you for the opportunity to submit these comments.

Respectfully Submitted,

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