September 20, 2016

VIA ELECTRONIC SUBMISSION

The Honorable Sylvia Burwell
Department of Health and Human Services
Centers for Medicare and Medicaid Services
Attention: CMS-9931-NC
P.O. Box 8010
Baltimore, MD 21244-1850

Re: Coverage for Contraceptive Services (CMS–9931–NC)

Dear Secretary Burwell:

The American Congress of Obstetricians and Gynecologists, the American Academy of Family Physicians, and the American Academy of Pediatrics write in response to the Request for Information (RFI), Coverage for Contraceptive Services, published in the Federal Register on July 22, 2016 at 81 Fed. Reg. 47741 et seq. We appreciate the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury (collectively, "the Departments") seeking input from a cross section of stakeholders in assessing whether there is a feasible alternative to the existing birth control coverage accommodation for religious entities. Our comments respond to the questions posed regarding how the proposed alternative accommodation procedures could impact women and families. While these questions pertain to group insurance plans, the same principles we articulate below also apply with respect to self-insured plans.

The American Congress of Obstetricians and Gynecologists, the American Academy of Family Physicians, and the American Academy of Pediatrics are committed to increasing birth control access, and we support the Patient Protection and Affordable Care Act's (ACA) birth control coverage requirement. We strongly believe that all individuals of reproductive age should have access to affordable birth control and that insurance coverage should provide for all Food and Drug Administration (FDA)-approved contraceptive methods – just as insurance coverage extends to other preventive care, including crucial immunizations for children. The benefits of birth control have been well documented. The Centers for Disease Control and Prevention (CDC) named birth control one of the top ten public health achievements of the past century[1], and birth control is also widely credited for contributing to women's societal, educational, and economic gains.[2] Currently more than 55 million adolescent girls and women benefit from the preventive services requirement,[3] and it is estimated that women saved more than $1.4 billion in out-of-pocket costs on birth control pills in 2013 alone as a result of the contraceptive coverage requirement.[4] Many of these women rely on employer-sponsored insurance plans to get the

[1] Guttmacher Institute, *Contraceptive Use in the United States, (2013),* available at http://www.guttmacher.org/pubs/fb_contr_use.html
[2] Sonfield, A., Hasstedt K., Kavanaugh, M., and Anderson, R. March 2013. "The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children." *Guttmacher Institute.*
[3] ASPE Data Point (May 14, 2015), available at https://aspe.hhs.gov/sites/default/files/pdf/139221/The%20Affordable%20Care%20Act%20is%20Improving%20Access%20to%20Preventive%20Services%20for%20Millions%20of%20Americans.pdf.
[4] 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

coverage they are entitled to by law, and safety-net programs like the Title X family planning program are not a viable alternative. Title X is designed to subsidize a program of care for the poor and low-income women and men who rely on it, not to pay all of the cost of any service or activity. Further, Congress has never sufficiently funded the program, and at current funding levels it is only able to serve about one third of the women in need.

We appreciate the Departments' effort to solicit input on the accommodation in light of the Supreme Court's order in *Zubik v. Burwell,* and we continue to support the Departments in their efforts to ensure that women insured by accommodated entities receive seamless coverage of contraception without barrier or cost. The existing accommodation adequately meets women's need for seamless, coordinated, and comprehensive care in a matter consistent with both the spirit and the letter of the ACA. However, we do not believe that further alternatives to the existing accommodation are necessary, and in fact, we believe such additional accommodations would serve to hinder access to seamless care for women.

The existing accommodation protects the proper and effective functioning of the patient-provider relationship. The health care professional and the patient share responsibility for the patient's health, and the well-being of the patient depends upon their collaborative efforts.[5] This is particularly true given the highly personal nature of the reproductive health and family planning services that are at issue here. Deciding on the best form of contraception for any specific patient should take place within the established patient-provider relationship. Prescribing birth control is typically far more intimate and intrusive than signing a prescription pad; in addition to medical screening to ensure that a particular birth control method is not contraindicated, a pelvic exam is required when prescribing a diaphragm or cervical cap or inserting an intrauterine device (IUD). A pelvic exam may also be warranted before prescribing other types of contraceptives, based on the woman's medical history.[6] Women should be able to make these personal decisions — decisions that often require sharing intimate details of their sexual history and family planning—with providers they have sought out and trust.

The alternatives opponents of the accommodation have proposed would remove contraceptive care from a woman's routine health services and require her to use a two-tiered system of access and coverage — one for her overall health needs and one limited to contraceptive care. The proposed alternatives to the accommodation, in varying degrees, all require that contraceptive coverage be provided outside of a woman's regular health services, whether it is through insurance coverage obtained separately, or obtaining services only at designated facilities, or requiring a cash outlay only possibly reimbursed through a tax credit. None of the alternatives proposed most often by opponents of the existing accommodation do what the accommodation does: provide plan beneficiaries with cost-free contraceptives from their pre-existing health insurance plan.

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http://content.healthaffairs.org/content/34/7/1204.full.pdf+html.

[5] Am. Med. Ass'n, *Opinion 10.01- Fundamental Elements of the Patient-Physician Relationship*, http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1001.page. See also Am. Coll. of Obstetricians & Gynecologists, Elective Surgery and Patient Choice, Comm. Op. 578, 122 OBSTET. & GYNECOL. 1134, 1135 (2013) ("The goal should be decisions reached in partnership between patient and physician.").

[6] Am. Coll. of Obstetricians & Gynecologists, *Well-Woman Visit*, Committee Op. 534, 120 OBSTET. & GYNECOL. 421, 422 (2012).

A lack of insurance coverage deters many women from choosing a high-cost contraceptive,[7] even if that method is best for her, and may result in her resorting to an alternative method that places her more at risk for medical complications or improper or inconsistent use, with the attendant risk of unintended pregnancy. In addition to preventing pregnancy, contraception has other scientifically recognized health benefits for many women. Hormonal birth control helps prevent menstrual migraines, treat pelvic pain from endometriosis, and decrease the need for hysterectomy by reducing heavy menstrual bleeding.[8] Oral contraceptives have been shown to have long-term benefits in reducing a woman's risk of developing endometrial and ovarian cancer, protecting against pelvic inflammatory disease and certain benign breast disease, and protecting against colorectal cancer in the short term.[9] Conversely, pregnancies that are too frequent and too closely spaced, which are more likely when contraception is more difficult to obtain, put women at significantly greater risk for permanent physical health damage. Such damage can include organ prolapse that can lead to pain, incontinence, and surgical treatments. Without the ability to control her fertility during her childbearing years, a woman risks having approximately twelve pregnancies during her lifetime. Additionally, women with short interpregnancy intervals are at greater risk for third trimester bleeding, premature rupture of membranes, puerperal endometritis, anemia, and maternal death.[10]

The ACA's contraception coverage requirement recognizes that women of childbearing age have unique health needs and that contraception counseling and services are essential components of women's preventive health care. Decisions concerning contraceptive use, like all health care decisions, should be made by patients in consultation with their health care professionals based on the best interests of the patient. This is best accomplished when contraceptive coverage is provided within the same overall framework as a woman's other health care services in consultation with a woman's chosen provider. The existing accommodation accomplishes this, while at the same time respecting an employer's sincerely held religious objections to contraception.

As mentioned previously, a decision to alter the current accommodation for contraceptive coverage under the ACA could have negative consequences concerning other preventive services crucial to the health of women and children. Currently, the ACA requires employer-based health plans to cover other preventive services without cost, including vaccines. If the current accommodation for contraceptive coverage is weakened, similar arguments may be made for vaccines and other preventive services, reducing their use by children and families by increasing the financial burden of receiving such care.

Throughout their work to implement the accommodation, the Departments have constantly kept women's health care access at the center of policymaking. We urge the Departments to continue

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[7] Inst. of Med., *Clinical Preventive Services for Women: Closing the Gaps* 108 (2011) ("IOM Report"); *see also* Megan L. Kavanaugh et al., *Perceived and Insurance-Related Barriers to the Provision of Contraceptive Services in U.S. Abortion Care Settings*, 21 WOMEN'S HEALTH ISSUES S26, S26 (3d Suppl. 2011) (finding that cost can be a barrier to the selection and use of long-acting reversible contraceptives and other effective forms of contraceptives, such as the patch, pills, and the ring).

[8] Ronald Burkman et al., *Safety Concerns and Health Benefits Associated With Oral Contraception*, 190 AM. J. OF OBSTET. & GYNECOL. S5, S12, S18 (2004).

[9] *Id. See also* IOM Report at 107.

[10] Augustin Conde-Agudelo & Jose M. Belizan, *Maternal Morbidity and Mortality Associated with Interpregnancy Interval: Cross Sectional Study*, 321 BRITISH MED. J. 1255, 1257 (2000).

to uphold that important principle in any future policymaking, and to ultimately ensure women receive the birth control services they are entitled to without barrier or delay.

We look forward to working with the Departments on our shared goal of fulfilling the promise of the ACA and increasing women's access to preventive care. Thank you for the opportunity to provide these comments. If you have any questions, please do not hesitate to contact Stefanie Jones at sjones@acog.org or 202-863-2544.

Sincerely,

American Academy of Family Physicians
American Academy of Pediatrics
American Congress of Obstetricians and Gynecologists