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April 3, 2023

Via Regulations.gov

The Honorable Janet Yellen
Secretary
U.S. Department of Treasury
1500 Pennsylvania Avenue, N.W.
Washington, D.C. 20220

The Honorable Julie Su
Acting Secretary
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: **Notice of Proposed Rulemaking, *Coverage of Certain Preventive Services Under the Affordable Care Act*, 88 Fed. Reg. 7236 (February 2, 2023).**

Dear Secretaries Yellen, Su, and Becerra:

We write on behalf of the Attorneys General of the states of Arizona, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Michigan, Minnesota, Nevada, New Jersey, New York, North Carolina, Oregon, Rhode Island, Vermont, and Washington, the Commonwealths of Massachusetts and Pennsylvania, and the District of Columbia ("the State AGs") regarding the proposed rulemaking by the U.S. Departments of the Treasury, Labor, and Health and Human Services ("the Departments") relating to the coverage of certain preventive services under the Affordable Care Act ("the ACA"). *See Coverage of Certain Preventive Services Under the Affordable Care Act*, 88 Fed. Reg. 7236 (Feb. 2, 2023) ("the Proposed Rule"). The Departments propose rescinding the moral exemption promulgated as part of the final rules in November 2018, which enabled entities with a moral objection to providing or covering contraception to be exempt from the contraceptive coverage mandate implemented

by the ACA and the Women's Health Amendment ("the 2018 Rules").[1] The Proposed Rule also seeks to establish a new individual contraceptive arrangement ("ICA") for individuals enrolled in plans or coverage that are sponsored, arranged, or provided by entities with a religious objection to providing or covering contraceptive services to obtain no-cost contraceptive coverage.

The State AGs applaud the Departments for their efforts to improve access to contraceptive coverage under the ACA. We support rescinding the moral exemption and offer recommendations on how to improve the ICA. However, we oppose the Departments' proposal to retain the expansive religious exemption promulgated by the 2018 Rules.

The State AGs have a substantial interest in protecting the medical and economic health of our residents and ensuring that all residents are free and able to fully advance their educational and economic goals. Contraception is necessary preventive healthcare that is vital for women, and everyone with capacity to become pregnant, to be able to aspire, achieve, participate in, and contribute to society based on their individual talents, capabilities, and timelines. The 2018 Rules created sweeping new exemptions that denied women across the country access to legally protected preventive healthcare. The 2018 Rules went far beyond what any court had deemed necessary to protect the rights of those with religious or moral objections, while also still ensuring that women "receive full and equal health coverage, including contraceptive coverage," as instructed by the Supreme Court.[2] The loss of contraceptive care is harmful not just to women and those with capacity to become pregnant, but also to their families, their communities, and taxpayers who bear the burden of publicly-funded programs that must supply health services in place of exempt entities.

The State AGs therefore strongly support rescinding the moral exemption as promulgated by the 2018 Rules, recommend narrowing the religious exemptions as expanded by the 2018 Rules, and commend the Proposed Rule's attempt to create an alternative means by which those who are covered under health plans sponsored by exempt employers or universities can access contraceptive services at no cost to the individual. We are disappointed to see that the Proposed Rule unnecessarily retains the overly broad religious exemption of the 2018 Rules. The State AGs thus urge the Departments to heed the recommendations and objections contained herein to ensure that all have access to no-cost contraceptive coverage as required by the ACA and the Women's Health Amendment.

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[1] *See* 83 Fed. Reg. 57536, 57592 (Nov. 15, 2018). Many of the State AGs who have joined this comment are currently involved in litigation challenging the November 2018 Rules as discussed, *infra* notes 13-17. In offering these comments, the State AGs are in no way conceding or abandoning the allegations and legal positions advanced in their respective lawsuits and reserve all rights to continue their respective litigations should they deem it necessary and appropriate based on the final result of the present rulemaking process. Nothing in this comment is intended to be a waiver of any such rights.

[2] *See Zubik v. Burwell*, 578 U.S. 403, 408 (2016).

In addition, while the ICA is a welcome step in the right direction, it requires significant improvements to deliver on its intended purpose of providing no-cost contraceptive care coverage to those who are currently without such coverage as a result of the 2018 Rules. The State AGs therefore propose several additions to the Proposed Rule with respect to the ICA that we believe are necessary for its operability. *See infra* Section III. In doing so, we hope the Departments will be able to ensure that all who would otherwise lack access to vital preventive services under the 2018 Rules will now have this access at no cost to the individual as required by the ACA and the Women's Health Amendment.

BACKGROUND

Among other reforms, the ACA sought to rectify historical inequities in women's health care by increasing access to preventative services like contraceptive coverage.[3] Before the ACA, "more than half of women delay[ed] or avoid[ed] preventive care because of its cost."[4] Thus, Congress passed the Women's Health Amendment as part of the ACA to require that group health plans and insurance issuers offering group or individual coverage must cover and "not impose any cost sharing requirements . . . with respect to women, such additional preventive care and screenings . . . as provided for in comprehensive guidelines supported by the Health Resources and Services Administration."[5] Congress expected that eradicating these discriminatory barriers to preventive care—including contraceptive care—would result in substantially improved health outcomes for women.[6] Pursuant to the Women's Health Amendment, the Health Resources and Services Administration ("HRSA"), based on recommendations from the Institute of Medicine (now the National Academy of Medicine), implemented guidelines in 2011 that defined preventive services necessary for women's health, including all contraceptive services approved by the U.S. Food and Drug Administration. These services include the full range of FDA-approved contraception, sterilization procedures, and patient education and counseling.

[3] 42 U.S.C. § 300gg-13(a); 155 Cong. Rec. S12027 (Dec. 1, 2009) (statement of Sen. Gillibrand) (explaining that the Women's Health Amendment sought to redress the discriminatory practice of charging women more for preventive services than men).

[4] *Id.*

[5] 42 U.S.C. § 300gg-13(a)(4). As part of the ACA, Congress carved out an exemption from the contraceptive coverage mandate for grandfathered plans—that is, certain health plans that were in effect when it passed the ACA.

[6] *See, e.g.*, 155 Cong. Rec. S12052 (Dec. 1, 2009) (statement of Sen. Franken) (describing "family planning services" as a "top priority," a "fundamental right of every adult American," and necessary for "women and families to make informed decisions about when and how they become parents," and stating "affordable family planning services must be accessible to all women in our reformed health care system"); *id.* at S12059 (statement of Sen. Cardin) ("General yearly well-women visits would be covered . . . [including] family planning services."); *id.* (statement of Sen. Feinstein) (same).

In 2010, the Departments promulgated and adopted rules requiring employers and plan sponsors to cover these necessary preventive services, including the full range of contraception set forth in the HRSA guidelines.[7] However, in an effort to accommodate those plan sponsors with religious objections to certain forms of contraception, the Departments exempted churches and closely-related entities from this contraceptive coverage mandate in its entirety ("the church exemption").[8] The Departments also created a separate "accommodation" process that allowed certain non-profit organizations that did not qualify for the church exemption to nonetheless provide notice of their religious objections to covering contraception and shift the burden for compliance with the mandate to their insurance carrier or third-party administrator ("TPA").[9] In this way, the issuer or TPA would exclude such contraception from the employer's group health plan and instead provide separate payments for any contraceptive services without cost to the insured. The issuer or TPA was also required to provide written notice to plan participants and eligible beneficiaries that the organization does not cover these benefits but that such benefits were available directly from the insurer. Shifting this burden to the issuer was not expected to impose additional costs on the issuer because it would yield cost savings from lower medical costs as a result of preventing unintended pregnancies.[10]

As a result of the accommodation process, unlike those covered by exempt entities, individuals covered by plans that utilized the accommodation still received notice and no-cost contraceptive coverage directly from their issuer or TPA. This provided seamless coverage for those employed by objecting entities that utilized the accommodation process to continue seeing their provider of choice and receiving medical care without disruption. The Departments later expanded the entities eligible for the accommodation to include closely-held for-profit entities following the Supreme Court's decision in *Burwell v. Hobby Lobby Stores*, 134 S. Ct. 2751 (2014).[11]

In 2018, the Trump Administration undermined and thwarted the Women's Health Amendment by implementing interim final rules and substantially similar final rules, which significantly expanded the scope of the existing exemption by allowing *any* non-governmental entity—including publicly traded corporations—to opt out of the mandate on the basis of a religious objection and, for the first time, allowed entities with a non-religious moral objection to opt out of the mandate as well.[12] These rules also rendered the accommodation process optional, thus eliminating the assurance that those who were insured by entities utilizing the accommodation would receive contraceptive coverage now that objecting entities could opt to

[7] 75 Fed. Reg. 41726 (July 19, 2010).
[8] 76 Fed. Reg. 46621 (Aug. 3, 2011).
[9] 78 Fed. Reg. 39870 (July 2, 2013).
[10] Since TPAs do not bear the costs for other benefits, such as coverage for unintended pregnancies, the regulations created a mechanism for the Department of Health and Human Services to reimburse TPAs for providing this coverage through user fees on the federally-facilitated exchange.
[11] 80 Fed. Reg. 41318 (July 14, 2015).
[12] 83 Fed. Reg. 57536 (Nov. 15, 2018).

use the exemption instead. Objecting entities were neither required to claim that compliance with the contraceptive coverage mandate would cause a substantial burden on their religious beliefs, nor to affirmatively notify the government or the issuer of that claim. The 2018 Rules, therefore, led to loss of contraceptive coverage for anyone covered by a plan sponsored by a religious or moral objector and did not provide a mechanism for obtaining contraceptive care without cost sharing from any other source.

Many of this comment's signatories initiated litigation against the Departments challenging the interim final rules and subsequent final 2018 Rules on both procedural and substantive grounds.[13] In the suit filed by 13 States and the District of Columbia, the district court issued a preliminary injunction, which was affirmed by the Court of Appeals for the Ninth Circuit.[14] In litigation brought by Pennsylvania and New Jersey, the district court issued a nationwide preliminary injunction of the 2018 Rules, which the Court of Appeals for the Third Circuit affirmed.[15] The Supreme Court, however, overturned the nationwide preliminary injunction and permitted the Departments to issue the religious and moral exemptions in *Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*, 140 S. Ct. 2367 (2020). The majority opinion, however, declined to reach the merits of the Religious Freedom Restoration Act ("RFRA") claim.[16] The Court remanded that case to the lower court where it is presently stayed.[17]

In the Proposed Rule, the Departments propose rescinding the moral exemption and implementing an alternative means for individuals to obtain no-cost contraceptive coverage. This proposed mechanism, the ICA, is intended to enable a participant or beneficiary in a group health plan or individual coverage sponsored by an objecting entity to find a participating provider that will provide contraceptive coverage at no cost to the individual. Providers participating in the

[13] States brought suit as to the final 2018 Rules as follows: Pennsylvania and New Jersey sued the President and the Departments in the Eastern District of Pennsylvania and secured a nationwide preliminary injunction, which was subsequently affirmed by the Third Circuit. *See Pennsylvania v. Trump*, 351 F. Supp. 3d 791 (E.D. Pa. 2019); *aff'd* 930 F.3d 543 (3d Cir. 2019). Massachusetts brought suit in the District of Massachusetts, which ruled in favor of the Departments on summary judgment. *See Massachusetts v. U.S. Dep't of Health & Human Servs.*, 513 F. Supp. 3d 215 (D. Mass. 2021). California, Connecticut, Delaware, Hawaii, Illinois, Maryland, Minnesota, New York, North Carolina, Rhode Island, Vermont, Virginia, Washington, and the District of Columbia brought suit in the Northern District of California and secured a preliminary injunction as to the litigant states, which the Ninth Circuit upheld. *See California v. Health & Human Servs.*, 351 F. Supp. 3d 1267 (N.D. Cal. 2019); *aff'd*, 941 F.3d 410 (9th Cir. 2019).

[14] *California v. U.S. Dep't of Health & Human Servs.*, 941 F.3d 410 (9th Cir. 2019*); cert. granted, judgment vacated sub nom. Little Sisters of the Poor Jeanne Jugan Residence v. California*, 141 S. Ct. 192 (2020) (remanding case to the Ninth Cir. for further consideration in light of *Little Sisters*).

[15] *Pennsylvania v. President U.S.*, 930 F.3d 543 (3d Cir. 2019).

[16] *Little Sisters*, 140 S. Ct. at 2383.

[17] The multistate suit is currently stayed as well, while Massachusetts's suit is held in abeyance on appeal.

ICA must have a signed agreement with an issuer that will reimburse the provider for the cost of contraceptive services as well as administrative costs. Issuers will be able to seek reimbursement from the federal government through an adjustment to their fees associated with the federally-facilitated exchange or state exchange on the federal platform.[18] No action is required on behalf of the objecting entities as part of the ICA. This proposed arrangement would operate independently from any health plan.

The Proposed Rule otherwise retains the changes made by the 2018 Rules that made the accommodation optional and drastically expanded the religious exemption to apply to any entity that objects on religious grounds.

I. THE PROPOSED RULE'S RESCISSION OF THE MORAL EXEMPTION BETTER ENSURES ACCESS TO CONTRACEPTIVE SERVICES WITHOUT COST SHARING AS CONGRESS INTENDED.

The State AGs strongly support the proposed elimination of the moral exemption.[19] The State AGs further commend the Departments for acknowledging missteps in the 2018 rulemaking,[20] and their recognition that the moral exemption erected unwarranted barriers to accessing contraceptive services.

As noted above, the purpose of Section 2713(a)(4) of the Women's Health Amendment is to ensure that group health plans and health insurance issuers cover women's preventive healthcare needs in accordance with HRSA-supported guidelines.[21] The HRSA guidelines have continuously included contraception as a service that is "necessary for women's health and well-being,"[22] and it is therefore essential that exemptions and accommodations crafted in relation to group health plans and coverage not diminish the importance of contraception as an HRSA-recommended preventive service. The moral exemption, however, did precisely that by

[18] 45 CFR § 156.50(d).

[19] *See* 88 Fed. Reg. 7247 ("the Departments propose to eliminate the exemption for entities with moral objections to contraceptive coverage at 45 CFR 147.133, and therefore to also make conforming edits to remove references to 45 CFR 147.133 that appear in paragraph (a)(1) of 45 CFR 147.130 and paragraph (a)(1)(iv) of 26 CFR 54.9815-2713, 29 CFR 2590.715-2713 and 45 CFR 147.130.").

[20] 88 Fed. Reg. 7243 ("[T]he Departments have determined that the November 2018 final rules failed to adequately account for women's legal entitlement to access preventive care, critically including contraceptive services, without cost sharing as Congress intended; the impact on the number of unintended pregnancies; the costs to states and individuals of such pregnancies; and the government's interest in ensuring women have access to this coverage.").

[21] *See* 42 U.S.C. § 300gg-13(a)(4); *see also Update to the Women's Preventive Services Guidelines*, 87 Fed. Reg. 1763 (Jan. 12, 2022) (the HRSA guidelines "address health needs specific to women").

[22] The HRSA-supported 2021 Women's Preventive Services Guidelines, *available at* https://www.hrsa.gov/womens-guidelines-historical-files.

depriving employees' access to necessary preventive care and screenings based on objecting employers' organizational views.

The moral exemption also suffers from critical legal infirmities — it is the product of unreasoned decision-making and discriminates against women in violation of Section 1557 of the ACA and Title VII of the Civil Rights Act. Rescission of the moral exemption falls squarely within the Departments' discretion, and they have provided reasoned justification in the Proposed Rule for doing so.

A. The Moral Exemption in the 2018 Rules is Arbitrary and Capricious in Violation of the Administrative Procedure Act.

As mentioned, many of the states that have joined this comment are currently involved in litigation challenging the 2018 Rules implementing the moral exemption as arbitrary and capricious and seeking to vacate it. Consistent with our position in those actions, we applaud the Departments' rescission of the moral exemption.

1. The Departments in 2018 provided no reasoned justification for the moral exemption.

The Departments justified the moral exemption in the 2018 Rules by relying on factors Congress did not intend them to consider, and consequently failed to provide a reasoned justification for the rule.[23] In October 2017, the Departments issued an interim final rule permitting employers with moral objections to forgo providing contraceptive coverage to employees.[24] Prior to the interim final rule, no moral exemption to the contraceptive mandate existed in any form. There is no religious or moral exemption in the text of the ACA or the Women's Health Amendment,[25] so the Departments justified the promulgation of the moral exemption by invoking unrelated instances of Congress respecting morally-informed objections to generally applicable laws.[26] The Departments deemed the moral exemption a reasonable exercise of agency discretion because of their history of using the discretion for religious exemptions.[27] They also noted that while Congress did not include conscience-based exemptions in the Women's Health Amendment, it also did not require that the Departments cover contraception.[28] The Departments hypothesized that had Congress known the Women's Health

[23] *See Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) ("Normally, an agency rule would be arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider[.]").

[24] *Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act*, 82 Fed. Reg. 47838 (Oct. 13, 2017).

[25] *Pennsylvania*, 351 F. Supp. at 821.

[26] 82 Fed. Reg. 47844-45; 83 Fed. Reg. 57598-600.

[27] 83 Fed. Reg. 57597.

[28] 83 Fed. Reg. 57603.

Amendment would encompass contraception, then it would have included a conscience exemption as well.[29]

However, the legislative record for the Women's Health Amendment is replete with evidence that Congress *did* expect contraception would be covered.[30] Moreover, the more plausible inference to draw from Congress having explicitly created moral exceptions to other generally applicable laws, but not to the ACA, would be that the difference is intentional.[31] The Departments in the 2018 Rules, however, rejected this canon, reasoning that such an inference would "negate not just [the moral] exemptions, but the previous [religious] exemptions[.]"[32] The Departments failed to recognize at the time that the existence of RFRA, 42 U.S.C. § 2000bb, et seq., only creates an obligation to consider religious interests.[33] Congress's omission of religious exemptions from the ACA is irrelevant because RFRA applies to all federal statutes and regulations.[34] In *Little Sisters*, the Supreme Court indeed concluded that it was appropriate for HRSA to consider the possibility of required exemptions under RFRA as a reason for establishing the religious exemption.[35] Whereas, "there is no analogous need to heed the possibility of successful claims to a non-religious moral exemption, because there is no moral-exemption statute similar to RFRA."[36] Thus, the Departments' past practice of accommodating substantial burdens on religion has no bearing on whether the Departments should accommodate non-religious moral opposition to contraception.

In sum, the Departments' analysis of legislative intent in choosing to adopt the moral exemption was contrary to the available evidence and thus cannot "survive administrative law's

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[29] *Id.* (asserting that the Departments created the moral exemption because "[i]t is not clear to the Departments that, if Congress had expressly mandated contraceptive coverage in the ACA, it would have done so without providing for similar [moral] exemptions. Therefore, the Departments consider it appropriate, to the extent we impose a contraceptive Mandate by the exercise of agency discretion, that we also include an exemption for the protection of moral convictions in certain cases"); *see also id.* (calling the moral exemption "consistent with the scope of exemptions that Congress has established in similar contexts").

[30] *See, e.g.*, 155 Cong. Rec. 28,841 (2009) (Sen. Boxer); *id.* at 28,843 (Sen. Gillibrand); *id.* at 28,844 (Sen. Mikulski); *id.* at 29,070 (Sen. Feinstein); *id.* at 29,311 (Sen. Nelson). And after the release of the first version of the Guidelines, which included contraception, Congress voted against adding conscience exemptions that functioned just as the moral exemption does. 158 Cong. Rec. 2621–34 (2012); *see also Hobby Lobby*, 573 U.S. at 719 n.30 (describing this legislative history).

[31] *See, e.g.*, *Loughrin v. United States*, 573 U.S. 351, 358 (2014) (explaining Congress's use of language in one section of a statute, but not another, ordinarily is intentional); *Marx v. Gen. Revenue Corp.*, 568 U.S. 371, 384 (2013) (applying same interpretive principles across statutes).

[32] 83 Fed. Reg. 57599.

[33] *Little Sisters*, 140 S. Ct. at 2382-84.

[34] 42 § U.S.C. 2000bb-3 (indicating that federal law adopted after 1993 is subject to RFRA, unless such law explicitly excludes application); *see Little Sisters*, 140 S. Ct. at 2383.

[35] 140 S. Ct. at 2383.

[36] 88 Fed. Reg. 7249.

demand for reasoned decision-making."[37] Insofar as the Departments unreasonably assumed Congress's expectations, the moral exemption in the 2018 Rules violated the Administrative Procedure Act (APA) limitations on agency rulemaking. And that is precisely what happened.

2. The Departments' analysis of the impact of the moral exemption in 2018 was arbitrary and capricious.

Moreover, the moral exemption in the 2018 Rules was premised on baseless assumptions about its impact. Specifically, the Departments neglected to conduct any reasonable analysis to estimate how many individuals would lose contraceptive coverage because of the moral exemption. At the time of the 2018 rulemaking, the Departments guessed without any data the number of employers that would be affected by the moral exemption.[38] And because the assumptions lacked any objective basis, the moral exemption failed to articulate "a rational connection between the facts found and the choice made" in violation of the APA.[39]

3. The Departments in 2018 failed to consider significant comments in creating the moral exemption.

The unreasonableness of the existing moral exemption is compounded by the Departments' failure in 2018 to address significant concerns raised by commenters in creating the moral exemption. No matter the substance of an agency's rule, an agency may not have arrived at its conclusions having "failed to consider an important aspect of the problem."[40] The Departments failed to respond to comments from the medical community that voiced concerns with many of the Departments' medical judgments. *See Pennsylvania v. Trump* (E.D. Pa. Case No. 2:17-cv-04540, ECF No. 253-3). Failure to address these significant comments is fatal to an agency's defense of the rule. *See Ass'n of Private Sector Colls. & Univs. v. Duncan,* 681 F.3d 427, 449 (D.C. Cir. 2012) (citing *Int'l Union, United Mine Workers v. Mine Safety & Health Admin.*, 626 F.3d 84, 94 (D.C. Cir. 2010).

Additionally, of the over 54,000 comments on the moral exemption received by the Departments, only ten comments were in support, none of which expressed the commenters'

[37] *Little Sisters*, 140 S. Ct. at 2397 (Kagan, J., concurring in the judgment).

[38] 83 Fed. Reg. 57626 ("The Departments . . . are currently unable to estimate the number of such entities. Lacking other information, we assume that the number is small. The Departments estimate it to be less than 10 and assume the exemption will be used by nine nonprofit entities."); *see also* 88 Fed. Reg. at 7249 ("[W]ithout data available to estimate the actual number of entities that would make use of the exemption for entities with sincere moral objections, the Departments assumed that the moral exemption would be used by nine nonprofit entities and nine for-profit entities. These assumptions were made in the absence of data.").

[39] *Motor Vehicle Mfrs.*, 463 U.S. at 43.

[40] *Id.*

own non-religious moral objections to contraception.[41] Put differently, just 0.018% of comments supported the moral exemption, and 99.98% opposed it. Yet nowhere in the final rule did the Departments acknowledge this overwhelming disparity, nor did they modify the moral exemption to increase contraceptive coverage as requested by the vast majority of commenters. Instead, the Departments treated these ten comments as bearing greater weight than the 54,000 comments opposing the moral exemption, effectively disregarding the vast majority of commenters.

While the number of comments on either side is not by itself dispositive, the imbalance of comments is relevant here because the Departments justified the moral exemption as responsive to comments.[42] Presenting the moral exemption as responsive to commenters' interests without addressing that the overwhelming weight of comments opposed the rules, and when none of the commenters in favor expressed their own non-religious moral objections to contraception, is a clear error of judgment.

B. The Moral Exemption Creates an Unreasonable Barrier to the Availability of Appropriate Medical Care in Violation of Section 1554 of the ACA.

Section 1554 of the ACA prohibits the Secretary of Health and Human Services from issuing any regulation that "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care."[43] Contraception is, for many individuals, "appropriate medical care." Indeed, according to the HRSA, contraception is among the preventive services "necessary for women's health and well-being."[44]

But the moral exemption does exactly that by allowing employers to deny individuals access to contraceptive care based on non-religious, moral objections to providing such care, and by making it more difficult to obtain care that the HRSA guidelines consider essential.[45] Since the moral exemption allows employers to deny coverage for contraception, it "creates . . . barriers" for those who wish to access such care. That some individuals denied coverage may be

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[41] 83 Fed. Reg. 57596 (providing number of comments); *see also Pennsylvania v. Trump* (E.D. Pa. Case No. 2:17-cv-04540, ECF No. 253-8).

[42] 83 Fed. Reg. 57595 and n.5 (noting that commenters had supported a moral exemption prior to 2017).

[43] 42 U.S.C. § 18114(1).

[44] *See* 2019 HRSA Guidelines, *available at* https://www.hrsa.gov/womens-guidelines-historical-files.

[45] *See id.*; 87 Fed. Reg. 1763 at 1764 ("recommend[ing] that adolescent and adult women have access to the full range of contraceptives and contraceptive care to prevent unintended pregnancies and improve health outcomes"); Institute of Medicine 2011, *Clinical Preventive Services for Women: Closing the Gaps*, 108-09, Washington, D.C.: The National Academies Press, *available at* https://doi.org/10.17226/13181 (explaining that availability of insurance without cost-sharing requirement promotes access to contraceptive care).

able to surmount these barriers and obtain contraception elsewhere (often at a significantly higher cost) does not change that. By allowing employers to deny coverage, the moral exemption makes it more difficult for them to access the care they need. And as the Departments acknowledged in the 2018 Rules, the government is under no obligation to provide a moral exemption in the first instance.[46]

As a result, the moral exemption creates "unreasonable barriers to the ability of individuals to obtain appropriate medical care," and is therefore unlawful under the ACA. The Proposed Rule's rescission of the moral exemption removes this barrier and facilitates seamless coverage by enabling individuals whose employers hold moral objections to the contraceptive coverage mandate to access cost-free contraceptive care without jumping through hoops to obtain it.

C. The Moral Exemption Violates Section 1557 of the ACA and Title VII of the Civil Rights Act.

The Departments' much needed rescission of the moral exemption would put their regulations back in compliance with federal anti-discrimination statutes as they pertain to employers with moral objections to coverage of contraceptive care. The existing moral exemption, by contrast, conflicts with two federal statutes that prohibit discrimination on the basis of sex: Section 1557 of the ACA and Title VII of the Civil Rights Act. Section 1557 prohibits "discrimination under[] any health program or activity, any part of which is receiving Federal financial assistance," on several grounds, including "the ground prohibited . . . under title IX of the Education Amendments of 1972."[47] Title IX in turn prohibits discrimination "on the basis of sex" in education, 20 U.S.C. § 1681, and its implementing regulations make clear that it prohibits discrimination on the basis of pregnancy or related conditions.[48] Similarly, Title VII prohibits employers from discriminating on the basis of sex.[49] In 1978, Congress enacted the Pregnancy Discrimination Act (PDA), which amended Title VII to clarify that discrimination

[46] 83 Fed. Reg. 57592, 57598; *see also* 88 Fed. Reg. at 7249 ("The Departments' adoption of the moral exemptions was not legally required but rather an exercise of the Departments' discretion to protect moral convictions."); *id.* ("RFRA does not require any exemption for non-religious moral objections that do not result in a substantial burden on someone's exercise of religion.").

[47] 42 U.S.C. § 18116(a).

[48] 20 U.S.C. § 1681; *see* 34 C.F.R. § 106.40(b)(1) ("A recipient shall not discriminate against any student . . . on the basis of such student's pregnancy, childbirth, false pregnancy, termination of pregnancy or recovery therefrom."). The Department of Education's 2022 Notice of Proposed Rulemaking regarding Title IX proposes an expansive definition of "pregnancy or related conditions" that includes medical conditions related to and recovery from pregnancy, childbirth, termination of pregnancy and lactation. *See* 87 Fed. Reg. 41390, 41515.

[49] 42 U.S.C. § 2000e-2(a).

because of "pregnancy, childbirth, or related medical conditions" is discrimination on the basis of sex.[50]

This same logic prohibits employers from treating contraception differently than analogous categories of health care. For example, if an employer provides prescription drug coverage to its employees, it cannot exclude contraceptive prescriptions without running afoul of Title VII.[51] Treating contraceptive benefits differently than other preventive services is unlawful because it discriminates on the basis of sex under Title VII and because it violates Congress's expressed intent that the PDA's protections should "extend[] to the whole range of matters concerning the childbearing process."[52]

Despite these statutes, the moral exemption authorizes differential treatment. Under the current rule, an employer who holds a non-religious moral objection may refuse to provide contraceptive coverage, even as that employer maintains an obligation to provide other preventive care and prescription benefits.[53] Section 1557 and Title VII each prohibit such discrimination, and the moral exemption, by *authorizing* that same discrimination, is unlawful under the APA.[54]

D. The Proposed Rescission of the Moral Exemption Comports with the APA.

The Departments' proposed elimination of the existing moral exemption is well within the Departments' authority and reasonably explained by the Proposed Rule. When an agency revises existing regulations, the agency needs to show that "the new policy is permissible under the statute," and "show that there are good reasons for the new policy."[55] The State AGs agree that the proposed rescission of the moral exemption is permissible under the ACA (and RFRA), and that the Departments provided a reasoned justification for their reversal on the exemption.

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[50] 42 U.S.C. § 2000e(k); *see also U.A.W. v. Johnson Controls, Inc.*, 499 U.S. 187, 199-200 (1991) (holding that in classifying employees based on their potential to become pregnant, employer's policy excluding women, except those determined to be infertile, from jobs involving exposure to lead violated Title VII's prohibition on sex discrimination).

[51] *See Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1269 (W.D. Wash. 2001) ("In light of the fact that prescription contraceptives are used only by women, [defendant's] choice to exclude that particular benefit from its generally applicable benefit plan is discriminatory."). *But see In re Union Pac. R.R. Emp't Practices Litig.*, 479 F.3d 936, 942 (8th Cir. 2007).

[52] *See* H. Rep. No. 95-948, at 5.

[53] *See* 42 U.S.C. § 300gg-13(a)(1); *id.* §§ 18022(b)(1)(F), (1)(I).

[54] *See* 5 U.S.C. § 706(2)(A); *see also Farrington v. Johnson*, 206 F. Supp. 3d 634, 635, 644 (D.D.C. 2016) (refusing to dismiss APA claim arising under Title VII); *Pima Cty. Cmty. Coll. Dist. v. EEOC*, No. 75-210, 1976 WL 548, at *2 (D. Ariz. 1976) (observing that Title VII is "certainly a relevant statute within the contemplation" of the APA).

[55] *FCC v. Fox Television Stations, Inc*., 556 U.S. 502, 515 (2009).

Initially, the Departments are under no legal obligation to provide moral exemptions under the ACA.[56] Section 2713(a)(4) of the Women's Health Amendment does not set forth any specific criteria or exemption to guide HRSA's formulation of the guidelines.[57] Congress granted broad discretion to the Departments to identify and craft exemptions,[58] so their proposal to remove the moral exemption falls well within their purview under the ACA. Moreover, there is also no moral-exemption statute similar to RFRA, so the Departments need not heed non-religious moral objectors without any congressional directive. In *Little Sisters*, the Supreme Court stated that the Departments may consider RFRA when framing the religious exemption because the ACA does not explicitly exempt RFRA, and the regulations implementing the contraceptive coverage mandate qualify as federal law that is subject to RFRA.[59] RFRA, however, does not require any moral exemptions that do not result in a substantial burden on someone's exercise of religion.[60]

In addition to acknowledging the above, the Proposed Rule further explains that the moral exemption in the 2018 Rules failed to adequately account for women's legal entitlement to access preventive care, the impact on the number of unintended pregnancies, the costs to states and individuals of such pregnancies, and the government's interest in ensuring women have access to this coverage.[61] The Proposed Rule also confirms that the moral exemption made assumptions in the absence of data regarding the number of employers and employees that would be affected by the moral exemption.[62] The Proposed Rule also explains that the Departments failed to consider potential harms to employees of objecting entities in the 2018 rulemaking, and their reliance on other statutory provisions seemingly demonstrating Congress's historical desire and intent to protect non-religious objections had factual flaws. Overall, the Proposed Rule rightfully reverses the moral exemption and reasonably explains how its rescission will eliminate barriers to accessing contraceptive coverage in accordance with the Women's Health Amendment and the ACA.

[56] 88 Fed. Reg. 7249.
[57] *Little Sisters*, 140 S. Ct. at 2380.
[58] *See* 42 U.S.C. § 300gg-13(a)(4); *see also Little Sisters*, 140 S. Ct. at 2380-81 ("By its terms, the ACA leaves the guidelines' content to the exclusive discretion of HRSA.").
[59] 140 S. Ct. at 2383.
[60] 88 Fed. Reg. 7249.
[61] 88 Fed. Reg. 7243.
[62] 88 Fed. Reg. 7249.

II. THE PROPOSED RULE'S RETENTION OF THE OVERBROAD RELIGIOUS EXEMPTION ESTABLISHED IN THE 2018 RULES IS UNWARRANTED AND INCONSISTENT WITH THE MANDATE OF PROVIDING NO-COST CONTRACEPTIVE COVERAGE.

While the State AGs agree with the Departments' decision to rescind the moral exemption, the State AGs do not support the Departments' proposal to maintain the religious exemptions from the 2018 Rules.[63] The religious exemptions are fatally overbroad in that they authorize exemptions from the contraceptive coverage mandate even when such exemptions are not compelled by an employer's sincerely held religious belief. As a consequence, the exemptions unjustifiably undermine the full and equal contraceptive coverage guaranteed by the ACA and thwart the ACA's purpose "to increase the use of preventive health services by making it as easy as possible for people to use them."[64] Moreover, the exemptions could be substantially narrowed in ways that would promote the Departments' goal of protecting and expanding access to contraceptive care while respecting the rights of religious objectors. The Departments must give careful consideration to these alternatives, and should the Departments decline to adopt them, the Departments must provide a sufficient justification in the Final Rule explaining their decision and explaining why the religious exemptions from the 2018 Rules are not fatally overbroad in their existing form for the reasons detailed below.[65]

A. The Departments Should Not Maintain the 2018 Religious Exemptions.

The State AGs strongly opposed the Departments' decision to create expanded religious exemptions in the 2018 Rules – and they continue to oppose those exemptions today. Among other problems, there is an unjustifiable "mismatch" between the scope of the exemptions and the problem that they were ostensibly created to address.[66] In the 2018 Rules, the Departments argued that it was necessary to create expanded exemptions to the contraceptive coverage mandate in order to address complicity-based objections to the accommodation.[67] The Departments asserted that, despite the ACA's mandate of full and equal contraceptive coverage, requiring employers with complicity-based objections to participate in the accommodation

[63] 88 Fed. Reg. 7247 ("This proposed rule would maintain the religious exemption from the November 2018 Religious Exemption final rules…The proposed changes in no way narrow the scope of the exemption…").

[64] Br. for Respondents at 74, *Zubik v. Burwell*, 136 S. Ct. 1557 (2016) (No. 14-1418), 2016 WL 537623.

[65] *Nat'l Tel. Coop. Ass'n v. FCC*, 563 F.3d 536, 541 (D.C. Cir. 2009) (rulemaking must be both "reasonable" and "reasonably explained"); *City of Brookings Mun. Tel. Co. v. FCC*, 822 F.2d 1153, 1169 (D.C. Cir. 1987) ("It is well settled that an agency has a duty to consider responsible alternatives to its chosen policy and to give a reasoned explanation for its rejection of such alternatives… The failure of an agency to consider obvious alternatives has led uniformly to reversal.").

[66] *Little Sisters*, 140 S. Ct. at 2398-2400 (Kagan, J., concurring in the judgment).

[67] 83 Fed. Reg. 57542, 57545.

violated RFRA.[68] But the Departments did not craft exemptions that were responsive to this narrow concern. Rather than exempting employers with complicity-based objections to the accommodation, the Departments "exempted all employers with [any] objections to the [contraceptive] mandate, even if the accommodation met their religious needs."[69] The Departments acknowledged that expanding the exemptions in this manner would deprive tens of thousands of women of the coverage they were receiving under existing regulations. As Justice Kagan observed in her concurring opinion in *Little Sisters*, this "all costs…no benefits" approach to rulemaking was "hard to see as consistent with reasoned judgment."[70]

Given that the Proposed Rule recognizes the shortcomings in the 2018 Rules, the Departments' proposal to maintain the religious exemptions in the same form is seriously problematic. The Departments acknowledge that the 2018 Rules "failed to adequately account" for the "critical importance" of contraceptive coverage and the harm the expanded exemptions would cause.[71] The Proposed Rule recognizes that protecting and expanding access to contraceptive services is a "national public health imperative."[72] In particular, the Departments find, correctly, that "access to contraception is an essential component of women's health care"[73]; that improving access to contraceptive care is "critical" to narrowing "racial-ethnic disparities…in reproductive health access and outcomes"[74]; that the Women's Health Amendment was enacted by Congress to ensure that all "women have seamless cost-free coverage of contraceptives…"[75]; and that this coverage is even more critical in light of the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*, 597 U.S. __ (2022).[76] And yet, the Departments are proposing to maintain exemptions that they acknowledge have resulted in well over 100,000 women losing contraceptive coverage – and which have disproportionately burdened low-income women of color.[77]

The State AGs acknowledge that the Departments have broad discretion to implement the Women's Health Amendment,[78] but that discretion is constrained by the APA's requirement of

[68] 83 Fed. Reg. 57545.
[69] *Little Sisters*, 140 S. Ct. at 2398-99 (Kagan, J., concurring in the judgment).
[70] *Id.* at 2399.
[71] 88 Fed. Reg. 7243.
[72] 88 Fed. Reg. 7240-41.
[73] 88 Fed. Reg. 7240.
[74] 88 Fed. Reg. 7241.
[75] 88 Fed. Reg. 7254.
[76] 88 Fed. Reg. 7240.
[77] 88 Fed. Reg. 7261 (accepting that at least 126,400 women lost coverage as a result of the 2018 expanded religious exemption); *id.* at 7241 (discussing impact on low-income/women of color).
[78] *Little Sisters*, 140 S. Ct. at 2381-82.

reasoned rulemaking.[79] Here, the Departments cannot exercise their discretionary authority to maintain overbroad exemptions that unnecessarily deprive women of their "legal entitlement to access preventive care, critically including contraceptive services, without cost sharing as Congress intended."[80] The State AGs strongly encourage the Departments to reconsider and pursue an alternative course that will minimize the impact on access to contraceptive coverage nationwide.[81]

To be clear, the State AGs do not support maintaining discretionary exemptions to the contraceptive mandate. The State AGs agree with the Departments' assessment that protecting and expanding access to contraceptive care is a "national public health imperative." The State AGs further agree with the nine federal Courts of Appeals that have concluded that the combination of the contraceptive mandate and the accommodation does not impose a substantial burden on religious exercise or violate RFRA.[82] The State AGs do not agree that the "possibility" that RFRA "might" require some type of exemption for "some objecting entities" in "some circumstances" [83] justifies rulemaking that imposes real, continuing, and immediate harm on tens of thousands of people needing access to contraceptive care.

B. Any Religious Exemption Must be Significantly Narrowed to Avoid Imposing Unnecessary Burdens on Women.

If the Departments choose to maintain a religious exemption, it must be no broader than necessary to address "religious objections to the contraceptive coverage requirement and the

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[79] *See Michigan v. EPA*, 576 U.S. 743, 750 (2015); *see also Little Sisters*, 140 S. Ct. at 2400 (Kagan, J., concurring in the judgment) ("Even in an area of broad statutory authority—maybe especially there—agencies must rationally account for their judgments.").

[80] 88 Fed. Reg. 7243; *see also Little Sisters*, 140 S. Ct. at 2400 (Kagan, J., concurring in the judgment).

[81] *See Little Sisters*, 140 S. Ct. at 2399 (Kagan, J., concurring in the judgment) (recognition that contraceptive mandate is "necessary for women's health and well-being" should have committed agencies to "minimizing the impact on contraceptive coverage, even as they sought to protect employers with continuing religious objections").

[82] *California v. Dep't of Health & Human Servs.*, 941 F.3d 410, 429-30 (9th Cir. 2019); *Eternal World Tel. Network, Inc. v. Sec'y of Health & Human Servs.*, 818 F.3d 1122, 1148 (11th Cir. 2016*); Mich. Catholic Conf. & Catholic Family Servs. v. Burwell*, 807 F.3d 738, 749-55 (6th Cir. 2015); *Catholic Health Care Sys. v. Burwell*, 796 F.3d 207, 218 (2d Cir. 2015); *Little Sisters of the Poor Home for the Aged v. Burwell*, 794 F.3d 1151, 1180 (10th Cir. 2015); *E. Tex. Baptist Univ. v. Burwell*, 793 F.3d 449, 463 (5th Cir. 2015); *Univ. of Notre Dame v. Burwell*, 786 F.3d 606, 615 (7th Cir. 2015); *Geneva Coll. v. Sec'y of Health & Human Servs.*, 778 F.3d 422, 442 (3d Cir. 2015); *Priests for Life v. Health & Human Servs.*, 772 F.3d 229, 252 (D.C. Cir. 2014); *Mich. Catholic Conf. & Catholic Family Servs. v. Burwell*, 755 F.3d 372, 390 (6th Cir. 2014); *Univ. of Notre Dame v. Sebelius*, 743 F.3d 547, 559 (7th Cir. 2014); *Eternal World Tel. Network, Inc. v. Sec'y of Health & Human Servs.*, 818 F.3d 1122, 1141-42 (11th Cir. 2016).

[83] 88 Fed. Reg. 7249-50.

existing accommodation."[84] This means that the Departments must, at a minimum, limit eligibility for any exemption to entities with complicity-based objections to the accommodation. Extending exemptions to entities that have "no religious need" for one does nothing to protect religious liberty,[85] but does "serious harm" to women's access to essential health care.[86] Narrowing the exemption will significantly reduce the number of individuals who lose coverage without imposing *any* burden on religious objectors. According to the Departments' analysis in the Proposed Rule, it seems likely that many of those who have lost coverage as a result of the 2018 expanded exemptions did so because their employers switched from using the accommodation to an exemption.[87] Given that many of these employers were previously using the accommodation without raising an objection, it seems likely that few had legitimate complicity-based objections to the process.[88]

In addition, employers should be required to certify their sincere religious objection to the Departments[89] in order to receive an exemption from the mandate and/or opt out of the accommodation. Without such notice, the Departments lack the basic information necessary to enforce the mandate or effectively regulate. The Departments now acknowledge that the

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[84] 88 Fed. Reg. 7254.

[85] Rather than lifting a burden on religious exercise, the religious exemptions in the 2018 Rules grant employers an improper religious veto over employees' access to contraceptive care. *See* 77 Fed. Reg. 8728 (exempting objecting employers from the contraceptive mandate would subject "employees to the religious views of the[ir] employer"). The record establishes that some employers have communicated to the Departments that they will seek to exempt themselves from any program that has the "purpose or effect of providing access to or increasing the use of contraceptive services." *See FAQs About Affordable Care Act Implementation Part 36*, at 7 (Jan. 9, 2017). The 2018 religious exemptions authorize employers to do exactly that: an employer may refuse to participate in the accommodation, and claim an exemption, not because of any complicity-based burden on their own religious exercise, but simply to deter employees from using contraception. Granting employers such authority is directly inconsistent with the Departments' stated goal of improving access to contraceptive care. 88 Fed. Reg. 7240-41.

[86] *Little Sisters*, 140 S. Ct. at 2399 (Kagan, J., concurring in the judgment); *see also* 88 Fed. Reg. 7240 ("Access to contraception is an essential component of women's health care.").

[87] In the 2018 Rules, the Departments projected that most women who would lose contraceptive coverage would do so because their employers would switch from using the accommodation to an exemption. 83 Fed. Reg. 57578. In the Proposed Rule, the Departments accept the 2018 projections. 88 Fed. Reg. 7260-61.

[88] 83 Fed. Reg. 57578 (explaining that the Departments "assume there is no overlap between" employers that were using the accommodation and employers that had been involved in litigation raising objections to the mandate or accommodation); *see also* 82 Fed. Reg. 47819 (acknowledging that there were few barriers to litigating objections to the accommodation including because "multiple public interest law firms publicly [offered to provide pro bono] … legal services for entities willing to challenge the Mandate").

[89] Alternatively, the Departments could require employers to notify their insurer or TPA of their objection and then separately require the insurer or TPA to notify the government. This approach – while more administratively complicated – is consistent with the "alternative approach" discussed below.

provision of no-notice exemptions under the 2018 Rules has created a situation where the Departments do not know whether employers are complying with the mandate in general, as required by federal law; nor do they know how many employers are claiming religious exemptions, or how many employees have lost coverage as a result.[90] This lack of information continues to impede the Departments' ability to develop regulations that ensure women receive contraceptive coverage while respecting religious objections to offering that coverage.

Employers would have no good-faith basis to object to this approach. In the *Little Sisters* oral argument, counsel for Little Sisters repeatedly confirmed that the organization had no "objection to simply objecting," or to the government independently arranging for insurers to provide coverage directly to their employees.[91] Similarly, in *Priests for Life v. U.S. Department of Health & Human Services*, then-Judge Kavanaugh endorsed a version of the accommodation in which an objecting entity could "submi[t] a simple notice to the Secretary of Health and Human Services in writing that it…holds itself out as religious and has religious objections to providing coverage for contraceptive services… [From there], the Government can independently determine the identity of the organizations' insurers and thereby ensure that … [they] provide contraceptive coverage."[92] Such approaches require nothing more from employers than simple notice and therefore cannot be subject to a complicity objection.

C. The Departments Should Also Make Adjustments to the Accommodation So That More People Retain Access to Seamless Contraceptive Coverage.

The Departments should also expand or adjust the accommodation to limit complicity objections, further reducing the need for harmful exemptions. The "alternative approach" for fully insured plans outlined in the Proposed Rule is an example of this approach. Under that plan, the contraceptive coverage requirement would apply directly to the health insurance issuer if a group health plan, a group health plan sponsor, or an institution of higher education is an objecting entity.[93] This proposed "alternative approach" should result in all those with fully insured plans receiving "seamless access to contraceptive coverage."[94] The Departments should implement this program (with the addition of the notice requirement discussed above).

An "alternative approach" should likewise be implemented for self-insured plans. The Proposed Rule fails to provide any satisfactory explanation for limiting the "alternative

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[90] *See* 88 Fed. Reg. 7245 (discussing concerns about noncompliance with mandate); *id.* at 7264 (Departments are unable to reliably estimate costs of regulation because they "do not know" how many employers have claimed an exemption or how many women have lost coverage).

[91] Tr. at 29, *Little Sisters of the Poor Saints Peter and Paul Home v. Pennsylvania* (No. 19-431) (explaining that the Little Sisters would have no objection to "just …an opt-out form, an objection form").

[92] 808 F.3d 1, 23-24 (D.C. Cir. 2015) (Kavanaugh, J., dissenting).

[93] 88 Fed. Reg. 7248 (describing alternative approach).

[94] 88 Fed. Reg. 7248.

approach" to fully insured plans.[95] In *Zubik v. Burwell*, the Departments represented to the Supreme Court that they had the ability to "relieve self-insured employers of any obligation to provide contraceptive coverage" through a regulatory process in which "the government … designate[d] the employer's [TPA] as a 'plan administrator' responsible for separately providing the required coverage…"[96] The State AGs acknowledge that in order to make this designation the government must know the identity of an employer's TPA.[97] But the Departments appear to have been able to identify TPAs without significant problem in the past.[98] And the Proposed Rule provides no explanation for why the Departments would be unable to make regulatory adjustments to improve their ability to identify TPAs as necessary moving forward. For example, the Departments could "make changes to … existing regulations" to require TPAs that administer plans that do not include the "contraceptive benefits guaranteed under the ACA" to provide notice of this fact to the government.[99] As the Departments acknowledge, TPAs would be well positioned to provide this notice because plan documents required by ERISA must disclose limits on coverage, including the exclusion of coverage for "a subset of contraceptive services."[100] Requiring this notice would help the Departments identify "potential violations of the contraceptive coverage requirement" – and facilitate the provision of coverage through an

[95] The State AGs acknowledge that the Departments have addressed questions about similar adjustments to the accommodation in the past. *See, e.g.*, *FAQs About Affordable Care Act Implementation Part 36*, at 9-10 (Jan. 9, 2017). But the Departments' responses do not adequately address the "alternative approach" discussed in the Proposed Rule and below. Further, the Departments' current willingness to pursue an "alternative approach" for fully insured plans indicates that its prior assessment of the costs and "complications" inherent in such an endeavor must be re-evaluated. *Id*. at 5-9 (discussing issues with alternative approaches to providing coverage for women in fully insured plans).

[96] Supplemental Br. for Respondents at 16-17, *Zubik v. Burwell*, 136 S. Ct. 1557 (2016) (No. 14-1418), 2016 WL 1445915.

[97] The State AGs are aware that the Departments have also stressed that "without a written plan instrument…there is no mechanism to designate a third-party administrator as the ERISA plan administrator for the purpose of arranging or providing separate payments for contraceptive services." *See FAQS About Affordable Care Act Implementation Part 36*, at 10 (Jan. 9, 2017). But the Departments have also indicated that a "written designation sent by the government to the TPA" satisfies this requirement. *Id.* at 9. The State AGs, therefore, understand that the only obstacle to the "alternative approach" is the fact that it "requires the government to know the TPA's identity." *Id*.

[98] Following *Wheaton College v. Burwell*, 573 U.S. 958 (2014), the Departments operated the accommodation in this manner. After *Wheaton College*, employers were permitted to provide the Departments with notice of objections to the contraceptive mandate without identifying their insurer or TPA. *Id.* at 958. This does not appear to have prevented the Department of Labor from carrying out its responsibility under then-existing regulations to notify TPAs of the employer's objection and arrange for the provision of alternative coverage through the accommodation. *See* 26 C.F.R. § 54.9815-2713AT(b)(2) (2014).

[99] 88 Fed. Reg. 7245 (acknowledging authority to make regulatory changes to help ensure that "women covered under group plans or health insurance coverage have access to contraceptive services at no cost").

[100] 88 Fed. Reg. 7253 n.128.

"alternative approach" where the exclusion was based upon a self-insured employer's sincere religious objection.[101]

The Departments have other options still. For example, some self-insured employers have acknowledged that their complicity-based objections would be eliminated if employees were required to affirmatively request coverage in order to trigger the accommodation.[102] Such a system could work by having an employee (rather than an employer) provide the Departments with notice of loss of coverage, after which the Departments could initiate the regulatory process of designating the employer's TPA as a plan administrator responsible for separately providing the required coverage.[103] In the past, the Departments have declined to pursue options such as this on the ground that it would not provide "seamless" coverage for women and "eliminate the … objections of all [employers]."[104] But in the Proposed Rule, the Departments are proposing to maintain exemptions that will deprive tens of thousands of individuals of *any* coverage, and they acknowledge that the ICA, as proposed, will "not achieve the Women's Health Amendment's goal of ensuring that women have seamless cost-free coverage of contraceptives, because [it] would require some additional action by the affected women and could require them to obtain contraceptive care from providers other than those from whom they typically receive health care."[105] At a minimum, then, the Departments should consider whether the accommodation can be altered to satisfy *some* employers' objections so that *some* women may retain coverage.

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There is no justification for maintaining the 2018 expanded religious exemptions in their entirety.[106] The Departments should narrow the exemptions in ways that would better "achieve the … goal of ensuring that [more] women have seamless, cost-free coverage…[while respecting] religious objections to the contraceptive requirement."[107] The Departments must give careful consideration to these alternatives and must address the significant issues raised by the State AGs concerning the fatal overbreadth of the 2018 expanded religious exemptions.[108]

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[101] *Id.* The Proposed Rule also provides no explanation for why the Departments could not require objecting entities to identify their TPAs, either in order to acquire an exemption or in connection with other regulatory filings, such as IRS Form 5500.

[102] *See, e.g.*, *Univ. of Notre Dame v. Burwell*, 786 F.3d 606, 612 (7th Cir. 2015).

[103] *Id*. Alternative versions of the accommodation that impose any burden on women should only be available to employers with complicity-based objections to the existing accommodation.

[104] 83 Fed. Reg. 57544.

[105] 88 Fed. Reg. 7254; *see infra* Section III (describing ways the ICA could be improved).

[106] *Motor Vehicle Mfrs.*, 463 U.S. at 43 (Departments must "articulate a satisfactory explanation for … [their] action[s]").

[107] 88 Fed. Reg. 7254.

[108] *Motor Vehicle Mfrs.*, 463 U.S. at 43 (Departments must "articulate a satisfactory explanation for … [their] action[s]").

III. THE ICA IS A STEP IN THE RIGHT DIRECTION BUT NEEDS IMPROVEMENT IF IT WILL SUCCEED IN SERVING ITS INTENDED GOAL.

The State AGs commend and support the Departments' attempt to create an alternative mechanism, the ICA, to increase access to no-cost contraceptive coverage. However, while the ICA will aid in reducing some of the harms of the religious exemptions in the 2018 Rules, we are concerned that, without improvements, it will fall short of the goal of providing effective access to contraceptive services for those who do not have insurance coverage.[109]

As the Departments acknowledge, access to contraceptive care has considerable benefits for women and their families.[110] Broad insurance coverage helps women access the contraceptive of their choice, increasing proper contraceptive use, which in turn reduces unintended pregnancies.[111] Those who experience unintended pregnancies have "higher rates of postpartum depression and mental health problems later in life."[112] And unintended pregnancies are associated with increases in low birthweight and preterm births, and those children are more likely to fare worse in school achievement and have less success when they enter the labor market.[113] Reducing unintended pregnancies is especially crucial in light of the current limited access to abortion for millions of women caused by *Dobbs*. In the aftermath of the *Dobbs* decision, many states have rushed to criminalize and severely restrict abortion, eliminating a core component of basic health care. Total or near-total bans on abortion are currently in effect in twelve states; still more have restrictions that impose severe penalties. Health care providers, clinic staff, and those seeking abortion suddenly face the prospect of both criminal and civil liability merely for obtaining or providing necessary health care. Given this landscape, it is crucial that women have full access to contraceptives to control their reproductive autonomy. The ICA will assist—in a narrow way—in fulfilling that goal.[114]

However, the State AGs have considerable concerns that the ICA, as proposed, will not be successful and effective. The State AGs recommend the Departments make the following changes in the Final Rule: A) expand the number of individuals eligible to participate in the ICA; B) publicize the ICA to increase use by eligible individuals, providers, and issuers; C) increase protections for eligible individuals who use the ICA; and D) improve the ICA's appeal for providers. Although the Departments acknowledge that the ICA will "not achieve the Women's Health Amendment's goal of ensuring that women have seamless cost-free coverage of contraceptives,"[115] implementing the State AGs' recommendations will help mitigate the harms of the religious exemption in the 2018 Rules and will increase access to coverage.

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[109] 83 Fed. Reg. 57536 (2018).
[110] 88 Fed. Reg. 7261-62.
[111] *Id.*
[112] *Id.* (collecting articles).
[113] *Id.*
[114] 42 U.S.C. § 300gg-13(a).
[115] 88 Fed. Reg. at 7254.

A. The Departments Should Expand Access to the ICA to a Wider Spectrum of Individuals who Lack Contraceptive Coverage.

The Departments should expand the ICA to include a wider spectrum of individuals who are excluded from contraceptive coverage, not just those with objecting employers. Specifically, the ICA should be available to individuals enrolled in grandfathered plans,[116] individuals in plans under the church exemption,[117] and plans where the employer has entered into a settlement with the federal government to omit contraceptive coverage.[118] The ICA should also be accessible to individuals without any insurance and those who reside in states where Medicaid does not cover the full range of contraceptive options. As noted above, contraceptive care confers significant benefits, and the Departments should do everything possible to increase access to this care. Further, the more people eligible for the ICA, the greater the incentive for providers and issuers to participate in the ICA.

B. The Departments Should Create a Publicity Campaign About the ICA.

The State AGs are concerned that eligible individuals in objecting plans will not know that the ICA exists, that they are eligible to participate in the ICA, or how to find an ICA-participating provider.[119] We are further concerned that providers will be unaware of the ICA or how to enroll. We offer some proposals to address these concerns.

1. <u>The Departments should engage in outreach to individuals and beneficiaries.</u>

The Final Rule should explicitly outline a public information campaign to ensure that eligible individuals know about the ICA. Among other things, the Departments should create a website that explains ICA eligibility and how the ICA works. The Departments could model such a website from the Centers for Medicare & Medicaid Services' ("CMS") website for the No Surprises Act.[120] The ICA website—and all informational material—should emphasize that use of the ICA involves no extra fees or costs on the part of the individual.[121] We also suggest that the Departments work with state agencies to create short informational pamphlets in multiple

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[116] *Contra* 88 Fed. Reg. 7253.

[117] 76 Fed. Reg. 46621.

[118] *See, e.g.*, *March for Life v. Burwell*, 128 F. Supp. 3d 116 (D.D.C. 2015) (permanently enjoining the federal government from enforcing the contraceptive mandate against March for Life); *Little Sisters v. Azar*, Case No. 13-cv-02611, Dkt No. 82 (D. Colo. May 29, 2018) (granting stipulated permanent injunction enjoining the federal government from enforcing the contraceptive mandate against Little Sisters of the Poor).

[119] 88 Fed. Reg. at 7252.

[120] *Ending Surprise Medical Bills,* Ctrs. for Medicare & Medicaid Services (Dec. 5, 2022), https://www.cms.gov/nosurprises.

[121] 88 Fed. Reg. at 7253.

languages[122] that participating providers can use to explain the ICA to individuals who visit participating providers.

The Final Rule should also require issuers to inform individuals in objecting plans about the ICA so that impacted employees and their beneficiaries can learn about the ICA and where to go for additional information. As the individuals will likely not obtain information about the ICA from their objecting employer, the issuer should be required to provide information about what the individual's plan does not cover and how to access the coverage. To that end, issuers should provide this information to eligible individuals and their beneficiaries to ensure widespread knowledge about the ICA.

2. The Departments should do more provider outreach.

The Departments should also work to ensure providers know about the ICA and how to sign up. The Departments should coordinate with state insurance commissioners, as well as state departments and boards that interact with providers, to ensure that providers receive information about the ICA. The ICA website should contain relevant information in a separate provider section. Any promotional materials should emphasize that providers will receive full reimbursement for actual costs and administrative costs incurred.[123]

As the Departments acknowledge, the result of a lack of provider participation will be especially acute for "people of color (and low-income people) [who] are more likely to live in areas in which the proportion of reproductive-aged residents have a lack of, or difficulty obtaining, reproductive and contraceptive health care—referred to as 'contraception deserts.'"[124] These contraception deserts also often include more rural and underserved areas,[125] where increasing provider participation is particularly essential.

3. The Departments should make it easier for individuals to find a participating provider.

The State AGs agree with the Departments' concern that individuals will not know how to find a participating provider once they determine they are eligible.[126] As such, we recommend requiring issuers to maintain lists of participating in-network providers, ideally through a website

[122] Outreach to individuals and beneficiaries must comply with Section 1557 of the ACA which requires recipients of federal financial assistance to provide meaningful access to health programs to limited English proficient persons.

[123] *Id.*

[124] 88 Fed. Reg. at 7262.

[125] Committee on Health Care for Underserved Women, Number 586, Am. College of Obstetricians and Gynecologists (Mar. 2009, Reaff'd 2021) (https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2014/02/health-disparities-in-rural-women).

[126] 88 Fed. Reg. at 7252.

portal. Insurance plans already provide enrollees and their beneficiaries with information on participating providers.[127] We further recommend that the Departments publicly identify participating providers on the Departments' ICA website. Providers should be able to opt out of public identification but the default should be opt-in. As the Departments are well aware, delays in finding care through a provider can result in care being denied for an individual seeking to access contraceptive coverage.

C. The Departments Should Make the ICA Easier for Providers to Join.

The State AGs are concerned about whether a sufficient number of providers will participate in the ICA, especially given the burdens of entering into an agreement with a variety of issuers and a complicated reimbursement process. Therefore, the State AGs recommend that the Departments do as much as possible to increase the number of participating providers. As outlined below, the Departments should (1) make the ICA easy to join, (2) specify reimbursement rates, (3) handle disputes and specify the speed of reimbursement, and (4) continuously monitor provider participation to ensure adequate coverage for all.

1. <u>The ICA should be easier to join.</u>

The State AGs have concerns about the difficulties in becoming a participating provider because the ICA requires individual arrangements and additional contracting with issuers.[128] The Departments should do more to make provider contracting with issuers as frictionless as possible. For example, the Departments could create and publicly offer a proposed contractual addendum for use by providers and issuers. Or generally, the Departments could create a baseline fee schedule in a geographical area that issuers can opt-into. Therefore, a provider who agrees to be reimbursed based upon the baseline fee schedule can send the bill directly to a participating issuer who has opted into the fee schedule without having to engage in individual contracting.

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[127] *See, e.g.*, Cal. Health & Saf. Code § 1367.27 ("[A] health care service plan shall publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to the plan's enrollees, including those that accept new patients); Cal. Ins. Code § 10133.15 ("[A] health insurer that contracts with providers . . . shall publish and maintain provider directory or directories with information on contracting providers that deliver health care services to the insurer's insureds, including those that accept new patients"); N.J. Admin. Code § 11:24C-4.5(a) (requiring carriers to maintain accurate and current information on all providers and make that information available to members and prospective members through network directories). Meanwhile, Pennsylvania relies on several different statutory authorities, including the Unfair Insurance Practices Act, 40 P.S. § 1171.1 et seq., and 40 P.S. § 991.2111(12) (requiring that a managed care plan shall "[p]rovide a list of health care providers participating in the plan to the department every two (2) years or as may otherwise be required by the department") to mandate insurers provide up-to-date provider directories.

[128] 88 Fed. Reg. at 7243.

2. The Departments should provide more guidance for reimbursement rates.

The Departments should provide additional guidance on fair reimbursement rates and administrative costs for participating providers.[129] For example, the Departments could establish that the reimbursement rate must be greater than the issuer's median commercial contracted reimbursement rate for in-network providers providing similar services, with the high floor being set to account for the providers' administrative costs. Ensuring reimbursement rates through rulemaking is important to encourage more providers to participate.

3. The Departments should engage in bill disputes and increase the speed of reimbursement.

The Departments should create a process for providers to dispute payments from issuers. It is entirely foreseeable that providers may not receive prompt payment from issuers. The Departments should remedy that by regulating strict timing for prompt payment by the issuer and allowing for any disputes to be remedied through a process handled by the Departments. Under the current proposal, an issuer would only be required to reimburse a provider within 60 days of receiving an adjustment to its user fee. These fees are collected monthly,[130] which can create up to 31 days of additional delay between when an issuer first requests a fee adjustment and the 60 day requirement for reimbursing the provider begins to run. Any delay by the issuer in requesting an adjustment—or processing delay by the government—will be felt by the provider. This is no way to recruit voluntary participation. A significant reduction in timing for reimbursement is necessary.

As noted, the proposed ICA's success and effectiveness will depend on providers' willingness to participate. Providers are already burdened by having to learn a new, separate, parallel billing process to participate in the ICA. Difficulty obtaining timely reimbursement for services rendered will further discourage providers from participating in the program.

4. The Departments should monitor provider participation.

The Departments should also continuously monitor provider participation and identify areas with low to no participating providers. The Departments should also monitor whether those geographic areas have overburdened participating providers because of the limited total number of participating providers. In the Final Rule, the Departments should outline the affirmative steps they will take to increase provider participation in "ICA provider deserts."

[129] 88 Fed Reg. at 7253.
[130] 45 C.F.R. § 156.50(c)(1).

D. Patients Should Have Additional Patient Protections.

The State AGs recommend additional patient protections to ensure that individuals who use the ICA will be properly protected. Specifically, the Final Rule should have additional provisions relating to privacy, protection from retaliation, and a process for contesting medical bills.

1. The Departments should protect the privacy of individuals using the ICA.

The Final Rule should explicitly state that HIPAA protections apply to individuals and beneficiaries who use the ICA. While providers and health plans are already mandated to maintain the privacy of patients, the Departments should make clear that these protections apply to protect individuals employed by objecting employers.[131]

The Final Rule should also make explicit that privacy protections extend to documents that an individual uses to confirm eligibility to participating provider(s). This should include the summary of benefits or attestation provided by the individual to the provider to confirm eligibility for the ICA.[132] Failure to maintain confidentiality may result in retaliation from the individual's employer, as discussed below.

2. Individuals using the ICA should be protected from retaliation.

The State AGs are also concerned that even with privacy protections, individuals may face retaliation or discrimination from their objecting employer if they are found to be using the ICA. As such, the Final Rule should explicitly state the ACA's Section 1557 anti-discrimination provisions apply to individuals who choose to utilize the ICA.[133] As the states have long argued, the religious exemption in the 2018 Rules violates Section 1557 because it licenses employers to discriminate on the basis of sex by permitting them to exclude women from full and equal participation in their employer-sponsored health plan and deny women full and equal health care benefits.[134] Permitting discrimination by employers against individuals who exercise the ICA would thus be discrimination based upon sex.[135] The Final Rule should protect individuals from such discrimination.

[131] *See generally* 42 U.S.C. § 1320d-1.
[132] 88 Fed. Reg. at 7253.
[133] 42 U.S.C. § 18116(a).
[134] *See, e.g.*, *California, et al. v. Azar, et al.*, Case No. 4:17-cv-05783-HSG, Dkts. Nos. 24, 311, 433.
[135] *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1739, 1741 (2020).

3. The Departments should create a process for contesting medical bills.

The State AGs are concerned that individuals using the ICA will receive erroneous medical bills or will be charged co-pays by participating providers, when those bills should have been paid for by the participating issuer.[136]

The Departments should plan for this and create a process through which individuals can report improper billing and participate in a medical bill dispute resolution process. This process should be widely advertised and easily accessible to consumers. Among other locations, the Departments should discuss the process and permit participation in the process through the proposed ICA website. Information about the process should also be included on any ICA pamphlets and issuer-provided materials. The Departments should also maintain a staffed phone number an individual can call to report a contested medical bill.

It is important that individuals have clear information on where to submit contested bills, and assurances that, under the ICA, individuals should not pay out-of-pocket for contraceptive coverage or associated co-pays. There should also be clear information that the individuals should not pay these disputed bills out-of-pocket while the dispute resolution process is pending.[137]

The Final Rule should also explicitly state that individuals who receive a bill when they attend a follow-up with a provider who previously participated in the ICA but is no longer a participating provider during the individual's subsequent appointments are still covered by the ICA. The individual should not have to pay out of pocket when the individual had a good-faith belief that they were visiting a participating provider.

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[136] 88 Fed. Reg. 7243.

[137] The State AGs further recommend that the Departments make this dispute resolution process open to all individuals who receive bills for contraceptive coverage, not just those with objecting employers. The State AGs have received reports of health plans—that are not established or maintained by objecting employers—that are violating the ACA by failing to cover all forms of contraception. *See* The Biden Administration Must Ensure the Affordable Care Act Contraceptive Coverage Requirement is Working for All, Nat'l Women's Law Ctr. (Oct. 14, 2021), https://nwlc.org/wp-content/uploads/2021/11/NWLC_BC_AffordCareAct-Oct_2021.pdf (discussing the thousands of women who have reported difficulty in accessing their ACA contraceptive coverage, indicating that the women who have reported difficulties are a fraction of the women who are not receiving proper coverage). Individuals with ACA compliant plans should not be paying out-of-pocket for services their health plan should be covering. The State AGs also support the revision to 45 CFR § 147.132 (a)(1)(iv) that would clarify that a health insurance issuer may not offer coverage that excludes some or all contraceptive services to any entity or individual that is not an objecting entity or objecting individual. 88 Fed. Reg. 7247-48.

In short, it is important to ensure that the ACA protects individuals' ability to access the contraceptive of their choice—via the ICA—without out-of-pocket expenses.[138] As the Departments note, the implementation of the ACA has led to out-of-pocket savings on contraceptive pills of approximately $1.4 billion between 2012 to 2013.[139] As a result, some studies have concluded that "[w]omen now save an average of 20% annually in out-of-pocket expenses, including $248 savings for IUDs and $255 for the contraceptive pill."[140] The Final Rule should ensure that women retain these savings. And, as discussed above, access to contraception is fundamental to ensuring women can exercise control over their lives, avoid unintended pregnancies, and fully participate in society.

CONCLUSION

The State AGs thank the Departments for the opportunity to comment. The State AGs support the Proposed Rule's rescission of the moral exemption from the 2018 Rules and commend the creation of the ICA so that individuals enrolled in plans sponsored or covered by objecting entities can obtain access to no-cost contraceptive coverage. We, however, strongly oppose the unwarranted retention of the expansive religious exemptions from the 2018 Rules and recommend significantly narrowing these exemptions. Finally, the State AGs propose several additions to the ICA to expand access, ensure individuals, providers, and issuers will participate in the ICA, and provide additional patient protections. For the foregoing reasons, the signatory State AGs urge the Department to swiftly adopt our recommendations in the Final Rule to ensure access to no-cost contraceptive coverage as required by the ACA and the Women's Health Amendment.

Sincerely,

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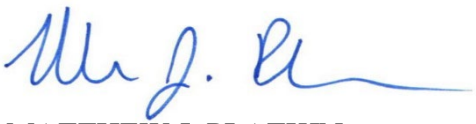
Massachusetts Attorney General

[138] 88 Fed. Reg. 7261.
[139] *Id.*
[140] N.V. Becker, et al., *Women Saw Large Decrease In Out-of-Pocket Spending For Contraceptives After ACA Mandate Removed Cost Sharing*, Health Affairs (2015), http://content.healthaffairs.org/content/34/7/1204.abstract#aff-2.).



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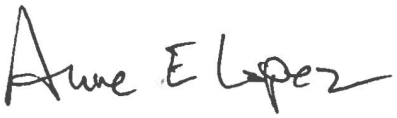

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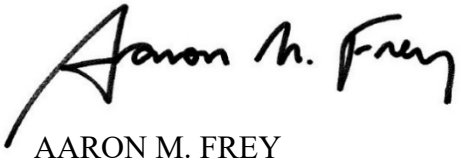

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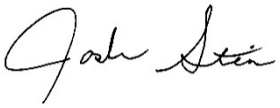

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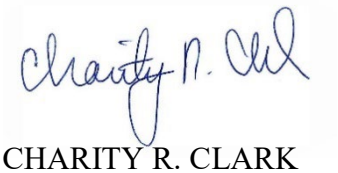

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