

September 13, 2016

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9931-NC  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, SW  
Washington, D.C. 20201

RE: CMS-9931-NC Coverage for Contraceptive Services

To whom it may concern:

The Institute for Science and Human Values (ISHV) is pleased to respond to the request for information regarding coverage for contraceptive services. The mission of ISHV is to test knowledge by science and reason and to develop ethical values without religious foundations that are relevant to the human condition. We are committed to the enhancement of human values and scientific inquiry. This combines both compassion and reason in realizing ethical wisdom. It focuses on the principles of personal integrity: individual freedom and responsibility. It includes a commitment to social justice, planetary ethics, and developing shared values for the human family.

ISHV thanks the Department of Health and Human Services (“HHS”), Department of Labor (“DOL”), and Department of the Treasury (“DOT”) for this opportunity to further engage in conversation regarding the importance of contraceptive coverage for the health and well-being of women, particularly for women of color and LGBTQ individuals, and their communities.

Our comment will mainly discuss the negative impact that women of color, LGBTQ individuals and progressive voices of faith will experience if any modifications to the accommodation are made, particularly those argued for by objecting employers in the *Zubik* litigation, that do not guarantee seamless coverage of contraception. The current accommodation already ensures that eligible organizations, including the objecting employers, do not have to contract, arrange, pay, or provide a referral for contraceptive coverage while guaranteeing that women enrolled in health plans maintained by eligible organizations receive seamless contraceptive coverage without financial, logistical, or administrative burdens.<sup>1</sup> The accommodation as it stands does not violate the Religious Freedom Restoration Act (“RFRA”) and should not be altered.

As HHS, DOL, and DOT, noted in the request for information, seamless coverage “is essential to achieving the purpose of the Affordable Care Act’s preventive services provision, which seeks to remove barriers to the use of preventive services and to ensure that women receive full and equal health coverage appropriate to their medical needs.”<sup>2</sup> Since it is highly likely that objecting employers, who are eligible for the accommodation, employ women of color and LGBTQ

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<sup>1</sup> Coverage for Contraceptive Services 81 Fed. Reg. 47741, 47742 (request for information proposed July 22, 2016).

<sup>2</sup> *Id.* at 47742.

individuals, it is even more important to recognize that any alteration to the accommodation has the potential to be detrimental to many of the employees who already face barriers to accessing comprehensive reproductive health care services.

Any modification of the accommodation that does not guarantee seamless and equal coverage to contraceptive services would undermine the Congressional intent of ensuring quality, affordable care responsive to the needs of women under the ACA.<sup>3</sup> As such, the proposed options of notification to insurers without self-certification, contraceptive-only insurance policies and separate, affirmative enrollment processes for these contraceptive-only plans, would most certainly delay, if not conclusively bar, a person and their dependents from receiving the contraceptive care they need when they need it. Seamless coverage of contraception and contraceptive counseling is of vital importance particularly given that many communities are experiencing the effects of the Zika virus. Employees of objecting employers, particularly those who are women of color and LGBTQ, would bear the cost and harms of any modification that does not ensure seamless contraceptive coverage. Without access to this coverage, employees and their dependents will lose the ability to plan for their families and future, face further economic insecurity, and continue to experience health inequities, such as unintended pregnancy.

Many within the LGBTQ community—including cisgender women, transgender men, intersex and gender-nonconforming people—can get pregnant and need affordable access to birth control and other reproductive health options to make the best decisions for themselves and their dependents.<sup>4</sup> LGBTQ individuals, especially LGBTQ people of color, already struggle to access vital health services. For instance, many within the LGBTQ community are more likely to be underinsured when compared with non-LGBTQ individuals. And even while many experience certain health challenges at higher rates, far too many LGBTQ people are outright denied services because of who they are.<sup>5</sup>

#### Notification to Issuers without Self-Certification

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<sup>3</sup> See, e.g., 155 CONG. REC. S12,027 (daily ed. Dec. 1, 2009) (statement of Sen. Gillibrand) (“The prevention section of the bill before us must be amended so coverage of preventive services takes into account the unique healthcare needs of women throughout their lifespan.”); *id.* at S12,026 (statement of Sen. Mikulski) (noting that the Women’s Health Amendment was a response to “punitive practices of insurance companies that charge women more and give [them] less in a benefit.”); 155 CONG. REC. H12,603 (daily ed. Nov. 7, 2009) (statement of Rep. Velazquez) (“Mr. Speaker, I rise in support of health care reform as it will empower millions of women, particularly of low income, with information they need to make wise decisions for themselves and their families.”); 155 CONG. REC. H12,599 (2009) (statement of Rep. Woolsey) (“Mr. Speaker, I ask unanimous consent to revise and extend my remarks in support of this bill because it will make healthcare affordable for women who still earn 77% less than men.”); *id.* at H12,601 (statement of Rep. Tsongas) (“Because women shouldn’t have to buy a separate policy for maternity care.... I ask unanimous consent to revise and extend my remarks in support of the Democratic bill.”).

<sup>4</sup> The National LGBTQ Task Force. Birth Control Access for LGBTQ People. March 2016. Available at: [http://www.thetaskforce.org/static\\_html/downloads/reports/fact\\_sheets/factsheet\\_birth\\_control\\_access.pdf](http://www.thetaskforce.org/static_html/downloads/reports/fact_sheets/factsheet_birth_control_access.pdf). Supplemental Brief of Respondents at 14, *Zubik v. Burwell*, 578 US (2016) Nos. Nos. 14-1418, 14-1453, 14-1505, 15-35, 15-105, 15-119, and 15-191.

<sup>5</sup> *Id.*

Any notification to issuers without self-certification would certainly delay women and LGBTQ persons from getting the contraceptive care they need if not make access to contraception impossible. As the government noted in their supplemental brief, the current requirement of a written self-certification plays an important role in effectuating the accommodation, and therefore cautioned that such a modification could “impose real costs on the parties whose rights and duties are affected—including objecting employers.”<sup>6</sup> Any delays or additional barriers resulting from notification to issuers without self-certification from objecting employers may not only have a negative economic impact on their employees and dependents but also threaten their health, wellbeing, and their ability to exercise bodily autonomy.

Before the contraceptive coverage benefit went into effect, some forms of contraception were prohibitively expensive. For instance, the intrauterine device (IUD) is considered the most effective contraception available on the market today, but the upfront costs of an IUD could cost upwards of \$1,000, nearly a month’s full time salary for a person employed in minimum wage work.<sup>7</sup> Because of the IUD’s high cost, only 6 percent of black women have used IUDs compared with 78 percent who have used birth control pills.<sup>8</sup> These costs would have particularly impacted women of color who are 23 percent of the minimum wage job workforce<sup>9</sup> as well as lesbian and transgender women who also experience the negative consequences of the wage gap.<sup>10</sup>

Additionally, cost of contraception most likely inhibited women of color from using contraception on a regular basis. One 2010 study found that 57 percent of Latinas ages 18-34 and 54 percent of African-American women in that same age group struggled with the cost of

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<sup>6</sup> Supplemental Brief of Respondents at 14, *Zubik v. Burwell*, 578 US \_\_ (2016) Nos. Nos. 14-1418, 14-1453, 14-1505, 15-35, 15-105, 15-119, and 15-191.

<sup>7</sup> National Women’s Law Center. *Zubik v. Burwell*: Non-Profit Objecting Employers Want to Make It More Difficult, If Not Impossible, for Women to Access Critical Birth Control Coverage. February 2016. Available at: <https://nwlc.org/resources/zubik-v-burwell-non-profit-objecting-employers-should-not-be-allowed-to-make-it-harder-for-women-to-access-critical-birth-control-coverage/>.

<sup>8</sup> Kira Shepard, The Context of Historical Racism Matters in the Birth Control Benefit Case. Rewire News. March 2016. Available at: <https://rewire.news/article/2016/03/25/context-historical-racism-matters-contraception-mandate-case>.

<sup>9</sup> National Women’s Law Center. Fair Pay for Women Requires a Fair Minimum Wage. May 2015. Available at: <https://nwlc.org/resources/fair-pay-women-requires-fair-minimum-wage/>.

<sup>10</sup> National Women’s Law Center. The Wage Gap: The Who, How, Why, and What to Do. April 2016; 2. Available at: <https://nwlc.org/wp-content/uploads/2016/04/The-Wage-Gap-The-Who-How-Why-and-What-to-Do-1.pdf>. According to the most recent analysis available, women in same-sex couples have a median personal income of \$38,000, compared to \$47,000 for men in same-sex couples and \$48,000 for men in different-sex couples. One study found that the average earnings of transgender women workers fall by nearly one-third after transition.

contraception at some point in their lives.<sup>11</sup> The Guttmacher Institute found that during the recession some women, particularly those who were financially struggling, decided not to use contraception on a consistent basis or did not use it all in order to save money.<sup>12</sup> Currently 1.3 million Asian American and Pacific Islander (AAPI) women live under the poverty level and 1.3 million AAPIs are uninsured.<sup>13</sup> Low-income AAPI women already face many barriers in access contraceptive coverage such as the current “5 year ban” preventing new immigrants from accessing Medicaid. This is coupled with a complete denial of low-income safety nets for the 650,000 undocumented AAPI women and girls in the United States. As the AAPI community grows, so does the poverty facing AAPI women. Creating more barriers to healthcare coverage will only hurt women and their families.<sup>14</sup> Without access to seamless contraceptive coverage, these employees, their dependents, and possibly those who work for other employers who receive the accommodation will be forced to make untenable choices between taking care of themselves and their families or paying for the contraceptive care they need.

Contraception is necessary for the health and well-being of communities who may experience sexual assault, unintended pregnancy, and face barriers to accessing healthcare, including reproductive healthcare. Any modifications to the accommodation that would disrupt seamless coverage of contraceptive care will have a severe impact on a person’s ability to plan their futures and their families, particularly for individuals who face sexual violence. Some LGBTQ communities experience disproportionate rates of sexual violence; for example, 46 percent of bisexual women have been raped compared with 17 percent of heterosexual and 13 percent of lesbian women.<sup>15</sup> The disproportionate experience of sexual violence in the overall LGBTQ community also parallels the experiences of LGB youth. The Center for Disease Control and Prevention recently reported that LGB students were 18 percent more likely to report being physically forced to have sex than their heterosexual peers.<sup>16</sup>

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<sup>11</sup> Planned Parenthood Federation of America. Survey: Nearly Three in Four Voters in America Support Fully Covering Prescription Birth Control. May 14, 2014. <https://www.plannedparenthood.org/about-us/newsroom/press-releases/survey-nearly-three-four-voters-america-support-fully-covering-prescription-birth-control> (last visited September 7, 2016).

<sup>12</sup> Guttmacher Institute. A Real Time Look at the Impact of the Recession on Women’s Family Planning and Pregnancy Decisions. September 2009; 5. Available at: [https://www.guttmacher.org/sites/default/files/report\\_pdf/recessionfp\\_1.pdf](https://www.guttmacher.org/sites/default/files/report_pdf/recessionfp_1.pdf)

<sup>13</sup> National Asian Pacific American Women’s Forum, *Zubik v. Burwell* + Asian American & Pacific Islander Women & Girls. March 2016. Available at: <https://napawf.org/wp-content/uploads/2009/10/Zubik-fact-sheet-FINAL.pdf>.

<sup>14</sup> *Id.*

<sup>15</sup> Beamesderfer A., Dawson L., et al. The Henry J. Kaiser Family Foundation. Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S. June 2016. Available at: <http://kff.org/report-section/health-and-access-to-care-and-coverage-for-lesbian-gay-bisexual-and-transgender-health-challenges/>.

<sup>16</sup> Centers for Disease Control and Prevention. Adolescent and School Health. Health Risks Among Sexual Minority Youth. <http://www.cdc.gov/healthyyouth/disparities/smy.htm>. (last visited September 7, 2016).

Many communities are also likely to experience unintended pregnancy due to lack of resources, lack of comprehensive sexuality education, lack of culturally and linguistically competent providers, and other systemic factors. These barriers to planning a pregnancy will be compounded by lack of seamless contraceptive coverage, including for young dependents of these plans. Women living with HIV already struggle to access contraception through HIV-related services.<sup>17</sup> Young people ages fifteen to twenty-four are more likely to experience unintended pregnancy.<sup>18</sup> Lesbian, gay, and bisexual youth may experience unintended pregnancies at even higher rates than their heterosexual peers.<sup>19</sup> Moreover, LGBTQ persons who are low income and of color often experience discrimination in healthcare settings at higher rates than their peers,<sup>20</sup> which may contribute to lack of access to culturally competent reproductive healthcare and preventive services, such as contraceptive counseling. In the 2011 National Transgender Discrimination Survey, 48 percent of female to male and 27 percent of male to female transgender respondents delayed accessing preventive health services due to provider discrimination and disrespect.<sup>21</sup>

Because contraception is a vital tool for communities who have lacked the resources and supports to make the best decisions about their health and well-being, it is vital that access to seamless contraceptive coverage is guaranteed for all individuals regardless of where they work.

A modification to the accommodation that does not entail self-certification will most likely impose severe, economic and personal costs to workers, their dependents, and others.

#### Other Approaches with Respect to Insured Plans Described in the Supplemental Briefing

Contraceptive coverage only policies and separate, affirmative enrollment processes for these plans as argued for by the plaintiffs in the *Zubik* litigation would also have the effect of delaying

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<sup>17</sup> The Global Network of People Living with HIV/AIDS (GNP+), *Advancing the Sexual and Reproductive Health and Human Rights of People Living with HIV*, 2009; 9. Available at: [https://www.unfpa.org/sites/default/files/resource-pdf/guidance\\_package.pdf](https://www.unfpa.org/sites/default/files/resource-pdf/guidance_package.pdf). Positive Women's Network USA, *Reproductive Justice Factsheet*. Available at: <https://pwnusa.wordpress.com/policy-agenda/reproductive-justice/rjfactsheet/>.

<sup>18</sup> Syed K. *Ensuring Young People's Access to Preventive Health Services in the Affordable Care Act*. *Advocates for Youth*, 2, 2014. Available at: <http://www.advocatesforyouth.org/storage/advfy/documents/Preventive%20Services%20in%20the%20ACA-11-24-14.pdf>. In 2014, Black and Latina youth experienced pregnancies at about twice the rate of their white counterparts. For Native American youth, they experienced pregnancy at one and a half times the rate of their white peers. Centers for Disease Control and Prevention. *Reproductive Health: Teen Pregnancy. Social Determinants and Eliminating Disparities in Teen Pregnancy*. <https://www.cdc.gov/teenpregnancy/about/social-determinants-disparities-teen-pregnancy.htm> (last visited on September 7, 2016).

<sup>19</sup> Lisa L. Lindley & Katrina M. Walsemann, *Sexual Orientation and Risk of Pregnancy Among New York City High-School Students*, 105 *American Journal of Public Health* 1379 (2015).

<sup>20</sup> Lambda Legal. *When Health Care Isn't Caring*, Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV, 2010; 11. Available at: [http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report\\_when-health-care-isnt-caring.pdf](http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf).

<sup>21</sup> Grant JM, Mottet LA, et al. *National Center for Transgender Equality & National Gay and Lesbian Task Force. Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. 2011; 76. Available at: [http://www.thetaskforce.org/static\\_html/downloads/reports/reports/ntds\\_full.pdf](http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf).

and/or ultimately deterring access to contraception for those employed by plaintiffs, their dependents, and possibly for those who work at other employers who are eligible to receive the accommodation. Although contraceptive coverage only plans have not been available in the past, the example of maternity care riders demonstrates that limited scope insurance products may not guarantee affordable access to the services covered in these products. Prior to the ACA, many insurance plans did not cover maternity care and would offer riders that covered this benefit.<sup>22</sup> These riders were costly and required waiting periods or denied beneficiaries coverage if they had pre-existing conditions, including pregnancy.<sup>23</sup> Maternity care riders show that contraceptive coverage only plans may delay or deny a person's ability to access affordable, timely contraception.

Regardless of whether these contraceptive coverage only plans would be effective in providing access to the services covered, these plans would be in violation of the ACA as it currently stands. The ACA requires that Qualified Health Plans sold in the Marketplaces are comprehensive and include essential health benefits.<sup>24</sup> These benefits are certified by the Marketplaces in each state.<sup>25</sup> Contraceptive coverage only plans could only be offered through these Marketplaces if Congress amended the ACA and each state passed or issued new laws or regulations.<sup>26</sup>

Separate enrollment processes for contraceptive coverage only plans would hinder if not deter an employee from gaining seamless coverage of contraceptive services. Objecting employers assume that navigating the healthcare system as an individual is a relatively easy process, but advocates and communities know that it can be a complicated effort requiring many resources—free time, regular and unlimited phone and internet access, privacy, transportation, ability to read and respond to complex paperwork—that the logistics alone can be preclusive. This is a likely scenario if separate enrollment processes for contraception only plans are adopted as solutions, particularly as concerns remain regarding current enrollment processes for Marketplace plans. These concerns include identity proofing which is required for submission of online applications, transparency of services and products covered in plans, affordability, and others. Particularly, identity proofing disproportionately impacts immigrant, mixed status families who

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<sup>22</sup> Alina Salganicoff. The Henry J. Kaiser Family Foundation. Huffington Post. Contraceptive-Only Plans: Questions and Answers. March 29, 2016. [http://www.huffingtonpost.com/alina-salganicoff/contraceptiveonly-plans-q\\_b\\_9559772.html](http://www.huffingtonpost.com/alina-salganicoff/contraceptiveonly-plans-q_b_9559772.html).

<sup>23</sup> *Id.*

<sup>24</sup> *Id.*

<sup>25</sup> *Id.*

<sup>26</sup> *Id.*

may not be able to produce proof of identity when applying on behalf of citizen children.<sup>27</sup>

Given these ongoing concerns with current enrollment processes for plans on the Marketplaces, separate enrollment processes for contraceptive coverage only plans should not be pursued.

### Economic Harm to Employees and Dependents of Objecting Employers

Each person should have the ability to plan their families and their futures without the interference of their employer. Many of the employees whose coverage is in question are people of color employed in low-wage work. If these employees do not have access to seamless contraceptive coverage, they will carry the economic burdens of having to choose between needed healthcare and daily expenses. Across job industries, people of color, and women of color in particular, have lower incomes<sup>28</sup> and less job flexibility. Women of color are widely employed in the health, elder care, and education sectors,<sup>29</sup> industries in which objecting employers of the *Zubik* litigation hire workers. Black and Latino people are the most represented in healthcare support occupations such as medical assistants, nursing, psychiatric, and home health aides.<sup>30</sup> For example, direct-care workers—a job category in which people of color are highly represented—care for elders at institutions like Little Sisters of the Poor Home for the Aged. Such workers have a median income of only \$16,100 per year and report unpredictable and part-time hours.<sup>31</sup>

Another objecting employer in the *Zubik* litigation, East Texas Baptist University, hires individuals as technicians to repair vehicles and small equipment and as building and grounds

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<sup>27</sup> Shaw T., Gonzales S. Center on Budget and Policy Priorities. Remote Identity Proofing: Impacts on Access to Health Insurance. January 7, 2016. Available at: <http://www.cbpp.org/research/remote-identity-proofing-impacts-on-access-to-health-insurance>.

<sup>28</sup> In 2014, over 23 percent of Latinos and over 26 percent of Black people lived under the federal poverty level, compared to 12% of White women. Census Bureau, *People in Poverty by Selected Characteristics: 2013 and 2014*. Only 11% of Asian American Pacific Islander (AAPI) women live below the FPL, but this does not reflect that many AAPI communities, including Hmong and Bangladeshi women, of whom 24.7% and 23.9% fall below this threshold, respectively. Census Bureau, 2011-2013 American Community Survey, Table S0201.

<sup>29</sup> In 2014, on average, over 41 percent of Black women, nearly 31 percent of Asian women, and 29 percent of Latinas were employed in education and health services. U.S. Bureau of Labor Statistics. BLS Reports. Labor Force Characteristics by Race and Ethnicity. November 2015; 36. Available at: <http://www.bls.gov/opub/reports/race-and-ethnicity/archive/labor-force-characteristics-by-race-and-ethnicity-2014.pdf>.

<sup>30</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. Sex, Race, and Ethnic Diversity of U.S. Health Occupations (2010-2012), Rockville, Maryland; 2014; 2, 7. Available at: <http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/diversityushealthoccupations.pdf>.

<sup>31</sup> Marquand A. Paraprofessional Healthcare Institute. Too Sick to Care: Direct-Care Workers, Medicaid Expansion, and the Coverage Gap. July 2015; 4. Available at: <http://www.phinational.org/policy/issues/health-coverage/too-sick-care-direct-care-workers-medicare-expansion-and-coverage-gap>.

maintenance workers.<sup>32</sup> In Texas, automotive service technicians and mechanics, make an average wage of \$19.93 an hour for an average annual wage of \$41,440.<sup>33</sup> Landscaping and grounds keeping workers in Texas make an average wage of \$12.15 per hour for an average annual wage of \$25,280.<sup>34</sup> Depending on the size of an employee's family, these salaries are not dramatically above or may fall exactly at the 2016 federal poverty guidelines of \$11, 880 for a family of one, \$16, 020 for two, \$20,160 for three, \$24,300 for four, and rising thereafter at about \$4,160 for each additional family member, reaching to \$40,890 for a family of eight.<sup>35</sup> Regardless, those who work at facilities run by objecting employers should not have to pay for a benefit that is guaranteed to them under the law. Given these examples, any modification to the accommodation that does not ensure seamless coverage of contraception will only further increase any economic insecurity that these employees, their families, and others who in the future may be impacted by the accommodation.

### The Accommodation Does Not Violate the Religious Freedom Restoration Act

We understand how important it is to preserve true religious freedom: many women of color and LGBTQ individuals are also people of faith and many are not. Real religious liberty maintains that everyone has access to worship and believe according to their consciences, as long as those beliefs do not cause harm or discriminate against others. Many women use contraceptives because of their moral and religious beliefs about planning their families and being responsible parents.<sup>36</sup> The birth control pill is one of the most-used preventative health services among women-including religious women.<sup>37</sup> Ninety-nine percent of sexually active Catholic and

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<sup>32</sup> East Texas Baptist University. Employment Opportunities. <https://www.etbu.edu/faculty-and-staff/human-resources/employment-opportunities/> (last visited September 7, 2016).

<sup>33</sup> United States Department of Labor. Bureau of Labor Statistics. Occupational Employment Statistics. May 2015 State Occupational Employment and Wage Estimates Texas. Installation, Maintenance, and Repair Occupations. March 30, 2016. [http://www.bls.gov/oes/current/oes\\_tx.htm#49-0000](http://www.bls.gov/oes/current/oes_tx.htm#49-0000).

<sup>34</sup> United States Department of Labor. Bureau of Labor Statistics. Occupational Employment Statistics. May 2015 State Occupational Employment and Wage Estimates Texas. Building and Grounds Cleaning and Maintenance Occupations. March 30, 2016. [http://www.bls.gov/oes/current/oes\\_tx.htm#37-0000](http://www.bls.gov/oes/current/oes_tx.htm#37-0000).

<sup>35</sup> U.S. Department of Health and Human Services. Office of the Assistant Secretary for Planning and Evaluation. Poverty Guidelines. January 25, 2016. <https://aspe.hhs.gov/poverty-guidelines>.

<sup>36</sup> Eleni Towns and Sally Steenland, "The Morality of Contraception," <https://www.americanprogress.org/issues/religion/news/2012/02/23/11133/the-morality-of-contraception/>.

<sup>37</sup> Tara Haelle, "Pill Remains Most Common Birth Control Method," <https://consumer.healthday.com/women-s-health-information-34/birth-control-news-62/the-pill-remains-most-common-method-of-birth-control-u-s-report-shows-694485.html>

Protestant women have used some form of contraception.<sup>38</sup> For instance, there are over 8.5 million Asian American and Pacific Islander women and girls living in America who are a diverse group with over fifty different ethnic identities consisting of many different religions or none at all. Religious freedom is a core value for AAPI communities.<sup>39</sup>

But using faith to deny other people access to healthcare is not religious freedom. It is illegal discrimination. We strongly believe that an employer's religion should not determine an employee's ability to control their own sexual and reproductive health.

Furthermore, if the accommodation is modified to enable employers to more easily use religion to deny their workers birth control coverage, it would set an incredibly dangerous precedent and create a slippery slope. It could lead to employers to also refuse to cover PrEP because it's been successfully used to reduce HIV transmission rates among gay and bisexual men. It is also not hard to imagine a case where a doctor refuses to treat a transgender woman with breast cancer by making a religious objection to treating transgender patients.

### Conclusion

We appreciate the opportunity to share our concerns regarding proposed modifications to the accommodation of the contraceptive coverage benefit. The accommodation does not violate RFRA and does not need to be altered. The contraceptive coverage benefit must continue to ensure seamless coverage of contraception. Otherwise, workers of objecting employers, students, and others, particularly women and LGBTQ persons of color and their dependents, will be delayed or deterred from accessing a benefit that is guaranteed to them under the ACA.

Thank you for your consideration of our comments.

Sincerely,

*Toni Van Pelt*

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Institute for Science and Human Values

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<sup>38</sup> Guttmacher Institute. Contraceptive Use in the United States. October 2015. Available at: <https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states>.

<sup>39</sup> National Asian Pacific American Women's Forum, *Zubik v. Burwell* + Asian American & Pacific Islander Women & Girls. March 2016. Available at: <https://napawf.org/wp-content/uploads/2009/10/Zubik-fact-sheet-FINAL.pdf>.