Jacobs Institute
of Women's Health
THE GEORGE WASHINGTON UNIVERSITY

March 31, 2023

Internal Revenue Service, Department of the Treasury
Employee Benefits Security Administration, Department of Labor
Centers for Medicare & Medicaid Services, Department of Health and Human Services

Re: Coverage of Certain Preventive Services Under the Affordable Care Act (RINs 0938-AU94; 1210-AC13; 1545-BQ35)

The Jacobs Institute of Women's Health at The George Washington University Milken Institute School of Public Health appreciates the opportunity to comment on the notice of proposed rulemaking (NPRM) "Coverage of Certain Preventive Services Under the Affordable Care Act," RINs 0938-AU94, 1210-AC13, 1545-BQ35.

The mission of Jacobs Institute of Women's Health is to identify and study aspects of healthcare and public health, including legal and policy issues, that affect women's health at different life stages; to foster awareness of and facilitate dialogue around issues that affect women's health; and to promote interdisciplinary research, coordination, and information dissemination, including publishing the peer-reviewed journal *Women's Health Issues*. We represent an interdisciplinary group of affiliated faculty members who are experts in research, health policy, and medical care related to women's health.

This comment focuses specifically on the proposed *Individual Contraceptive Arrangement for Eligible Individuals*. A major concerning aspect of the proposed rule is a two-fold assumption: (1) that a geographic area has 10 clinicians who can provide contraception, and (2) that those 10 clinicians will provide contraception under this rule. We note some aspects of this assumption that should be addressed before the rule is finalized.

First, "geographic area" is not well-defined. There may be substantial differences in the number of contraception providers per area when examined by county, state, or region level. We propose clarifying what "geographic area" means in relation to established definitions such as state, county, region, or similar.

Second, we know from available data that the number of contraception prescribers varies substantially across counties, states, and regions,[1] even before the introduction of this arrangement. Recent research led by some of our faculty at The George Washington University found that over 1,000 counties had fewer than 10 prescribers of prescription contraception.[2] On average, counties had 4.6 prescribers of the pill, patch, and ring per 1,000 reproductive aged women, but this is not evenly distributed across states or counties; nearly half a million reproductive aged women lived in counties with at most one prescriber per 1,000 women. Even assuming that all current prescribers of contraception will opt into the Arrangement, nearly a third of the 3,142 counties in the US will not meet the minimum number of providers specified. The assumption should reflect the state of current evidence on the workforce providing this care.

Third, the proposed rule also assumes that 10 pharmacies in a geographic area will participate, in addition to the 10 individual providers described above. As we have argued in a recent publication,[3] pharmacists are critical members of the workforce providing contraception care, but a number of policy and practice barriers may hinder them from doing so. Smaller, independent pharmacies may have particular barriers to participation, and the rule suggests that participating pharmacies will primarily be larger chains. However, independent pharmacies make up 30% of all pharmacies in the US.[4] To include this piece of the contraceptive access picture, the proposed rule should include measures to reduce administrative burden in order to support participation by independent pharmacies.

Lastly, accessibility to pharmacies will vary, and pharmacy access is important to recognize as a health equity issue. In 2021, 8% of rural counties did not have a retail pharmacy of any kind and 44% did not have a chain pharmacy.[5] There are also disproportionately fewer pharmacies in Black and Hispanic/Latinx neighborhoods compared to white neighborhoods.[6] Individuals may need to travel further than they already do to visit a pharmacy participating in the individual contraceptive arrangement. These individuals may have a limited selection of contraception providers to begin with,

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[1] Chen C, Strasser J, Banawa R, Luo Q, Bodas M, Castruccio-Prince C, Das K, Pittman P. (2022). Who is providing contraception care in the United States? An observational study of the contraception workforce. *American Journal of Obstetrics & Gynecology,* 226(2):232.e1-232.e11

[2] Fitzhugh Mullan Institute for Health Workforce Equity. (2023). 2019-2021 Prescription Contraception Workforce Tracker. Washington, DC: George Washington University. https://www.gwhwi.org/tracker-contraception-workforce.html

[3] Strasser J & Schenk E. (2023). Prescribing Authority for Pharmacists is Integral to Protecting Reproductive Health and Rights. *Health Affairs Forefront*, March 21,2023. https://www.healthaffairs.org/content/forefront/prescribing-authority-pharmacists-integral-protecting-reproductive-health-and-rights

[4] IQVIA. (2021). U.S. National Pharmacy Market Summary 2021: Market Insights Report. https://www.onekeydata.com/downloads/reports/IQVIA_OneKey_US_Pharmacy_Market_Summary_September_2021.pdf

[5] Constantin J, Ullrich F, Mueller KJ. (2022). Rural and Urban Pharmacy Presence – Pharmacy Deserts. Rural Policy Research Institute Center for Rural Health Policy Analysis. https://rupri.public-health.uiowa.edu/publications/policybriefs/2022/Pharmacy%20Deserts.pdf

[6] Guadamuz JS, Wilder JR, Mouslim MC, Zenk SN, Alexander GC, Qato DM. (2021). Fewer Pharmacies In Black And Hispanic/Latino Neighborhoods Compared With White Or Diverse Neighborhoods, 2007-15. *Health Affairs*, 40(5):802-811.

and the number of providers who participate in the individual contraceptive mandate may be even smaller. As the proposed rule suggests, patients may need to find a new contraception provider if their current provider or pharmacy does not choose to participate. While this rule cannot, on its own, solve the challenge of equitable access to pharmacy services, it is important to recognize the disparate impact it may have on different communities.

Thank you for this opportunity to comment in response to the NPRM. If you have any questions, please contact Jacobs Institute managing director Liz Borkowski at 202-994-0034 or borkowsk@gwu.edu.