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11/2011

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June 19, 2012

By Electronic Submission

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW.
Washington, DC 20201

Re: Advance Notice of Proposed Rulemaking Regarding Preventive Services, CMS-9968-ANPRM, RIN 0938-AR42

To Whom It May Concern:

The Church Alliance submits this comment in response to the advance notice of proposed rulemaking regarding preventive services ("ANPRM") issued jointly by the Internal Revenue Service, the Department of Labor and the Department of Health and Human Services (HHS) (together, the "Departments") and published at 77 Fed. Reg. 16501 (Mar. 21, 2012). In light of the Departments' stated intent to revise the amended interim final regulations published on February 15, 2012 (77 Fed. Reg. 8725) (the "Final Regulations"), we offer additional comments on how the Final Regulations should be revised or clarified. The Church Alliance had previously commented on the then interim final rules published at 76 Fed. Reg. 46621 (Aug. 3, 2011). A copy of that comment (the "Prior Comment") is attached.

The Church Alliance members, listed on the left of this letterhead, provide medical coverage to approximately one million participants (clergy and lay workers) serving over 155,000 churches, synagogues and affiliated organizations. These medical programs are defined as "church plans" under section 3(33) of the Employee Retirement Income Security Act of 1974 (ERISA) and section 414(e) of the Internal Revenue Code (the "Code").

As noted in our Prior Comment, most of the health care plans associated with the members of the Church Alliance do not impose any specific restrictions on contraceptive services. A few programs, reflecting the religious beliefs of the churches with which they are associated, exclude coverage for all contraceptives. Other programs whose associated churches do not object to contraception but hold fundamental convictions against abortion, exclude coverage for contraceptives that are or could be abortifacients, such as the so-called "morning-after pills" or "emergency contraceptives." However, regardless of their religious beliefs, all the members of the Church Alliance share the common view that a church or an employer associated with a church should not have to

face the choice of violating its faith or violating the law in order to maintain a health care plan for its workers.[1]

I. EXEMPTION IN THE FINAL REGULATIONS FOR "RELIGIOUS EMPLOYERS"

A. Should be extended to include all church employers under Code section 414(e) church plans

In the comprehensive guidelines issued by the Health Resources and Services Administration (HRSA) on August 1, 2011 (the "HRSA Guidelines"),[2] HRSA exercised its discretion under the then interim final regulations so that group health plans established or maintained by "religious employers" (and any group health insurance coverage provided in connection with such plans) are not required to cover any contraceptive services. In the Final Regulations, the Departments adopted the definition of "religious employer" in the amended interim final regulations, noting:

> The Departments emphasize that this religious exemption is intended *solely* for purposes of the contraceptive coverage requirement pursuant to section 2713 of the PHS Act and the companion provisions of ERISA and the Code. Whether an employer is designated as "religious" for these purposes is not intended as a judgment about the mission, sincerity, or commitment of the employer, and the use of such designation is limited to defining the class that qualifies for this specific exemption. The designation will not be applied with respect to any other provision of the PHS Act, ERISA, or the Code, nor is it intended to set a precedent for any other purpose.
>
> Alternatively, the intended regulations could base their definition on another Federal law, such as section 414(e) the Code and section 3(33) of ERISA, which set forth definitions for purposes of "church plans." A definition based on these provisions may include organizations such as hospitals, universities, and charities that are exempt from taxation under section 501 of the Code and that are controlled by or associated with a church or a convention or association of churches.

For the reasons discussed in its Prior Comment, the Church Alliance again urges HHS to extend the religious employer exemption to all employers that maintain or participate in "church plans" as defined in Code section 414(e).

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[1] Section 4980B of PPACA imposes a penalty on large employers that fail to offer their employees (and their dependents) the opportunity to enroll in minimum essential coverage. If an employer offers general coverage, but omits contraceptive coverage, it may be subject to an excise tax imposed by Code section 4980D of $100/day for each covered individual denied such coverage. Congressional Research Service, *Enforcement of the Preventive Care Services Requirements of the Patient Protection and Affordable Care Act*, 7-8 (Feb. 24, 2012).

[2] The HRSA Guidelines are available at http://www.hrsa.gov/womensguidelines.

B. Should clarify the application of the religious employer exemption to church-affiliated employers participating in denominational and other multiple-employer church plans

The Church Alliance was pleased to note that the following hypothetical fact pattern was included in the ANPRM:

> In addition, we note that this exemption is available to religious employers in a variety of arrangements. For example, a Catholic elementary school may be a distinct common-law employer from the Catholic diocese with which it is affiliated. If the school's employees receive health coverage through a plan established or maintained by the school, and the school meets the definition of a religious employer in the final regulations, then the religious employer exemption applies. If, instead, the same school provides health coverage for its employees through the same plan under which the diocese provides coverage for its employees, and the diocese is exempt from the requirement to cover contraceptive services, then neither the diocese nor the school is required to offer contraceptive coverage to its employees. 77 Fed. Reg. at 16502.

The Church Alliance reiterates its support for this approach and example, and would like to see this policy clarified and reflected in a final rule. This example was discussed at length at a meeting on April 4, 2012, between representatives of the Church Alliance and HHS personnel. Based on that meeting, the representatives of the Church Alliance understood that the Departments intend to make the fact pattern in this example part of a final rule.

The intended result could be reached most easily by revising the exemption to apply to church plans, as defined in Code section 414(e), rather than employer by employer. This was the approach suggested by the Church Alliance in its Prior Comment. However, if HHS is concerned that such an exemption would be too broad, HHS could draft the exemption more narrowly so that if an employer affiliated with a church or a convention or association of churches did not satisfy the four-part test for religious employers, it could nevertheless be entitled to the benefit of the exemption (i.e., be completely exempt from the requirement to provide contraceptive services without cost-sharing), if it participated in a multiple employer church plan (e.g., a denominational plan) in which at least one participating employer satisfies the four-part test.

This approach would be slightly narrower than an exemption based solely on Code section 414(e). It might result in some church plans being exempt (multiple employer church plans, like many of the denominational plans represented by the Church Alliance, among others), while others, certain single employer church plans, not being so exempt unless the individual employer satisfies the four-factor test.

Applying the multiple employer church plan exemption in this manner would recognize the unique nature of multiple employer church plans, particularly the fact that such plans cover many houses of worship (often primarily covering clergy and employees at churches) but also cover some employers associated with the church that may not satisfy the four-part test.

Thus, for example, a church that views outreach ministries to non-members as a primary component of its religious mission and may therefore not satisfy the four-factor test could remain exempt if the church participates in its denomination's multiple employer church plan in which at least one employer satisfies the four-factor test.

The clarification urged by the Church Alliance regarding participants in multiple employer church plans is consistent with the recognition in the ANPRM that different accommodations may be required for plans that pool their risks:

> The Departments also recognize that various denominations may offer coverage to institutions affiliated with those denominations. For example, their plans may be offered as ''church plans'' (described above) to individual churches as a means of pooling their risk. The Departments seek comment on whether different accommodations are needed for such plans. 77 Fed. Reg. at 16508.

Most of the denominations represented by the Church Alliance maintain national health plans. These plans are church plans as defined in Code section 414(e). They are also typically structured as multiple employer plans. That is, they cover numerous small local churches and church offices. The plans also often cover closely affiliated church employers, e.g., church foundations, regional church offices, seminaries, freelance pastors and evangelists. The plans, at times, also cover employers that are controlled by or associated with the church, such as parochial schools, church camps, nursing homes, hospitals and post-secondary schools. These employers are permitted to participate in these plans under the terms of the Code and the Treasury Regulations.

These plans work by covering all of these employers through one or more multiple employer health plans in which some or all of the actuarial risks of the covered employees and dependents are pooled or shared among all participating employers. This also often means that contributions for coverage (premiums) are consistently determined across multiple (often very different) employers. The premiums paid by a local church (a house of worship that is apt to satisfy the four-factor test and thereby be exempt from the contraceptive coverage requirement) are pooled, typically in a trust, with premiums paid by affiliated employers, e.g., parochial schools, which may not satisfy the four-factor test.

The employees of the church and those of the school are usually covered in the same type of plan (benefit design). Claims from all covered employees are paid from pooled assets held by the health care trust or benefit board. Federal law has recognized this unique arrangement before. The Church Plan Parity and Entanglement Prevention Act ("Parity Act") (P.L 106-244) specifically recognizes, in its Section 2(a), that church health plans, defined in Code section 414(e), are often multiple employers plans:

> For purposes of determining the status of a church plan that is a welfare plan under provisions of a State insurance law...such a church plan (and any trust under such plan) shall be deemed to be a plan sponsored by a single employer that reimburses costs from general church assets, or purchases insurance coverage with general church assets, or both.

Congress passed the Parity Act because some states attempted to regulate church health plans as multiple employer welfare arrangements (MEWAs) under their insurance laws. The Parity Act preempted these state laws, and established a Federal policy that these plans should be viewed, for state insurance regulatory (risk-pooling or actuarial) purposes, as plans of single employers – the church or denomination – and that the contributions from church employers in a multiple employer church plan, once paid to the benefit board or trust funding the plan, should be treated as church assets, thereby deeming the plan as unfunded. The Parity Act thus resolved the administrative difficulties facing church plans that might otherwise have been treated as a MEWA under state law.

The Parity Act supports the Departments making an accommodation under the preventive services rule for multiple employer church plans that cover exempt religious employers and non-exempt religious employers in the same pool of risk. By deeming the contributions to these plans to be "church assets", the Parity Act bolsters the argument that all employers participating in a church plan that covers at least one religious employer that satisfies the four-factor test should benefit from the from the exemption.

C. Should clarify that contraceptive coverage includes FDA sterilization procedures and patient education and counseling

The chart of preventive services for women set forth in Required Health Plan Coverage Guidelines issued by the Health Resources and Services Administration (HRSA)[3] appears to exempt "religious employers" from any requirement to cover Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. However, the preamble of the ANPRM states that the exemption "is intended <u>solely</u> for purposes of the contraceptive coverage requirement ...." 77 Fed. Reg. at 16502 (original emphasis). The revised final regulations should clarify that the term "contraceptive coverage" is just shorthand for contraceptives, sterilization, and related education and counseling, as the HRSA suggests.[4]

D. Should be extended to cover student insurance programs sponsored by educational institutions that otherwise are "religious employers"

The four-part religious employer exemption set forth in the Final Regulations only applies to employees covered by "group health plans established or maintained by religious employers." 29 C.F.R. §2590.715–2713(a)(1)(iv) and 45 C.F.R. §147.130(a)(1)(iv)(A). It does not apply to religiously affiliated colleges and universities with respect to the medical coverage provided to their students.

[3] The guidelines are available at www.hrsa.gov/womensguidelines.

[4] For convenience, we use "contraceptive coverage" in this manner.

The final regulations regarding student insurance provide that the one-year temporary enforcement safe harbor issued by HHS on February 10, 2012 (the "Temporary Safe Harbor")[5] applies to student health plans with respect to the students and their dependents.

77 Fed. Reg. 16453, 16456-57 (Mar. 21, 2012). Additionally, the ANPRM indicates that the Departments' proposed accommodation for religious organizations will also extend to nonprofit institutions of higher education with religious objections to contraceptive coverage with respect to student plans. *Id.*

We suggest that the Final Regulations be revised to extend the religious employer exemption to insured student insurance programs sponsored by religiously affiliated institutions of higher education that meet the expanded religious employer exemption described in Section I of this letter.[6] Otherwise, after the end of the one-year temporary safe harbor period, institutions that otherwise constitute religious employers for purposes of the Final Regulations will be in the odd position of having to provide contraceptive coverage for their students (perhaps with the benefit of accommodation) if they provide student health coverage, but exempt from having to provide such coverage to their employees.

The extension of this exemption to institutions of higher education will be consistent with section 1560(c) of Patient Protection and Affordable Care Act ("ACA") which provides:

> (c) STUDENT HEALTH INSURANCE PLANS.- Nothing in this title (or an amendment made by this title) shall be construed to prohibit an institution of higher education (as such term is defined for purposes of the Higher Education Act of 1965) from offering a student health insurance plan, to the extent that such requirement is otherwise permitted under applicable Federal, State or local law.

HHS has properly interpreted ACA section 1560(c) as rendering other provisions of ACA inapplicable if, as a practical matter, they would have the effect of prohibiting an institution of higher education from offering a student health plan otherwise permitted under Federal, State or local law." *See*, 77 Fed. Reg. 16453, 16454 (Mar. 21, 2012).

Already, two Catholic colleges have announced that they will drop their student insurance programs on account of the contraceptive coverage requirement. See, Louise Radrofsky, *Big Changes in College Health Plans,* Wall St. J. at A5 (June 4, 2012). Other colleges are dropping their student insurance programs simply because of the increased costs of such coverage. *Id.*

[5] The Temporary Safe Harbor is located at http://cciio.cms.gov/resources/files/Files2/02102012/20120210-Preventive-Services-Bulletin.pdf.

[6] Self-funded student health programs are not covered by PPACA and therefore not subject to the preventive services mandate.

II. PROPOSED ACCOMMODATION FOR "RELIGIOUS ORGANIZATIONS"

A. What organizations should qualify as "religious organizations"?

1. The proposed accommodation should extend at least to all organizations covered by the Temporary Safe Harbor

The ANPRM posed the following questions for comments: "What entities should be eligible for the new accommodation (that is, what is a 'religious organization')?" The second question is not a restatement of the first question. Rather, it is a discrete question, which appears to indicate the Departments' intent to limit the accommodation to "religious organizations." The Temporary Safe Harbor did not limit the accommodation to such organizations. Instead, that announcement described an accommodation and temporary safe harbor for "certain non-exempted, nonprofit organizations with religious objections to covering contraceptive services whose group health plans are not grandfathered health plans." The Temporary Safe Harbor apparently recognized that nonprofit organizations outside the category of "religious organizations" could be sufficiently affiliated with a church, synagogue, mosque, temple or other similar entity that objects on a religious basis to covering contraceptive services, so that the nonprofit organizations should also be exempted from covering contraceptive services.

Narrowing the accommodation to "religious organizations" fails to acknowledge that other categories of nonprofit organizations have religious objections to covering contraceptive services. Such narrowing forces those nonprofit organizations to violate their religious beliefs, simply because they seek to put their faith into action through mercy and service shown in charitable, educational, benevolent and similar activities. Those organizations that primarily engage in religious work will be favored by such a limited accommodation, while those that serve others based on religious beliefs will be penalized.

However, the purported intent of the accommodation is to accommodate a broader category of organizations than those that are exempted under the "religious employer" exemption under the Final Regulation. To accomplish this intent, the Church Alliance respectfully suggests that the accommodation extend at least to all organizations covered by the Temporary Safe Harbor, i.e., for all non-exempted, nonprofit organizations with religious objections to covering contraceptive services, whose group health plans are not grandfathered health plans. Such a result simply avoids a contraction of the accommodation.

Consistent with the current Temporary Safe Harbor, the accommodation also should include any group health insurance coverage provided in connection with a health plan provided to employees of a non-exempted, nonprofit organization with religious objections to covering contraceptive services. This inclusion would serve to treat such organizations with religious objections similarly, regardless of the type of health plan they offer their employees.

2. The proposed accommodation should <u>not</u> be limited to religious organizations encompassed by one or more exemptions under state insurance laws

The accommodation should not be limited to religious organizations encompassed by one or more of the exemptions under state insurance laws. The exemptions provided under state insurance laws are inappropriate models for an accommodation for the same reasons indicated in our Prior Comment that they were inappropriate models for an exemption. In particular, state laws are not constrained by the federal Religious Freedom Restoration Act of 1993 (RFRA), unlike PPACA and the regulations and guidelines thereunder. Also, the burden upon religious organizations attempting to comply with state laws requiring contraceptive coverage is much less significant than under PPACA. A religious organization located in a state requiring contraceptive coverage without an applicable exemption can avoid violating its faith by either dropping pharmaceutical benefits for its employees or self-insuring such benefits. A religious organization with more than 50 full-time employees cannot drop pharmaceutical benefits for its employees without incurring a substantial penalty under PPACA. *Supra* at 2 n. 1.

Finally, we note that since the issuance of the ANPRM at least one state with an exemption similar to the four-factor exemption set forth in the final regulations has amended its laws to broaden its exemption to include all other religious employers. Arizona, whose exemption was similar to that included in the Final Regulations except that it did not require that inculcation of religious values be the purpose of the employer, on May 11, 2012, amended its exemption to include an entity "whose articles of incorporation clearly state that it is a religiously motivated organization and whose religious beliefs are central to the organization's operating principles."[7]

3. The proposed accommodation should include religious organizations that provide coverage for some, but not all, FDA-approved contraceptives consistent with their religious beliefs

An accommodation for religious organizations should include those organizations that have consistently and historically provided some, but not all, of the FDA-approved contraceptives required under the HRSA Guidelines. The Temporary Safe Harbor appears to apply to religious organizations that did not provide any contraceptive coverage, as the required notice and certification included in the Temporary Safe Harbor provides that the health plan of the religious organization must not have provided contraceptive coverage at any time after February 10, 2012.

There are certain religious organizations that would not be able to issue the notice and certification in its present form because they provide some, but not all, of the FDA-approved contraceptive services for women. This fact was explained during the meeting between HHS and representatives of several Church Alliance Members on April 4, 2012.

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[7] H.B. 2625, amending Ariz. Rev. Stat. §§ 20-826, 20-1057.08, 20-1402, 20-1404 and 20-2329.

However, despite the wording of the notice included in the Temporary Safe Harbor, the ANPRM states:

> The bulletin established a temporary enforcement safe harbor for group health plans sponsored by non-profit organizations that, on or after February 10, 2012, do not provide *some or all* of the contraceptive coverage otherwise required, consistent with any applicable State law, because of the religious beliefs of the organization (and any group health insurance coverage provided in connection with such plans). (emphasis added)

The ANPRM was the first time that the Departments acknowledged in their formal guidance that there are group health plans of religious organizations providing some, but not all, contraceptive services based on these organizations' religious convictions regarding the sanctity of life. The health plan coverage of contraceptive services varies among religious organizations. For example, some organizations will cover certain prescriptions for birth-control purposes only, others will also cover sterilization for women and men, and still others will cover contraceptives only for non-contraceptive purposes (for instance, if used in conjunction with the treatment of cervical cancer). Some religious organizations cannot cover contraceptives that are or may be abortifacients. The position of these religious organizations is deeply rooted in their religious beliefs and convictions regarding the beginning of life.

These religious organizations need an accommodation to continue to provide preventive and medical coverage of contraceptive services that is consistent with their religious beliefs.

4. The proposed accommodation should extend <u>beyond</u> organizations that qualify for the Temporary Safe Harbor to include organizations that inadvertently provided (or provide) contraceptives contrary to the terms of the plan

In order to qualify for the Temporary Safe Harbor an institution cannot have provided contraceptive coverage on account of religious objections. Some religious employers with insured plans have discovered that their insurance policies inadvertently provided contraceptive coverage, sometimes on account of the sponsoring employer's insurance broker failing to follow the employer's instructions. Similarly, some religious employers with self-funded plans have discovered that their third party service providers inadvertently provided contraceptive coverage contrary to the employer's instructions. These employers should not be excluded from the final accommodation.

B. Application of the Proposed Accommodation to Self-Insured Plans

1. Religious organization should not be required to switch from self-insured to insured plans

The ANPRM indicates that religious organizations that currently self-insure their employee benefit plans could avoid any involvement in providing contraceptive benefits by insuring their plans. 77 Fed. Reg. at 16507. Setting aside that they may object to providing such

benefits even on an insured basis,[8] religious organizations should not have to give up the cost savings associated with self-insurance to accommodate their religious beliefs.

2. Third party administrators are not the appropriate parties to provide contraceptive coverage

The ANPRM indicates that the Departments may impose upon third party administrators (TPAs) the obligation to provide contraceptive coverage in a self-insured plan. TPAs are not the appropriate parties to provide contraceptive coverage for a number of reasons, including the following:

- some church plans have TPAs that are themselves religious organizations, which could not administer contraception coverage programs without violating their religious beliefs;
- TPAs are not licensed to provide contraceptive coverage on a self-insured basis and may not be able to purchase such coverage on an insured basis on account of state insurance laws;
- TPAs would not be able to be paid for their services regarding the provision of contraceptive coverage from drug rebates, service fees, disease management program fees because these fees are typically credited against the fees payable by the employers covered by the plan for the TPA's administrative services. (Retention of these fees by TPAs without crediting them to the employers could violate state law.); and
- TPAs are unlikely to be paid for their services by third-parties.

3. Insurers offering multi-state plans in each state could provide contraceptive coverage

The ANPRM indicates that the Departments could impose the obligation to provide contraceptive coverage on insurers that offer multi-State plans. The key advantage to this proposal is that it generally removes the religious organization from the process of providing contraceptive coverage. It is also a less restrictive manner of providing contraceptive coverage within the meaning of the RFRA. Nevertheless, the Church Alliance has some concerns about this possible accommodation.

One possible method of implementation would require the TPA of an accommodated organization to provide the Office of Personnel Management with the names and addresses of plan participants, for this information to then be transmitted to a private insurer. It seems unlikely that the TPA would provide this additional service to an accommodated organization at no charge.

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[8] See Section II.C *infra* at 11.

We also are concerned about the provision of such private information about our plan participants to multiple outside entities. For example, health plans are bound by the Health Insurance Portability and Accountability Act ("HIPAA") to keep such information confidential. What assurances would the accommodated organizations have that the recipients of this information would abide by those privacy and security requirements? Even if HIPAA requirements would be imposed on those recipients, who would be responsible when a breach occurs, as one invariably will, since so much private information routinely will be transmitted multiple times? What assurances will the accommodated organizations have that the insurers will not otherwise misuse, lose, or use such information for commercial purposes, such as for marketing or sales purposes?

Moreover, with the transmission of participants' names and addresses for the purpose of providing contraceptive coverage, the objecting organizations would be cooperating in the provision of objectionable coverage to their participants.

One workable solution — and perhaps the only workable solution — to both the practical issues and the religious conscience problems triggered by having religious employers involved at all in providing contraceptive coverage in violation of their religious tenets and beliefs is only to require such an objecting organization to provide a notice to plan participants, stating that it does not provide the objectionable coverage. Plan participants then would be responsible for obtaining coverage from insurers that offer such coverage. In order to obtain the coverage, the participants could provide a copy of the notice from the objecting organization, as evidence of the need for such free coverage.

C. Application of the Proposed Accommodation to Insured Plans

Our comments on the ANPRM are primarily directed to the application of the proposed accommodation to self-insured plans. With respect to insured plans, the ANPRM notes that the Departments intend to:

> require issuers to offer group health insurance coverage without contraceptive coverage to such an organization (or its plan sponsor) and simultaneously to provide contraceptive coverage directly to the participants and beneficiaries covered under the organization's plan with no cost sharing. 77 Fed. Reg. at 16503.

The ANPRM notes that "[a]ctuaries and experts have found that coverage of contraceptives is at least cost neutral, and may save money, when taking into account all costs and benefits for the issuer." 77 Fed. Reg. at 16503. We are highly skeptical of the claim that the provision of contraceptives is at least cost neutral, especially with respect to a population of gainfully employed individuals whose employers provide them with health coverage. The authority cited by the ANPRM for this proposition is an internal Issue Brief prepared by HHS officials that does not make clear which "contraceptives" it is talking about. The study cited by the Issue Brief for the proposition that there is no cost to providing contraceptives coverage

appears to focus only on prescription contraceptives.[9] We suspect that many of the academic studies looking at this issue focused on oral contraceptives, which are both generally available and inexpensive. Planned Parenthood indicates that birth control pills may be available for as little as $15 per month and anecdotal reports indicate that generic birth control pills may be available for as little as $4 per month. However, according to Planned Parenthood, sterilization for women (tubal sterilization) can cost up to $6,000.[10]

Even if the provision of contraceptive coverage is cost neutral or better in the long run, in the short run it isn't, so at least initially, the employer is contributing to the cost of contraceptive coverage under an insured plan.

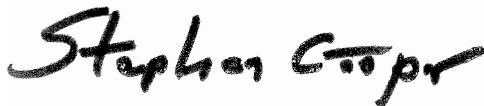
Finally, the proposed accommodation for insured plans – as well as self-insured plans – fails to address the religious liberty concerns of religious organizations that object to the provision of contraceptive services based on religious beliefs. The proposed accommodation still requires an objecting non-exempt religious organization to serve as a conduit for objectionable services for its own employees. Typically, a religious organization's religious tenets and beliefs do not distinguish between providing objectionable contraceptive services directly or knowingly committing this moral offense through a third party. Only an exemption from the requirement to provide such objectionable services will suffice.

III. SUMMARY

We appreciate the Departments' efforts to "accommodate" the religious tenets and beliefs of religious employers. However, it seems that the only workable solution for self-insured plans is to have the contraceptive coverage provided by a third party with no direct or indirect involvement by the religious employers.

Please contact the undersigned at 202-661-3882 if you have any questions or wish to discuss this matter further.

Sincerely,



Stephen H. Cooper
Government Affairs Counselor, K&L Gates
On Behalf of the Church Alliance

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[9] National Women's Law Center, "Covering Prescription Contraceptives in Employee Health Plans: How this Coverage Saves Money," May 2006, available at: http://www.cluw.org/PDF/ContraceptiveCoverageSavesMoney.pdf.

[10] See, http://www.plannedparenthood.org/health-topics/birth-control/sterilization-women-4248.htm. Male sterilizations (vasectomies) are not covered by the contraceptive mandate. See ANPRM, 77 Fed. Reg. 16504 n. 2.