December 5, 2017

Acting Secretary Eric Hargan
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW., Room 445–G,
Washington, DC 20201

Re: Religious Exemptions and Accommodations for Coverage of Certain Preventive Services under the Affordable Care Act. CMS-9940-IFC

The American Academy of Nursing (Academy) submits the following comments in response to the Interim Final Rules ("the Rules") titled "Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act,"[i] published in the Federal Register on October 13, 2017, by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services ("the Departments").[1]

The Academy unequivocally opposes the Departments' efforts to undermine the Patient Protection and Affordable Care Act's (ACA) contraceptive coverage requirement through this Interim Final Rule (IFR). We urge the Departments to withdraw this Rule (as well as the IFR") titled "Moral Exemptions and Accommodations for Coverage of Certain Preventive Services under the Affordable Care Act".

The Academy is on record supporting evidence-based policies that 1) ensure that all people have full access to affordable, sexual and reproductive health services, 2) facilitate expansion of clinical knowledge and evidence-based women's preventive health services especially related to preventing unintended pregnancies, and 3) assure that all women's health care, including reproductive health services, is grounded in scientific knowledge and evidence-based policies and standards of care.

As a national nursing organization deeply committed to ensuring that all people have access to affordable health care, including contraceptive coverage as intended by the Affordable Care Act,[2] the Academy has a particular interest in this rule because nurses know and understand the importance of women having seamless contraception coverage to protect their health and ability to work, both of which are essential for the economic security of families across America.[3]

In this comment, we discuss how these Rules are at odds with science and research, have serious implications for women's health, and disregard the compelling interests furthered by the contraception coverage requirement and regulations included in the Affordable Care Act; as well as jeopardizing services to which some may object.[4]

1. The Rules Should Be Withdrawn Because They Are Based on Falsehoods, Undermine Scientific Integrity, and Harm Women's Health

The Academy believes that health policy decision-making must be fully informed by scientific evidence and the best available data, and that the public has reliable access to independent scientific information

[1] Statement prepared for the Academy by members Diana Taylor (Women's Health Expert Panel co-chair) and Ellen Olshansky (AAN Board), 12/4/2017
[2] Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, amended by Pub. L. No. 111-152, 124 Stat. 1029.
[3] Berg JA, Taylor D, Woods NF (2013). Where we are today: Prioritizing women's health services and health policy. A report by the Women's Health Expert Panel of the American Academy of Nursing. Nursing Outlook **61**(1): 5-15, http://dx.doi.org/10.1016/j.outlook.2012.06.004
[4] Religious Exemptions and Accommodations for Coverage of Certain Preventative Services Under the Affordable Care Act, 82 Fed. Reg. 47792 et seq.

and analysis produced and acquired by the federal government. The role of scientific evidence in public health decision-making is imperative, and we oppose any efforts to diminish the role of science in federal policymaking. Unfortunately, the Rules are a prime example of regulatory decision-making that ignores scientific evidence and the best available data. The Departments understate the efficacy and health benefits of contraceptives and overstate the health risks of contraceptives by selectively interpreting data, overlooking well-established evidence, and promoting unfounded doubt. Further, both Rules falsely assert certain types of FDA-approved contraceptive methods to abortifacients.

Contraceptive care is a vital service, as integral to a person's health as primary prevention of unintended pregnancy as well as prevention and treatment of common women's health problems. Indeed, nearly 60-percent of women use contraception to help treat several medical conditions specific to women.[5,6,7] There is no principled reason to separate contraceptive coverage from the range of services health insurance provides. Moreover, the current rationale justifying the IFR with respect to contraceptive care could be used in the future to justify denying any number of services. Therefore, it is not just contraceptive care that is at risk due to this IFR. Patients being refused care based on religious or moral beliefs of hospitals, clinics, and health professionals may suffer devastating health consequences.[8]

The Rules thus cause dual harm by undermining women's access to essential preventive health care and undermining the integrity of science in governance. Public health policy should be informed by the best available scientific evidence. Instead, the Departments use false claims about contraception that are contrary to medical and public health evidence, misstate or ignore research, and undermine the agencies' role as a source of accurate health information.

The Departments serve a critical role in collecting and managing important information and data on issues that are vital to the public. In making policy, it is essential that the Departments enhance their credibility on issues of science and evidence, not undermine it. The Rules, however, show that the Departments did not seriously consider these elements, which can only undermine the Departments' reputations as reliable sources of information.

2. Contraceptive Care is Integral to Women's Health Care and Prevention of Unintended Pregnancy

Contraceptive efficacy at preventing unintended pregnancy is supported by decades of rigorous evidence and by the government itself.[ii] The U.S. Food and Drug Administration ("FDA") must approve all new drugs and devices by showing that they are safe and effective through rigorous scientific testing. The federal government itself has thus approved contraceptives for safely and effectively preventing unintended pregnancies. The Departments' misrepresentation of "complexity and uncertainty in the relationship between contraceptive access, contraceptive use, and unintended pregnancy"[iii] is false and does not reflect the weight of scientific and clinical evidence. In truth, contraception enables women, including teens, to prevent unintended pregnancy and control the timing of a desired pregnancy.[iv] The

---

[5] Jones, R.K. (2011). Beyond Birth Control: The Overlooked Benefits of Oral Contraceptive Pills. Retrieved from http://www.guttmacher.org/pubs/Beyond-Birth-Control.pdf

[6] Johnson-Mallard V, Kostas-Polston EA, Woods NF, Simmonds KE, Alexander IM, Taylor D (2017). Unintended pregnancy: a framework for prevention and options for midlife women in the U.S. Women's Midlife Health Journal, web access.

[7] This comment uses the term "women" because women are targeted by the IFRs. Notably, we recognize that the denial of reproductive health care and insurance coverage for such care also affects adolescents and people who do not identify as women, including some gender non-conforming people and some transgender men.

[8] For documented instances where religious healthcare providers denied care to patients on the basis of religious beliefs, *see* Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. PUBLIC HEALTH 1774 (2008), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458/; National Women's Law Center, *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/ (last visited Oct. 20, 2017).

Centers for Disease Control and Prevention named family planning one of the ten great public health achievements of the past century,[v] and family planning is widely credited for contributing to women's societal, educational, and economic gains.[vi] The ACA's guarantee of no-copay coverage of contraception has contributed to a dramatic decline in the unintended pregnancy rate in the United States, now at a 30-year low.[vii] The teen pregnancy rate is also at the lowest point in at least 80 years.[viii]

Contraception improves health outcomes for women and children because unintended pregnancies have higher rates of short- and long-term health and social problems. Women with unintended pregnancies are more likely to delay prenatal care, leaving their health problems unaddressed.[ix] They are also at increased risk of maternal mortality and morbidity, maternal depression, experiencing physical violence during pregnancy,[x] infant mortality, birth defects, low birth weight, and preterm birth.[xi] Unintended pregnancies are also associated with long-term negative physical and psychosocial effects on children.[xii] Contraception, by contrast, is considered a major factor in reducing rates of maternal mortality and morbidity.[xiii] The Departments' new Rules do not reflect this vast body of research and the clear health benefits of contraception.

3. **HHS should focus on the promotion of the health of the public and the assurance that program beneficiaries have access to essential health services supported by science.**

The focus of Departments' Rules are both flawed and misplaced. The IFR misses the mark in two important ways. First, the IFR ignores the reality that many faith-based organizations and employers have objections to essential health services that are the foundation of longstanding, critical HHS programs. In the arena of health care, and particularly family planning and sexual health, HHS-funded programs cannot achieve their fundamental objectives if the program contractors or grantees refuse to provide essential services, such as contraception, or if they discriminate against patient populations, including women, people of color and LGBT people.

Second, the IFR fails to consider the needs of program beneficiaries and the entities currently participating in already overburdened and underfunded HHS programs. HHS should be working to eliminate existing discrimination in HHS programs and activities, including refusals to provide reproductive health care or to serve certain populations. In addition, HHS must examine how to improve patient access to the essential health care services funded through HHS programs, which would include examining the barriers current health care providers face in meeting the needs of their patients through these programs.

One of the main benefits of the Affordable Care Act is its guarantee of certain basic minimum requirements for health care policies (to the extent those policies are not able to take advantage of a grandfather clause), no matter where one is employed. Although only one step towards truly seamless health care, the ACA nevertheless was supposed to make it easier, not more difficult, for people to live their lives and work where they wanted without worrying about what services may or may not be covered. With this IFR, that is no longer the case. By singling out those who work for employers or attend a university claiming a religious objection and deeming them not as important as others with respect to their reproductive rights, HHS is violating religious rights under the guise of protecting them.

The Academy urges the Departments to prioritize the needs of the beneficiaries of HHS programs and the health care providers that already serve them at the forefront of any consideration of achieving HHS' "mission of improving Americans' health and well-being."[9]

[9] STRATEGIC PLAN FY 2014-2018, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS), *available at*: https://www.hhs.gov/about/strategic-plan/introduction/index.html#mission.

4. Religious Exemptions in Health Care Cause Harm

The Religious Exemptions IFR expands eligibility for the complete exemption—formerly reserved for houses of worship—to *all* nonprofit and for-profit employers. It also retains the accommodation, formerly available to non-profit and closely-held for-profit employers, as an optional alternative for any employer. Under the Rule, there is no guaranteed right of contraceptive coverage for the employees, dependents, and students of these organizations. This is a potentially dramatic change in the availability of contraceptive coverage for the employees of a vast number of entities, and a significant departure from what was guaranteed to these employees under prior rulemaking and the *Hobby Lobby* decision.

The Academy opposes the Religious Exemptions IFR for several reasons. Allowing restrictions on the availability of health care services based on the religious beliefs of others—already too prevalent in reproductive health care—sets a dangerous precedent for access to health care for many, including LGBT people. And the Rule is unlawful, in violation of the Administrative Procedure Act, the First Amendment, and the Fifth Amendment.

Furthermore, there is often insufficient consideration given to the impact of overly broad conscience laws on patients. In other words, the playing field is already tilted heavily in favor of those seeking to deny care. And given the nature of the services to which religious exemptions are most commonly applied, these refusal laws have a discriminatory impact on LGBT people and women seeking reproductive health care.

At the federal level, there are already numerous statutory protections for health care providers' religious beliefs. These laws include the Church,[10] Weldon,[11] and Coats[12] amendments, which allow providers to refuse to perform or otherwise facilitate abortion services. The Church Amendment also reaches sterilization services.[13]

Most states have similar laws; forty-five allow individual healthcare providers, and forty-three allow institutions, to refuse to provide abortion services.[14] Provider conscience clauses at the state level apply not only to abortion services but also to contraceptive care. Twelve states permit some healthcare providers to refuse to provide contraception and related services (such as counseling). Refusal provisions targeting contraception delay access, increase costs, and may result in unintended pregnancies. Eighteen states allow providers to refuse to provide sterilization services.

The ACA (and implementing regulations) require all new insurance plans to cover "[a]ll Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity" without cost-sharing requirements in order to protect women's health, ensure that women do not pay more for insurance coverage than men, and advance women's equality and well-being.[15] In addition, section 1554 of the ACA prohibits the Departments from issuing regulations that "create[s] any unreasonable barriers to the ability of individuals to obtain appropriate medical care"[16] and Section 1557 of the ACA prohibits sex discrimination in certain health programs and activities.[17]

---

[10] 42 U.S.C. § 300a-7 et seq.
[11] Consolidated Appropriations Act, 2012, Pub. L. No. 112-74, 125 Stat 786.
[12] 42 U.S.C. § 238(n).
[13] 42 U.S.C. § 300a-7 et seq.
[14] GUTTMACHER INST., REFUSING TO PROVIDE HEALTH SERVICES 2 (2015), http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf.
[15] *See* 4 2 U.S.C. § 300gg-13(a)(4); 45 C.F.R. § 147.130 (2013)(a)(1)(iv).
[16] 42 U.S.C. § 18114(1).
[17] 42 U.S.C. § 18116.

By permitting objecting institutions to deny no-cost contraceptive coverage, the Religious Exemptions IFR erects unreasonable barriers to medical care, violating Section 1554 of the ACA. By permitting objecting institutions to deny coverage for contraceptives, and thus deny women essential health coverage, the Rules discriminate based on sex, in violation of section 1557 of the ACA. Because the Religious Exemptions IFR violates the ACA, this IFR also violates the APA and must be set aside on that basis.

5. **The Departments' Explanation that Other Programs Can Meet the Need for Birth Control Coverage Is Faulty**

The Departments assert that existing government-sponsored programs, such as Medicaid and Title X, and state coverage requirements can serve as alternatives for individuals who will lose access to contraceptive coverage without cost sharing as a result of this IFR.[18] This assertion fails to recognize that Medicaid and Title X are not designed to absorb the needs of higher income, privately insured individuals and do not have the capacity to meet the needs of current enrollees *and* those seeking care at Title X health centers. Further, the existence of the programs is threatened by legislative and administrative proposals. With respect to the state laws, the Departments' claim misconstrues the scope and protections of state contraceptive coverage laws which cannot fill in the coverage gaps caused by this IFR.

a. **Medicaid and Title X Programs Are Not Designed to Meet The Needs of Individuals Who Will Lose Contraceptive Coverage and Do Not Have Capacity to Do So.**

Safety net programs like the Title X family planning program and Medicaid are not designed to absorb the unmet needs of higher-income, insured individuals. Title X is the nation's only dedicated source of federal funding for family planning services, and federal law requires Title X-funded health centers to give priority to "persons from low-income families."[19] Congress did not design Title X as a substitute for employer-sponsored coverage.

Further, the IFR argues that Title X-funded health centers could fill the gap in contraceptive coverage it creates, and provide care to more patients than are currently served by the program. However, with current funding and resources, the Title X provider network cannot meet the existing need for publicly funded family planning, let alone absorb the increase in demand that would result from the Department's rules. Reductions in funding for Title X already limit the number of patients Title X-funded providers are able to serve.[20] Since 2010, the reported annual number of clients served at Title X sites has dropped from approximately 5.2 million patients to just over 4 million.[21] This decline corresponds to over $30 million in cuts to Title X's annual appropriated amount over the same period.[22] Requiring otherwise higher-income, privately insured individuals to use Title X-funded health centers would deplete resources from an already overburdened and underfunded program.

---

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

[19] *See* Fam. Plan. Servs. & Population Res. Act of 1970, Pub. L. No. 91-572, 84 Stat. 1504, and 42 CFR § 59.5 (a)(6-9).

[20] August, Euna M. et al., "Projecting the Unmet Need and Costs for Contraception Services After the Affordable Care Act," *American Journal of Public Health* (2016), available at http://doi.org/10.2105/AJPH.2015.302928. Congress would have to increase federal funding for Title X by over $450 million to adequately address the existing need for publicly funded contraception.

[21] *See* Fowler, CI, Lloyd, SW, Gable, J, Wang, J, and Krieger, K, *Family Planning Annual Report: 2010 National Summary*, RTI International (Sept. 2011), available at https://www.hhs.gov/opa/sites/default/files/fpar-2010-national-summary.pdf; Fowler, C.I, Gable, J., Wang, J., & Lasater, B, *Family Planning Annual Report: 2016 national summary*, RTI International (Aug. 2017), available at https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf.

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

Similarly, Medicaid is a source of coverage designed to meet the unique health care needs of individuals who are low-income. However, unlike Title X, which requires the health centers it funds to take all patients, Medicaid has income and other eligibility requirements for individuals to participate.[23] Many individuals enrolled in Medicaid have extremely low incomes and minimal savings at hand. These individuals also face severe health problems and lack any resources to address these issues on their own, unlike individuals with higher incomes and employer-sponsored coverage.

Medicaid enrollees have robust access to health care, including family planning services and supplies, and Medicaid already operates as a very lean program. In spite of this, provider shortages have persisted. The majority (two-thirds) of state Medicaid programs face challenges to securing an adequate number of providers to furnish services to patients.[24] This is particularly true with respect to primary care, public health and specialty providers, including Nurse Practitioners, Nurse-Midwives, and OB/GYN physicians.[25] Given this provider shortage and Medicaid's eligibility requirements discussed above, Medicaid does not have capacity to serve individuals who lose coverage as a result of this IFR.

For many women who will lose access to the contraceptive coverage benefit, Title X and Medicaid will not be real alternatives for securing contraceptive care and counseling.

b. The Political Assault on Medicaid, Title X, and Planned Parenthood Health Centers Threaten Women's Access to Contraceptive Care.

Within the last year, as part of the numerous, failed attempts to repeal the ACA, policymakers have sought to radically alter the financial structure of Medicaid.[26] Policymakers continue to try to impose steep cuts to the Medicaid program through the budget process and to undermine the program through regulatory measures. Congress and the Trump Administration have blatantly threatened women's health by attempting to block Planned Parenthood from participating in Medicaid despite the outsized role that Planned Parenthood plays in delivering family planning care to people with Medicaid coverage. In fact, in 57 percent of counties with a Planned Parenthood health center, Planned Parenthood serves at least half of all safety-net family planning patients with Medicaid coverage.[27]

---

[23] In states that have not expanded Medicaid, income eligibility for this program is quite limited. The median income limit for parents in these states is an annual income of $8,985 a year for a family of three in 2017, and in most states that have not expanded Medicaid, childless adults remain ineligible for this program. Rachel Garfield & Anthony Damico, The Henry J. Kaiser Family Foundation, The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid, (2017), https://www.kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.

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

[25] A recent report from the HHS Office of Inspector General found that many Medicaid managed care plans had provider shortages, with only 42 percent of in-network OB/GYN providers able to offer appointments to new patients. U.S. Department of Health and Human Services, supra at note 7.

[26] The most recent legislative proposal sponsored by Senators Lindsey Graham and Bill Cassidy would have decimated the Medicaid program by cutting over one trillion dollars to the program over the next ten years. Cong. Budget Office, Preliminary Analysis of Legislation That Would Replace Subsidies for Health Care with Block Grants, 6, (Sept. 2017), https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/53126-health.pdf. The proposal would have repealed Medicaid expansion, converted Medicaid's financing structure to a per capita cap, and would have permitted states to block grant their Medicaid programs for certain communities, resulting in drastic cuts to coverage and services that individuals enrolled in Medicaid need and deserve. Mara Youdelman & Kim Lewis, Nat'l Health Law Program, Top 10 Changes to Medicaid Under the Graham-Cassidy Bill, (Sept. 14, 2017), http://www.healthlaw.org/publications/browse-all-publications/top-10-changes-to-medicaid-under-graham-cassidy-bill#.Wft9mmhSzIV.

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

Unfortunately, Medicaid is not the only health care program that has faced administrative and congressional attacks despite playing a critical role in the health care safety net; Title X has also been targeted. In fact, Title X-funded health centers play a particularly important role in serving communities of color.[28] In addition to severe cuts to Title X's budget since 2011, political opponents of reproductive health have repeatedly sought to defund or interfere with patients' access to care under the program.[29] The administration has not only signaled its support for these efforts, but has also put forth its own proposals to restrict access to publicly funded family planning under Title X.[30]

Needless to say, these dangerous proposals would severely limit access to high-quality family planning care for the populations that turn to Title X-funded providers and those who provide care to individuals enrolled in the Medicaid program, including low-income and uninsured women, LGBTQ individuals, communities of color, and young people. Indeed, it is puzzling – to say the least – that the Department would specifically mention Title X and Medicaid as fail safes for those who will lose coverage as a consequence of its IFRs given the administration's clear record of hostility toward these programs.

c. Most State Coverage Requirements Fail to Guarantee the Full Range of Contraceptive Methods, Services, and Counseling With No Cost-Sharing.

Similarly, the IFR suggests that the existence of state-level contraceptive coverage requirements somehow diminish the need for a federal requirement. This suggestion ignores the fact that twenty-two states do not have contraceptive coverage laws at all, and that the federal contraceptive coverage requirement made several important advances over laws in the other twenty-eight states.[31] Only four state laws currently match the federal requirement to cover contraception without copayments, deductibles and other out-of-pocket costs.[32] Moreover, few state laws match the federal requirement in terms of the breadth and specificity of the contraceptive methods, services, and counseling that are included.[33] And in any event, no state has the authority to regulate plans offered by employers that self-insure, which cover 60% of covered workers nationwide.[34]

---

[28] In 2016, 21 percent of Title X clients identified as Black or African American, 3 percent identified as Asian, and 1 percent identified as either Native Hawaiian, Pacific Islander, American Indian or Alaska Native. Also, 32 percent of Title X patients identified as Hispanic or Latina/o. Fowler, C. I., Gable, J., Wang, J., & Lasater, B., *Family Planning Annual Report: 2016 national summary*, RTI International (Aug. 2017), available at https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf.

[29] In 2011, the House voted for the first time in the history of the Title X program to defund the program and the House has proposed to defund it once again for FY 2018. *Title X, Budget & Appropriations*, Nat'l Family Planning & Reprod. Health Ass'n, https://www.nationalfamilyplanning.org/title-x_budget-appropriations, (last updated visited Nov. 3, 2017).

[30] The President's FY 2018 budget plan proposed blocking low-income and uninsured patients from obtaining federally-funded health care services, including Title X-funded care, at Planned Parenthood health centers, even though Planned Parenthood health centers currently serve 41 percent of patients that access contraception through Title X nationwide. Kinsey Hasstedt, Beyond the Rhetoric: The Real-World Impact of Attacks on Planned Parenthood and Title X, *Guttmacher Policy Review,* (Aug. 2017), available at https://www.guttmacher.org/gpr/2017/08/beyond-rhetoric-real-world-impact-attacks-planned-parenthood-and-title-x

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

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

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

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

In addition, the lack of insurance coverage for contraception significantly contributes to disparities among racial and ethnic groups regarding unintended pregnancies.[35] Although these disparities decreased after the contraceptive coverage provision, there is no doubt that the IFRs will disproportionately hurt communities of color by limiting access to contraceptive care without cost sharing. The Departments' are wrong that other programs and legal requirements can meet the need for contraceptive coverage created by this rule.

Final Statements:

The Academy urges HHS to remain religiously and morally neutral in its funding, policies, and activities to ensure that individuals do not feel proselytized by providers or receive a limited scope of services due to the moral or religious nature of an organization.

This IFR will cause people to lose contraceptive coverage, and harm their health and well-being. It is discriminatory, violates multiple federal statutes, ignores Congress' intent that birth control be covered by the ACA, and distorts both the science, as well as federal and state programs which support contraception. For these reasons, the American Academy of Nursing calls on the Departments to rescind the IFR.

Sincerely,

Cheryl Sullivan
AAN CEO

---

[i] Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47,792 (Oct. 13, 2017) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 147).

[ii] *See, e.g.,* Institute of Medicine. (2011). *Clinical Preventive Services for Women: Closing the Gaps*. Washington, DC: The National Academies Press; American College of Obstetricians and Gynecologists. (2016, December). *Women's Preventive Services Initiative: Recommendations for Preventive Services for Women Final Report to the U.S. Department of Health and Human Services, Health Resources & Services Administration* (p. 82–91). Retrieved 27 November 2017, from https://www.womenspreventivehealth.org/final-report/; Trussell, J. (2011, May). Contraceptive failure in the United States. *Contraception*, *83*(5), 397–404; Hatcher, R.A., Trussell, J., Nelson, A.L., Cates, W., Kowal, D., & Policar, M.S. (Eds.). (2011). *Contraceptive Technology* (20th ed.). Atlanta, GA: Bridging the Gap Communications; Declaration of Dr. Lawrence Finer in Support of Plaintiffs' Motion for Preliminary Injunction at 4–5, California v. Wright, No. 4:17-cv-05783-HSG (Nov. 9, 2017) ("Sexually active couples using no method of contraception have a roughly 85% chance of experiencing a pregnancy in a one-year period, while the risk for those using a contraceptive method ranges from 0.05% to 28%.") (citing Sundaram, A., Vaughan, B., Bankole, A., Finer, L., Singh, S., & Trussell, J. (2017, March). Contraceptive failure in the United States: Estimates from the 2006-2010 National Survey of Family Growth. *Perspectives on Sexual and Reproductive Health*, *49*(1), 7–16); Peipert, J.F., Madden, T., Allsworth, J.E., & Secura, G.M. (2012, December). Preventing unintended pregnancies by providing no-cost contraception. *Obstetrics & Gynecology, 120*(6), 1291–1297; Finer, L.B., & Zolna, M.R. (2016, March). Declines in unintended pregnancy in the United States, 2008–2011. *New England Journal of Medicine, 374*(9), 843–852; Harper, C.C., Rocca, C.H., Thompson, K.M., Morfesis, J., Goodman, S., Darney, P.B., . . . Speidel, J.J. (2015, June). Reductions in pregnancy rates in the USA with long-acting reversible contraception: A cluster randomised trial. *The Lancet, 386*(9993), 562–568; Speidel, J.J., Harper, C.C., & Shields, W.C. (2008, September). The potential of long-acting reversible contraception to decrease unintended pregnancy. *Contraception, 78*(3), 197–200.

[iii] Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47,792, 47,804 (Oct. 13, 2017) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 147).

[iv] *See, e.g.,* Boonstra, H.D. (2014, September 3). What is behind the declines in teen pregnancy rates? *Guttmacher Policy Review, 17*(3), 15–21; Lindberg, L., Santelli, J., & Desai, S. (2016, November). Understanding the decline in adolescent fertility in the United States, 2007–2012. *Journal of Adolescent Health, 59*(5), 577–583.

[v] Centers for Disease Control and Prevention. (2013, April 26). *Ten Great Public Health Achievements in the 20th Century.* Retrieved 27 November 2017, from https://www.cdc.gov/about/history/tengpha.htm

---

[35] CHRISTINE DEHLENDORF ET AL, *Disparities in Family Planning*, Am J Obstet Gynecol. 2010 Mar; 202(3): 214–220. doi: 10.1016/j.ajog.2009.08.022; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2835625/

[vi] *See, e.g.,* Sonfield, A., Hasstedt, K., Kavanaugh, M.L., & Anderson, R. (2013, March). *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children*. Retrieved 30 November 2017, from the Guttmacher Institute website: https://www.guttmacher.org/sites/default/files/report_pdf/social-economic-benefits.pdf

[vii] Guttmacher Institute. (2016, September). *Unintended Pregnancy in the United States* (p. 2). Retrieved 27 November 2017, from https://www.guttmacher.org/sites/default/files/factsheet/fb-unintended-pregnancy-us_0.pdf

[viii] Kost, K., Maddow-Zimet, I., & Arpaia, A. (2017, August). *Pregnancies, Births and Abortions Among Adolescents and Young Women In the United States, 2013: National and State Trends by Age, Race and Ethnicity*. Retrieved 27 November 2017, from the Guttmacher Institute website: https://www.guttmacher.org/sites/default/files/report_pdf/us-adolescent-pregnancy-trends-2013.pdf).

[ix] Mayer, J.P. (1997). Unintended childbearing, maternal beliefs, and delay of prenatal care. *Birth, 24*(4), 247–252. Hellerstedt, W.L., Pirie, P.L., Lando, H.A., Curry, S.J., McBride, C.M., Grothaus, L.C., & Nelson, J.C. (1998, April). Differences in preconceptional and prenatal behaviors in women with intended and unintended pregnancies. *American Journal of Public Health, 88*(4), 663–666;

[x] *See* Tsui, A.O., McDonald-Mosley, R., & Burke A.E. (2010, April). Family planning and the burden of unintended pregnancies. *Epidemiologic Reviews*, *32*(1), 152–174; Joyce, T.J., Kaestner, R., & Korenman, S. (2000, February). The effect of pregnancy intention on child development. *Demography*, *37*(1), 83–94; Gazmararian, J.A., Adams, M.M., Saltzman, L.E., Johnson, C.H., Bruce, F.C., Marks, J.S., & Zahniser, S.C. (1995, June). The relationship between pregnancy intendedness and physical violence in mothers of newborns. The PRAMS Working Group. *Obstetrics & Gynecology, 85*(6), 1031–1038; Goodwin, M.M., Gazmararian, J.A., Johnson, C.H., Gilbert, B.C., & Saltzman, L.E. (2000, June). Pregnancy intendedness and physical abuse around the time of pregnancy: Findings from the pregnancy risk assessment monitoring system, 1996-1997. PRAMS Working Group. Pregnancy Risk Assessment Monitoring System. *Maternal and Child Health Journal, 4*(2), 85–92.

[xi] Orr, S.T., Miller, C.A., James, S.A., & Babones, S. (2000, October). Unintended pregnancy and preterm birth. *Paediatric and Perinatal Epidemiology, 14*(4), 309–313; Conde-Agudelo, A., Rosas-Bermúdez, A., & Kafury-Goeta, A.C. (2006). Birth spacing and risk of adverse perinatal outcomes: A meta-analysis. *JAMA, 295*(15), 1809–1823. *See also* Goldthwaite, L.M., Duca, L., Johnson, R.K., Ostendorf, D., & Sheeder, J. (2015, September). Adverse birth outcomes in Colorado: Assessing the impact of a statewide initiative to prevent unintended pregnancy. *American Journal of Public Health, 105*(9), e60–e66 (establishing an association between use of long-acting reversible contraception and a lower risk of preterm birth).

[xii] *See, e.g.,* Barber, J.S., Axinn, W.G., & Thornton, A. (1999, September). Unwanted childbearing, health, and mother-child relationships. *Journal of Health and Social Behavior, 40*(3), 231–257. *C.f.* Mayer, J.P. (1997). Unintended childbearing, maternal beliefs, and delay of prenatal care. *Birth, 24*(4), 247–252; Orr, S.T., Miller, C.A., James, S.A., & Babones, S. (2000, October). Unintended pregnancy and preterm birth. *Paediatric and Perinatal Epidemiology, 14*(4), 309–313.

[xiii] Ahmed, S., Li, Q., Liu, L., & Tsui, A.O. (2012, July). Maternal deaths averted by contraceptive use: An analysis of 172 countries. *The Lancet*, *380*(9837), 111–125.