AMA
AMERICAN MEDICAL ASSOCIATION

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April 3, 2023

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

The Honorable Julie Su
Acting Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

RE: Coverage of Certain Preventive Services Under the Affordable Care Act

Dear Secretaries Becerra, Su, and Yellen:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide comments to the Departments of Health and Human Services, Labor, and the Treasury (the Departments) in response to the Notice of Proposed Rulemaking entitled, "Coverage of Certain Preventive Services Under the Affordable Care Act," published in the Federal Register on February 2, 2023.

At a time when unrestricted access to reproductive health services is under threat in many areas of our country, access to affordable contraceptive options has become even more of a critical women's health issue. Coverage and cost can present a major barrier in accessing birth control, particularly for low-income and historically minoritized communities. While the Affordable Care Act (ACA) mandates coverage without co-insurance for contraceptives, we recognize that some individuals have limited access to contraception through restrictive coverage policies. These efforts were emboldened by 2018 rulemaking that expanded the religious exemption and established a separate moral exemption for coverage of contraception options.

In this notice of proposed rulemaking, the Departments seek to reinforce ACA protections for birth control coverage by reversing or revising the expanded moral and religious exemptions. Specifically, the rule would eliminate the moral exemption and establish a new, independent pathway for individual enrollees to access contraceptive services directly from a willing provider or facility at no cost, while leaving the religious exemption for employers or plans intact.

The AMA recognizes that reproductive health services, including contraception, are an integral part of women's comprehensive health care, and thus a fundamental human right. We acknowledge that contraceptive coverage is historically safe and evidence-based medicine that is effective at reducing unintended pregnancy, which can have negative health and personal economic consequences for women and families and exacerbate maternal health disparities. The AMA opposes any effort to undermine the

basic principle that all clinical decisions should be made by a patient and his/her physician, not an employer, insurance carrier, or the government. We further oppose any legislative and regulatory actions that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population and support policies that require health insurance carriers to cover and adequately reimburse for a full spectrum of evidence-based medicine, including contraception.

For these reasons, we generally support this rule's proposals to reverse the moral exemption and revise the religious exemption to expand access to birth control coverage. However, while we understand and appreciate the Administration's intent behind establishing the individual contraceptive arrangement pathway as a way to ensure women can obtain contraceptive services at no cost while respecting objecting entities' religious objections, we have logistical questions about complexities and burdens that may arise for patients and physicians under such an approach and include several recommendations to help facilitate a smooth implementation, as explained below.

I. Establishing an "Individual Contraceptive Arrangement Pathway" for Individuals Covered by Plans with Religious Objections

The AMA supports comprehensive coverage of and access to a full range of reproductive services, including contraception coverage. We appreciate that the simplest solution would entail requiring all non-grandfathered health plans to offer coverage of contraception without cost sharing and compelling any objecting entities to opt into the accommodation process, but recognize this may be difficult to enforce and would likely lead to further litigation. We therefore understand the Administration devising a solution in which action is undertaken by the individual, rather than the objecting entity.

We do have some logistical questions and considerations we believe the Administration should carefully consider should it move forward with the proposed individual contraceptive arrangement pathway. Our general concern with this approach is that physician practices have difficulty keeping up with varying enrollment requirements for hundreds of insurance products as it is. Placing the onus on physicians to negotiate and sign separate, individual contraceptive arrangement agreements with each qualified issuer risks adding additional burden to already overwhelmed physician practices, particularly given the relatively small segment of the population that this policy would cover. As a result, HHS may experience lower-than-anticipated physician participation due to bandwidth, not necessarily opposition to the policy. If a reasonable supply of physicians and other clinicians do not willingly enter into agreements with issuers, this could result in patient access issues.

Accordingly, while we appreciate the Departments' deference to providers and qualified issuers, we believe that standardizing certain elements of the provider-issuer agreements, particularly regarding payment, would help to streamline the contracting process and may encourage more physicians to participate in the individual contraceptive coverage pathway. HHS should play an active role in educating issuers, physician practices, and pharmacists about this new pathway once finalized, and in connecting willing physicians with qualified issuers to form these contracts. Further, the AMA suggests providing sample contract language and looking for efficiencies with existing credentialing processes and contracts between issuers and physicians, including potentially recognizing existing contracts and rates for purposes of the provider issuer agreements for the individual contraceptive arrangement pathway, rather than requiring a separate contract be executed in each case.

Regarding payment, the AMA appreciates and supports the recommendation to allow physicians to calculate their own costs and define the terms for payment in their contracts with qualified issuers. We also strongly support the Departments' proposal to include all items and services integral to furnishing the service, including any administrative or ancillary costs, in the total cost of the service. However, we also recognize that determining payment rates and setting up contracts with individual issuers has the potential to be burdensome. We are further concerned that requiring all physicians to set up individual contracts with issuers will be disproportionately burdensome for clinicians with fewer resources, and may cause them not to participate in the individual contraceptive coverage pathway, potentially exacerbating access issues for already underserved patient populations. **Accordingly, we recommend CMS establish a base reimbursement floor based on Medicare rates that physicians could opt into, while giving physicians the option to set their own payment rates with issuers should they elect to do so.** We believe this approach would allow physicians to decide what is most appropriate given their unique patient populations and circumstances, and would maximize physician interest in participating in this new individual contraceptive coverage pathway, thereby maximizing access for patients.

Regarding frequency of payments, the proposed rule would require that the physician be paid within 60 days of the issuer receiving the adjustment to their user fee. However, the user fee adjustment takes place in the benefit year following the year that the services are provided, which could mean a wait of up to 14 months. This would be challenging, particularly for safety net practices. Mandating a more predictable cashflow, such as providing an upfront payment during the benefit year in which services are rendered based on estimated cost of services, would lessen financial burdens on physician practices and encourage more physicians to participate in this new pathway, particularly those serving a high number of low-income, or uninsured or underinsured patients, thus avoiding exacerbating access inequities.

To further expand access, the AMA also supports the Departments' proposal to include services provided via telehealth or mail. We believe this will help to expand the pool of eligible providers, and therefore patient access, particularly for difficult-to-reach populations.

The AMA also believes that certain proposed flexibilities around documentation and verifying patient eligibility are integral to soliciting support from physicians for this potential new pathway. The AMA strongly supports the proposal to afford physicians discretion in choosing how to confirm and document an individual's eligibility for the individual contraceptive arrangement, including attestation and documentation in a patient's medical record. We further support the proposal to retain a clinician's ability to receive reimbursement for contraceptive services furnished if representation as to the individual's eligibility is later determined to be incorrect. In the interest of avoiding gaps of coverage and minimizing burden on practices, we would encourage the Departments to include individuals enrolled in plans established or maintained by an objecting entity that has invoked the optional accommodation and to consider expanding the pathway in the future to other individuals lacking access to no-cost contraception options. Additionally, we support the proposal that participating issuers, but not providers of contraceptive services, would be required to submit documentation demonstrating the provider-issuer agreement. We agree with the Departments' reasoning that affording physicians these critical flexibilities and assurances will reduce operational burdens and will likely result in a greater amount of physician support and participation in this new pathway.

While we believe that all of the considerations above would help to expand the pool of interested physicians, there are many lingering logistical questions that are not addressed by the rule, such as the timing for setting up such a pathway, or how individuals who opt into this pathway would identify a

participating provider. Accordingly, should the Departments move forward with finalizing the individual contraceptive arrangement pathway, **we would encourage them to regularly engage the stakeholder community throughout the development process and deploy sufficient resources to educate and engage physicians, patients, pharmacists, and issuers on this new pathway. We also implore the Departments to closely monitor the number of physicians, pharmacies, and issuers who participate in this new pathway and its effectiveness at expanding access to no-cost birth control coverage for new patient populations and to consider making further changes through rulemaking as warranted.**

II. Elimination of the Moral Exception

Given the AMA's support of expanded access to contraception including birth control coupled with our afore-mentioned logistical questions with the proposed new individual contraceptive arrangement pathway, **the AMA would be in support of the Administration's proposal to remove the moral exception**. That being said, should the Administration determine that the practical implications of removing the moral exception are not worth the potential ramifications including but not limited to further litigation, **the AMA would also be in favor of the proposed alternative approach** (which would entail retaining the moral exception and applying the individual contraceptive arrangement to plans sponsored by non-religious moral objectors) **provided the Administration works to address our above concerns with the individual contraceptive arrangement pathway.**

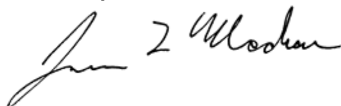
III. Clarifying Language

The AMA is generally supportive of proposals to add clarifying language, including that an issuer may not offer coverage that excludes contraceptive services to any entity or individual that is not an objecting entity, which reaffirms the importance of broad access to contraceptive services, as well as adding ''evidence-informed'' to describe HRSA-Supported Guidelines, which underscores that contraception is safe, evidence-based medicine.

Conclusion

The AMA remains firmly committed to ensuring women have access to the entire spectrum of reproductive health care services, including easy and affordable access to contraceptives. We appreciate this opportunity to comment on these proposals and look forward to continuing to work with you to support women's right to access essential health care services. Please contact Margaret Garikes, Vice President, Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409 with questions or to discuss the contents of this letter.

Sincerely,



James L. Madara, MD