TOSS UP

Federal Legislative and Regulatory Action on Family Planning and Sexual Health in 2013

National
Family Planning
& Reproductive Health Association

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Introduction

2013 was a year of breakthroughs and breakdowns, of turning points and déjà vu. In some ways, it held the same political fights and ideological rancor as in recent years; yet in other ways, 2013 was a year of great change, as the health reform law turned from promise to reality. For family planning and sexual health, it was a year of wins and losses, of highs and lows. The constant, however, in the toss-up year that was 2013, was the dedication and commitment of the nation's publicly funded family planning providers to ensuring access to high-quality family planning and sexual health services for all.

The year began much as the previous one ended, with Congress locked in an ongoing battle over federal spending. The term "sequestration" entered the public lexicon as the first round of spending cuts required by 2011's Budget Control Act took effect. The impact was felt across the country, as nearly all non-defense discretionary federal funding – from education to public health – took a 5-9% funding cut. Agencies were forced to cut spending, furlough workers, and scale back programs on which millions of Americans rely. After sequestration, an across-the-board rescission, and an intra-departmental transfer, Title X's funding was cut to $278.3 million – its lowest funding level in a decade.

Congress continued to wage war with itself through the remainder of the fiscal year, debating the impacts of sequestration even as it considered further funding cuts. As the beginning of a new fiscal year neared with no consensus on spending levels, House Republicans added a new wrinkle: they would not pass a funding bill for fiscal year (FY) 2014 unless it included anti-Affordable Care Act (ACA) amendments. Despite frantic negotiations in the final days, congressional leaders and the White House remained at an impasse, and at midnight on October 1, 2013, the federal government shut down for the first time in 16 years.

Ironically, the first day of the government shutdown coincided with the first day that Americans could enroll in insurance coverage through the ACA's health insurance marketplaces. The US Department of Health and Human Services (HHS) spent much of 2013 finalizing regulations and moving resources to prepare for the launch of open enrollment, as many states worked frantically to make decisions and implement the procedures and infrastructure needed to enroll patients into coverage. Medicaid eligibility expanded in 25 states and the District of Columbia, but researchers made it clear that even in the non-expansion states, Medicaid enrollment would increase thanks to the "welcome-mat" effect.

The first month of open enrollment was plagued with technical problems, which some used to bolster their arguments that the ACA should be repealed. However, by year's end, many of the technical issues had been resolved, and millions – though fewer than the Obama administration had hoped for – enrolled in commercial insurance and Medicaid in time to receive coverage as of January 1, 2014.

Despite these problems, the ACA is finally in effect, and with it comes the reality that millions of uninsured will now have coverage, some for the first time. Because of the ACA, this coverage will include essential health benefits like preventive care, disease screening, and annual exams. Because of the ACA, millions will now have a means of paying for their family planning and sexual health services, which will reduce barriers for low-income individuals seeking care and help offset costs to publicly funded family planning providers, better enabling them to help meet the unmet need that will remain.

Section I: Publicly Funded Family Planning: Budget and Appropriations

Surviving the Fiscal Cliff: A Gridlocked Start to 2013

After a long, tumultuous 2012 election cycle and an unproductive "lame duck" session, members of Congress returned to Washington in December 2012 from a truncated winter holiday recess to avert a "fiscal cliff" of expiring tax cuts and deficit reduction measures set to take place at the start of the new year. Following the Joint Select Committee on Deficit Reduction's failure to produce an agreement containing $1.2-$1.5 trillion in spending reductions over ten years (as required by the "Budget Control Act of 2011"), a series of automatic, across-the-board spending cuts known as "sequestration" were set to go into effect on January 2, 2013.[1] Additionally, a number of tax and payment extensions were set to expire, including the Bush tax cuts of 2001 and 2003, as well as an adjustment to the payment calculation for physicians who provide care to Medicare patients (known as the "Sustainable Growth Rate" or SGR).[2] With these issues culminating at the same time, policy and opinion elites across the nation adopted the term "fiscal cliff" because if Congress could not produce legislation to address these issues, the United States' economy was expected to be negatively impacted at levels similar to that of the Great Depression.

To help educate the membership on the budget, NFPRHA produced a weekly series in *Reproductive Health Watch* entitled "Facing the Fiscal Cliff: A Look at the Current Federal Budget and Deficit Reduction Proposals" which took a closer look at the various proposals being considered to reduce the deficit, and avoid sequestration.

After much debate that lasted right up to the final hour, on January 2, 2013, President Barack Obama signed into law H.R. 8, the "American Taxpayer Relief Act of 2012," which delayed sequestration until March 1, 2013, through a combination of other spending cuts and revenue increases.[3] The bill also contained modifications to the Affordable Care Act (ACA), including a retraction of $1.9 billion in loans to states to create Consumer Operated and Oriented Plans (CO-OPs), plans that were to be offered by non-profit health issuers in the marketplaces, and a repeal of the "Community Living Assistance Services and Support program (CLASS) Act," a public, long-term care insurance option.[4] The measure passed the House of Representatives by a vote of 257-167, with some Republican support.[5] The bill had previously passed the Senate on January 1, 2013, on a bipartisan vote of 89 to 8.[6]

Congress Continues Budget Negotiations with Little Agreement

With a new March deadline looming, Congress continued budget negotiations. Both parties put forth proposals that were more vehicles for political messaging than proposals formed to gain enough bipartisan traction to pass. President Obama and congressional Democrats emphasized the "devastating" impact sequestration would have on critical federal programs.

NFPRHA staff, as a part of the Coalition for Health Funding, participated in a series of meetings with top White House officials advocating against additional cuts to non-defense discretionary funding, including Title X.

1 National Women's Law Center, *A Roadmap to the 2013 Federal Budget Debates*, May 2013, http://www.nwlc.org/sites/default/files/pdfs/federalbudgetroadmap.pdf.

2 Congressional Budget Office, *Economic Effects of Reducing the Fiscal Restraint That Is Scheduled to Occur in 2013*, May 2012, http://cbo.gov/sites/default/files/cbofiles/attachments/FiscalRestraint_0.pdf.

3 Matt Smith, "Obama signs bill warding off fiscal cliff," *CNN*, January 3 2013, http://www.cnn.com/2013/01/02/politics/fiscal-cliff.

4 American Taxpayer Relief Act of 2012, Public L. No. 112-240, 126 Stat. 2313 (2013). For more on the Affordable Care Act, see the "Affordable Care Act" section starting on page 15.

5 Vote 659, US House of Representatives Roll Call Votes, 113th Cong. (2013), January 1, 2013, http://clerk.house.gov/evs/2012/roll659.xml.

6 Vote 251, US Senate Roll Call Votes, 112th Cong. (2013), January 1, 2013, http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=112&session=2&vote=00251.

On February 8, the White House released a fact sheet on the impact of sequestration, highlighting many non-defense discretionary programs that would face cuts.[7] House Appropriations Democrats released similar documents that outlined the effects of discretionary cuts up to that time (pre-sequestration), including a report from House Democrats outlining the projected impact of sequestration on health programs.[8] In late February, the Office of Management and Budget (OMB) provided new information about how sequestration could impact programs that disperse funds on varying grant cycles, like Title X and the federally qualified health center (FQHC) program. Depending on their specific grant cycle, OMB projected Title X grantees faced cuts between 5.1% and 9%.

Along with 20 other leaders from women's and public health organizations, NFPRHA's President & CEO Clare Coleman participated in a Senate Democratic Steering and Outreach Committee meeting where she alerted senators to the impact of sequestration and continued budget cuts on the publicly funded family planning network.

Over the Fiscal Cliff: Title X Cut by $14.9 Million

Despite the extension for lawmakers to reach consensus on the budget crisis, Congress was unable to reach an agreement and on March 1, 2013, OMB released its official order directing agencies to implement sequestration.[9] OMB projected the reductions for non-defense discretionary programs could reach as high as 9% due to the fact that the cuts were now required to be reached within the remaining seven months of the fiscal year rather than spread out over the original term of the full fiscal year.[10]

NFPRHA hosted an emergency membership-wide call, released a "Sequestration 101" fact sheet, and collaborated with the Center for American Progress on an article outlining the impact of sequestration on the Title X network.

Notably, many Title X grantees with grant cycles starting January 1, reported that they received reductions in their initial grant awards in anticipation of the sequester. In the Health Resources and Services Administration's (HRSA) fiscal year (FY) 2013 operating plan that was released in May, the agency revealed that Title X did indeed take a 5% cut, reducing its funding by $14.9 million in 2013.[11] During this same period, HRSA's overall discretionary authority decreased $366 million to just more than $5.8 billion. Including sequester cuts, rescissions, and a US Department of Health and Human Services (HHS) department transfer, Title X program funding was reduced from its FY 2012 funding of $293.9 million to $278.3 million for FY 2013.[12]

The Funding War Continues with Sequester Intact

The week after sequestration took effect, the House Appropriations Committee released its appropriations legislation for the remainder of FY 2013. The legislation not only kept sequestration in place but also included an additional across-the-board cut of 0.098% to non-security discretionary programs. The legislation, H.R. 933, also included a full year of defense, military construction, and veterans' affairs appropriations.[13]

Despite strong partisanship on both sides of the aisle, Senate Appropriations Chairwoman Barbara Mikulski (D-MD) and Ranking Member Senator Richard Shelby (R-AL) attempted to return to the regular order of passing actual funding legislation rather than continuing the recent practice of passing temporary continuing resolutions (CRs). While their bipartisan proposal did not fix the sequester either, it did include full FY 2013 appropriations bills for Agriculture; Commerce, Justice and Science; Defense; Homeland Security; and the Military Construction and Veterans Affairs Appropriations Acts. It contained CR provisions for the remaining federal departments, including Labor, Health and Human Services, and Related Agencies (Labor-HHS).[14]

7 White House, *Fact Sheet: Examples of How the Sequester Would Impact Middle Class Families, Jobs and Economic Security*, February 8, 2013, http://www.whitehouse.gov/the-press-office/2013/02/08/fact-sheet-examples-how-sequester-would-impact-middle-class-families-job.

8 House Appropriations Committee Democrats, *Report on Sequestration*, February 13, 2013, http://www.democrats.appropriations.house.gov/images/user_images/gt/sequester%20full%20report.pdf.

9 Executive Office of the President of the United States, Office of Management and Budget, *Memorandum: Issuance of the Sequestration Order Pursuant to Section 251A of the Balanced Budget and Emergency Deficit Control Act of 1985, as Amended*, March 1 2013, http://www.whitehouse.gov/sites/default/files/omb/memoranda/2013/m-13-06.pdf.

10 Executive Office of the President of the United States, Office of Management and Budget, *OMB Report to the Congress on the Joint Committee Sequestration for Fiscal Year 2013*, March 1 2013, http://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/fy13ombjcsequestrationreport.pdf.

11 US Department of Health and Human Services, Health Resources and Services Administration, *Sequestration Operating Plan for FY 2013*, May 9, 2013, http://www.hrsa.gov/about/budget/operatingplan2013.pdf.

12 Ibid.

13 Consolidated and Further Continuing Appropriations Act, 2013, H.R. 933, 113th Cong. (2013), http://www.gpo.gov/fdsys/pkg/BILLS-113hr933enr/pdf/BILLS-113hr933enr.pdf.

14 Ibid.

NFPRHA staff provided the Senate Democratic Policy and Communications Committee with information about Title X to help them assemble state-by-state fact sheets on the potential impact of the House Republican budget on women.

During the Senate debate, the Senate rejected an amendment to the legislation offered by Senator Tom Harkin (D-IA), which would have substituted a full FY 2013 Labor-HHS appropriations bill, by a vote of 54-45 - the vote failed to reach the 60-vote threshold required by Senate rules for passage.[15] The amendment would have flat-funded most programs, including Title X at $293.9 million, and applied a 0.127% across-the-board cut to all programs to comply with previously set spending caps; however, Senate Democrats were unable to support Chairman Harkin's amendment for fear the entire legislation might fall apart.[16] The Senate's overall funding package was passed by 73-26 on March 20, 2013.[17] On March 21, 2013, by a vote of 318-109,[18] the House of Representatives approved the Senate package, which the president signed into law, bringing an end to at least the FY 2013 appropriations process. Unfortunately, because the final agreement did not include a fix to sequestration, the 5% cut to Title X stayed in effect.

FY 2014 Budget Blueprints – Senate and House Produce Polar Opposite Agendas

On March 12, 2013, House Budget Chairman Paul Ryan (R-WI) unveiled the "Path to Prosperity," House Republicans' budget proposal, for FY 2014.[19] The proposal was nearly identical to his previous editions – containing significant cuts to Medicare, Medicaid, and discretionary spending, as well as eliminating the ACA. The Ryan proposal would have reduced the deficit $4.6 trillion over ten years, and transformed Medicaid into a "block grant" that would essentially cap the amount of money spent on the program each year.[20] As expected, the legislation quickly passed the House of Representatives by a party-line vote of 221-207.[21]

On the same day as the House Budget Committee voted to pass the "Path to Prosperity," Senate Budget Committee Chairman Patty Murray (D-WA) released the Democratic budget proposal for FY 2014. The "Foundation for Growth: Restoring the Promise of American Opportunity," proposed to replace the sequester and achieve $1.85 trillion of savings over 10 years through a mix of spending cuts and tax increases, mostly through reforming the tax code.[22] The spending cuts included $240 billion from defense, and $493 billion from domestic programs, including $265 billion from Medicare and $10 billion from Medicaid, with the instruction that any cuts to those two programs were prohibited from negatively impacting beneficiaries.[23] The proposal also contained strong protections for women and vulnerable families, including calls to support funding for women's health care programs. The legislation also strongly supported the Medicaid expansion under the ACA.[24] The stark differences between the Republican and Democratic proposals set the tone of what would become another contentious appropriations season. For the first time in more than four years, on March 23, 2013, the Senate approved a budget: Chairman Murray's budget passed by a slim margin of 50-49.[25] The legislation only needed a simple majority because no senators invoked the rules of a filibuster to raise the passage threshold to 60, presumably because the previously passed "No Budget, No Pay Act" required passage of a budget no later than April 15, or senators' salaries would be held in escrow until a budget was passed.[26]

During the final floor debate, multiple senators introduced numerous amendments pertaining to family planning and sexual health care. By a bipartisan vote of 56-43, the Senate adopted an amendment introduced by Senators Jeanne Shaheen (D-NH) and Debbie Stabenow (D-MI) that allowed the budget chair to revise funding caps for women's health and family

15 Vote 36, US Senate Roll Call Votes, 113th Cong. (2013), March 14, 2013, http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=113&session=1&vote=00036.

16 Staff Report, "Harkin Amendment Will Offer Negotiated FY 13 Labor, Health, Education Bill to Continuing Appropriations Act," Office of Senator Tom Harkin (D-IA) (blog), March 12, 2013, http://www.harkin.senate.gov/blogitem.cfm?i=6c9150b9-61c2-4e37-ab1a-51b78e302f98.

17 Vote 44, US Senate Roll Call Votes, 113th Cong. (2013), March 20, 2013, http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=113&session=1&vote=00044.

18 Vote 89, US House of Representatives Roll Call Votes, 113th Cong. (2013), March 21, 2013, http://clerk.house.gov/evs/2013/roll089.xml.

19 US House of Representatives Budget Committee, *The Path to Prosperity: A Responsible, Balanced Budget: Fiscal Year 2014 Budget Resolution*, March 2013, http://budget.house.gov/uploadedfiles/fy14budget.pdf.

20 Ibid. For information on Medicaid-funded family planning, see the "Publicly Funded Family Planning: A Programmatic Look" section, starting on page 28.

21 Susan Davis, "House narrowly passes Paul Ryan's budget plan," *USA Today*, March 21, 2013, http://www.usatoday.com/story/news/politics/2013/03/21/house-ryan-budget-balance-medicare/2005613.

22 US Senate Budget Committee, *The Foundation for Growth: Restoring the Promise of American Opportunity: Fiscal Year 2014 Budget Resolution*, March 2013, http://www.budget.senate.gov/democratic/public/index.cfm/fiscal-year-2013-budget.

23 Fiscal Year 2014 Senate Budget Resolution, S. Con. Res. 8, 113th Cong. (2013).

24 US Senate Budget Committee, *The Foundation for Growth: Restoring the Promise of American Opportunity*: Fiscal Year 2014 Budget Resolution.

25 Vote 92, US Senate Roll Call Votes, 113th Cong. (2013), March 23, 2013, http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=113&session=1&vote=00092.

26 Ted Barrett and Alison Harding, "Senate passes its first budget proposal in four years," *CNN*, March 23, 2013, http://www.cnn.com/2013/03/23/politics/senate-budget-bill/.

planning-related programs.[27] Republican Senators Susan Collins (R-ME), Lisa Murkowski (R-AK), and Mark Kirk (R-IL), broke party lines to support the measure. Senators Mike Lee (R-UT), David Vitter (R-LA), and Marco Rubio (R-FL), each introduced anti-choice amendments, including a 20-week abortion ban for DC and a bill to criminalize individuals who help minors cross state lines to obtain an abortion.[28] None of these amendments were called for a vote. The Senate also defeated an amendment offered by Senator Ted Cruz (R-TX), which called for the full repeal of the ACA.[29]

President Obama Releases FY 2014 Budget: A Victory for Title X

On April 10, the White House released President Obama's FY 2014 budget request. Similar to the budget proposal passed by the Senate, the president's budget replaced sequestration. NFPRHA was elated that while the president's FY 2014 budget request proposed level funding for several other public health programs, the budget mirrored the reproductive health community's request of $327.4 million for Title X, an increase of $33.1 million over FY 2012 funding.[30] The budget proposal protected Medicaid and maintained the program's current state-federal partnership, avoiding many administrative changes included in the House-passed budget that would have shifted costs to states and potentially undermined access to care.[31] While the proposal did modify the current abortion ban for Peace Corps volunteers by allowing the Hyde-permissible exceptions of rape, incest, and life of the woman, the president's budget failed to delete the harmful Hyde language which prohibits the use of federal Medicaid funds for abortion, except in those limited circumstances.

NFPRHA President & CEO Clare Coleman, Planned Parenthood Federation of America President Cecile Richards, and National Women's Law Center Co-President Marcia Greenberger met with key Office of Management and Budget (OMB) officials, advocating for continued support of the Title X family planning program at $327 million for FY 2014.

Mirroring the same request as the FY 2013 budget proposal, the president again signaled the administration's support for two activities impacting family planning and sexual health. First, the budget proposed $3 million for the Center for Disease Control and Prevention's (CDC) Division of Adolescent and School Health (DASH) for evaluation of HIV school health activities.[32] Second, President Obama's budget would have set aside $13 million for the creation of a "Foster Youth Pregnancy Prevention Initiative" to provide competitive funds to state or local child welfare agencies with innovative plans to reduce pregnancy for youth in foster care.[33] The funds would have come from unspent Title V abstinence-only education funding. While the president's budget did not receive a congressional vote, it set a precedent for increased Title X funding that Senate Democrats would soon follow.

Title X Champions Call for Increased Funding

Soon after the president released his FY 2014 budget, members of Congress began circulating their annual appropriations letters supporting various federal programs. As they had in the past, Representative Joseph Crowley (D-NY) and Senator Barbara Boxer (D-CA) led the Title X letter which also requested $327.4 million - equal to the president's request. Unfortunately, House Republicans were unwilling to cede ground on the need for increased discretionary public health funding. House Appropriations Chairman Hal Rogers (R-KY) approved 302(b) allocations (the amount of funding allocated for spending bills) for the Labor-HHS bill that was more than 18% below FY 2013 sequestration funding levels.[34] The committee approved the allocations over the objections of House Democrats as well as a handful of Republicans nervous about the backlash certain to occur from attempting to pass a bill with such drastic cuts. An

27 Vote 54, US Senate Roll Call Votes, 113th Cong. (2013), March 22, 2013, http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=113&session=1&vote=00054.

28 NARAL Pro-Choice America, "Anti-Choice Amendments Piling Up on Senate Budget plan – Urgent Action Needed," *Blog for Choice* (blog), March 21, 2013, http://www.blogforchoice.com/archives/2013/03/now-that-congre.html. For more information on abortion policies, see the "Access to Abortion Care" section, starting on page 38.

29 Vote 51, US Senate Roll Call Votes, 113th Cong. (2013), March 22, 2013, http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=113&session=1&vote=00051.

30 Executive Office of the President of the United States, Office of Management and Budget, *Fiscal Year 2014 Budget of the U.S. Government*, April 2013, http://www.whitehouse.gov/sites/default/files/omb/budget/fy2014/assets/hhs.pdf.

31 For more on Medicaid-funded family planning, see the "Publicly Funded Family Planning: A Programmatic Look" section starting on page 28.

32 Executive Office of the President of the United States, Office of Management and Budget, *Fiscal Year 2014 Budget of the U.S. Government*. For information on additional public health achievements, see the "Family Planning Services and Supplies" section, starting on page 34.

33 Ibid.

34 House of Representatives Appropriations Committee, *Report on the Suballocation of Budget Allocations for Fiscal Year 2014*, June 2013, http://www.researchamerica.org/uploads/fy14302ballocations.pdf.

amendment offered by Ranking Member Nita Lowey (D-NY), to postpone consideration of the 302(b) allocations to give the House and Senate time to reconcile their different budgets, failed on a party-line vote.[35]

Thanks to the outreach efforts of NFPRHA members and national partners, both Title X congressional appropriations letters closed with a record number of signatories. The House letter closed with 139 signatures, up from 112 the previous year, and the Senate letter closed with 37, up from 33 in 2012.

Towards the end of July, it was announced that the House Labor-HHS Subcommittee would mark up their Labor-HHS bill. However, on July 24, the subcommittee backtracked, postponing the markup.[36] A new date was never set. Continuing the steady drumbeat for the need to return to regular order, House Appropriations Ranking Member Lowey and Labor-HHS Subcommittee Ranking Member Rosa DeLauro (D-CT) sent a letter to House Appropriations Chairman Rogers and Labor-HHS Subcommittee Chairman Jack Kingston (R-GA) calling for a full markup of the FY 2014 Labor-HHS bill in early September.[37]

While Congress continued to debate the fiscal crisis, NFPRHA President & CEO Clare Coleman, as well as other NFPRHA staff, delivered presentations focused on the changing health care system and the implementation of the ACA during the biennial Title X Grantee meeting in July.

In the Senate, Labor-HHS Subcommittee Chairman Harkin, along with his Democratic colleagues, approved its FY 2014 Labor-HHS funding bill.[38] Shortly thereafter, the full Senate Appropriations Committee approved the measure by 16 to 14.[39] The bill would have provided $164.3 billion in total for all programs, approximately $7.8 billion above the FY 2013 pre-sequestration levels.[40] This legislation matched the president's Title X request, as well as NFPRHA's request, at $327.4 million. As with President Obama's budget, the Senate proposal did not take into account that sequestration was in effect.

The FY 2014 Senate Labor-HHS Appropriations Subcommittee also proposed:

- Level funding for the Teen Pregnancy Prevention Initiative (TPPI) at $113.2 million, including approximately $105 million for grants and $8.2 million for TPPI evaluation.
- Increased funding for the CDC's DASH by $1.55 million over FY 2013 actual to $29.8 million.
- Increased funding for community health centers by $700 million, slightly above the president's request of $3.76 billion. This funding would have included both discretionary funds, as well as funds mandated by the ACA.
- Level funding for the Prevention and Public Health Fund, a mandatory program, at $1 billion, the same as in FY 2013, and equal to the amount requested by the president.

While there were no amendments related to women's health introduced during the markup, Senate Republicans did introduce a number of unsuccessful amendments to dismantle portions of the ACA, including repealing the Independent Payment Advisory Board (IPAB), defunding the marketplaces (also known as exchanges), and delaying the employer and individual insurance coverage mandates.[41]

35 Dave Moore, "House Republican Appropriators Propose to Slash HHS Funding," Association of American Medical Colleges *Washington Highlights* (blog), May 24, 2013, https://www.aamc.org/advocacy/washhigh/highlights2013/343370/052413houserepublicanappropriatorsproposetoslashhhsfunding.html.

36 "Postponed: Subcommittee Markup - FY 2014 Labor, Health and Human Services, and Education," official website of the US House of Representatives, Committee on Appropriations, accessed March 2014, http://appropriations.house.gov/calendar/eventsingle.aspx?EventID=343432.

37 Niels Lesniewski, "Appropriations Democrats Seek Labor-HHS-Education Markup," *Roll Call*, September 6, 2013, http://blogs.rollcall.com/218/appropriations-democrats-seek-labor-hhs-education-markup/.

38 Office of Senator Tom Harkin (D-IA), "Summary: Fiscal Year 2014 Labor, Health and Human Services, and Education, and Related Agencies Appropriations Bill: Subcommittee Mark," news release, July 9, 2013, http://www.harkin.senate.gov/press/release.cfm?i=345284.

39 United States Senate Committee on Appropriations, "Appropriations Committee Approves FY 2014 Labor-HHS-Education and Legislative Branch Bills," news release, July 11, 2013, http://www.appropriations.senate.gov/news/appropriations-committee-approves-fy-2014-labor-hhs-education-and-legislative-branch-bills.

40 Ibid.

41 "Senate Appropriations Committee - Markup of FY14 Labor, HHS, Education and Related Agencies Appropriations Bill," *Friends of Cancer Research* (blog), July 11, 2013, http://www.focr.org/july-11-2013-senate-appropriations-committee-markup-fy14-labor-hhs-education-and-related-agencies. For more on the health care marketplaces, see the "Affordable Care Act," section starting on page 15.

A Series of Volleys Before the Government Shutdown

Given the dramatic differences between the Senate and House 302(b) funding allocations, it was unlikely that both chambers would eventually agree upon final FY 2014 funding, especially for a Labor-HHS bill.[42] The negotiations focused on a series of CRs to keep the government running without the prospect of a long-term agreement.

As the government shutdown became imminent, NFPRHA created a "Government Shutdown" resource section on its website that provided NFPRHA members and the public with information about how Title X providers might have been affected during the shutdown.

On September 20, 2013, a little more than a week before the deadline to avert the government shutdown, the House first passed a proposal that would have funded the government through December 15, 2013, at $986.2 billion, a level slightly below FY 2013 post-sequestration levels. Although considered a fairly "clean" bill, without controversial riders, the package did repeal funding for the ACA.[43] The measure was passed along nearly but not strictly party lines – Representative Scott Rigell (R-VA) voted against the bill and Representatives Mike McIntyre (D-NC) and Jim Matheson (D-UT) voted in favor of the resolution.[44] Both Senate Democrats and President Obama quickly voiced their opposition to the measure, adamant that they would oppose any legislation unless it included funding for health reform.[45] However, the Senate, as a concession, passed legislation that would accept the House-passed sequestration levels for a shorter period of time (through November 15, 2013) without the rider to defund the ACA.[46]

The weekend before the end of the fiscal year, the House rejected the Senate's overtures, instead passing a nearly identical measure.[47] The legislation still contained anti-health reform restrictions, including a one-year delay of health care reform, a repeal of the medical device tax - which generated revenue earmarked to fund ACA implementation - and the repeal of an ACA provision enabling congressional staff to have their health insurance subsidized by their employers. Additionally, the House proposal included a "conscience clause" for employers to opt out of providing coverage of the preventive health services benefit (including no-cost coverage of contraception) through January 1, 2015. True to their word, the Senate stripped out these anti-health reform provisions, sending a "clean" funding bill back to the House.

With the battle over funding for the ACA and the women's preventive health benefit leaving lawmakers at an impasse, OMB issued a memo to agencies advising them how to prepare for sequestration in the event that no agreement was reached.[48]

In a last-ditch effort to avoid shutdown, the House of Representatives then passed several piecemeal CRs that would have funded specific government programs such as the Special Supplemental Nutrition Program for Women, Infants, and Children and provided back pay for federal employees who would be furloughed by the shutdown.[49] Both the Senate and the Obama administration rejected this approach, continuing to push for a clean CR. With no agreement reached, on October 1, for the first time in 16 years, the federal government was forced to shut down.

A Peace Treaty – The Government Re-Opens

With the government shutdown in effect, members of Congress realized yet another pressing deadline was on the horizon – the US Treasury Department would reach the debt limit on October 17, rendering the government unable to continue borrowing money unless Congress raised the limit prior to the appointed date. Without increasing the debt limit (a process that has in the past been non-controversial and bipartisan), the United States risked defaulting on its loans and causing severe economic

42 Erik Wasson, "Senate moves Labor, Health bill with 25 percent higher funding than House," *The Hill*, July 9, 2013, http://thehill.com/blogs/on-the-money/appropriations/309947-senate-moves-labor-health-bill-with-25-percent-higher-funding-than-house.

43 Jake Sherman and John Breshanan, "Senate turns to CR that defunds Obamacare," *Politico*, September 21, 2013, http://www.politico.com/story/2013/09/house-defunds-obamacare-97124.html?hp=t1_3.

44 Ibid.

45 Jake Miller, "House passes bill funding government, defunding Obamacare," *CBS News*, September 29, 2013, http://www.cbsnews.com/news/house-passes-bill-funding-government-defunding-obamacare/.

46 Lauren Fox, "Senate Passes Bill to Avert Government Shutdown," *US News and World Report*, September 27, 2013, http://www.usnews.com/news/articles/2013/09/27/senate-passes-bill-to-avert-government-shutdown.

47 Lori Montgomery, Paul Kane, and Rosalind S. Helderman, "House Pushes U.S. to the edge of a shutdown" *Washington Post*, September 29, 2013, http://www.washingtonpost.com/politics/house-republicans-to-propose-one-year-delay-in-obamacare/2013/09/28/1e884de6-2859-11e3-9256-41f018d21b49_story.html?hpid=z1.

48 Executive Office of the President of the United States, Office of Management and Budget Director Sylvia Burwell, *Memorandum to the Heads of Executive Departments and Agencies*, September 17, 2013, http://www.whitehouse.gov/sites/default/files/omb/memoranda/2013/m-13-22.pdf. For more information on the Affordable Care Act, see the "Affordable Care Act" section starting on page 15.

49 Ned Resnikoff, "The piecemeal party," *MSNBC*, October 5, 2013, http://www.msnbc.com/all/the-piecemeal-party.

consequences. Members of both parties agreed defaulting was unacceptable, so this reality served as a catalyst for Majority Leader Harry Reid (D-NV) and Minority Leader Mitch McConnell (R-KY) to broker an agreement that would not only re-open and fund the government through January 15, 2014, at sequestration levels, but would also extend the debt limit until February 7, 2014.[50] The agreement also included back pay for furloughed federal employees and added income verification requirements for health exchange subsidy recipients.[51] Another key outcome included in the final legislation that re-opened the government was the creation of a bipartisan, bicameral budget conference committee of 29 members charged with providing recommendations for a long-term budget agreement no later than December 13. The conferees were to be led by House and Senate Budget Chairmen Ryan and Murray. Despite efforts by anti-choice legislators to include contraceptive coverage refusal language, the bill did not include any women's health-related provisions.[52]

Once the Senate agreement became public, House Republicans realized they would not be able to agree on an alternative to this bipartisan deal. Passed first by the Senate on a vote of 81 to 18, the House approved the measure on October 16, 2013, by a vote of 285-144, with Democrats unanimously supporting the measure, and 87 Republicans joining them.[53] President Obama signed the legislation into law shortly thereafter, bringing an end to the budget impasse and reopening the government.

With news of the continued budget negotiations and sequestration cuts, NFPRHA created a way for its members and other publicly funded providers to confidentially share their stories about how these cuts and stalled budget agreements continue to affect their health center operations and patients. These anecdotes continue to be persuasive advocacy tools in the fight against funding reductions.

Senate Finance Committee Reauthorizes PREP Program Amid Budget Battle

On December 12, 2013, the Senate Finance Committee approved a five-year extension for the Personal Responsibility Education Program (PREP) for FY 2015-2019 as part of the larger package entitled "The SGR Repeal and Medicare Beneficiary Access Improvement Act of 2013."[54] Originally authorized in FY 2010 for five years, PREP provides states with grants to implement evidence-informed or innovative programs to prevent teen pregnancy and HIV/STDs, as well as youth development and adulthood preparation programs for young people. The majority of PREP funding goes to state health departments, but also funds local entities, community- and faith-based organizations, tribes, and tribal organizations.[55]

The reauthorized legislation also expanded those targeted populations in the PREP program to include youth at risk for being victims of sex trafficking or another severe form of trafficking. It unfortunately also included funding for the Title V abstinence-only-until-marriage program through FY 2019. The full Senate did not take up the measure in 2013.

Bipartisan Budget Agreement Reached

On December 10, 2013, Budget Conference Committee Chairmen Murray and Ryan announced they reached a two-year budget agreement, covering both FY 2014 and FY 2015.[56] The package included $85 billion in total savings; estimates stated that it would reduce the deficit by $23 billion over 10 years. The deal did not include substantial changes to Medicaid or Social Security.[57]

50 Burgess Everett, Jake Sherman, and Manu Raju, "Senate moving toward vote on budget deal," *Politico*, October 16, 2013, http://www.politico.com/story/2013/10/government-shutdown-debt-ceiling-default-update-98390.html#ixzz2htyUFG40.

51 Continuing Appropriations Act of 2014, H.R. 2775, 113th Cong. (2013).

52 For more on contraceptive coverage refusals, see the "Contraceptive Coverage Benefit Caught in Religious, Legal Crosshairs" section starting on page 19.

53 Alexander Bolton and Pete Kasperowicz, "Shutdown ends; Obama signs deal," *The Hill*, October 17, 2013, http://thehill.com/blogs/floor-action/house/328989-congress-approves-deal-to-end-shutdown-raise-debt-ceiling.

54 David Pittman, "3-Month 'SGR Fix' Passes House," *MedPage Today*, December 12, 2013, http://www.medpagetoday.com/PublicHealthPolicy/Medicare/43411.; United States Senate Committee on Finance, *Description of the Chairman's Mark: The SGR Repeal and Medicare Beneficiary Access Improvement Act of 2013*, December 10, 2013, http://www.finance.senate.gov/imo/media/doc/Chairmans%20Mark%20of%20SGR%20Repeal%20and%20Medicare%20Beneficiary%20Access%20Improvement%20Act%20of%202013%20FINAL.pdf.

55 "Personal Responsibility Education Program (PREP) Competitive Grants under the Affordable Care Act," official website of the US Department of Health and Human Services, Administration for Children and Families, Family and Youth Services Bureau, accessed January 9, 2014, http://www.acf.hhs.gov/programs/fysb/programs/adolescent-pregnancy-prevention/programs/prep-competitive.

56 John Bresnahan and Jake Sherman, "Budget agreement reached," *Politico*, accessed December 17, 2013, http://www.politico.com/story/2013/12/budget-deal-update-patty-murray-paul-ryan-100960.html?hp=l2.

57 For more information on Medicaid-funded family planning, see the "Publicly Funded Family Planning: A Programmatic Look" section starting on page 28.

A key component of the agreement essentially eliminated the sequester for two years by raising the FY 2014 cap on spending from $986 billion up to $1.012 trillion[58] and the FY 2015 cap to $1.014 trillion in FY 2015, totaling an increase of $63 billion over two years.[59] The increases included in the agreement would be split evenly between defense-discretionary and NDD spending.

The measure passed both chambers with strongly bipartisan votes – first passing the House on December 12, 2013, by 332 to 94,[60] and then the Senate by 64 to 36 on Wednesday, December 18, 2013.[61] President Obama signed the measure into law on December 26, 2013.[62]

58 John Bresnahan and Jake Sherman, "Budget agreement reached."

59 Sam Stein and Michael McAuliff, "Budget Deal Announced By Patty Murray, Paul Ryan," *Huffington Post*, December 10, 2013, http://www.huffingtonpost.com/2013/12/10/budget-deal-2013_n_4421624.html.

60 Darrel Cameron, "House passes 2-year budget deal," *Washington Post*, December 12, 2013, http://www.washingtonpost.com/wp-srv/special/politics/dec-2013-budget-vote/.

61 Ted Barrett and Tom Cohen, "Senate approves budget, sends to Obama," *CNN*, December 18, 2013, http://www.cnn.com/2013/12/18/politics/senate-budget-deal/.

62 Staff Report, "Obama Signs Bipartisan Budget Deal, Easing Spending Cuts Over The Next 2 Years," *Huffington Post*, December 26, 2013, http://www.huffingtonpost.com/2013/12/26/obama-budget-deal_n_4479638.html.

Federal Funding for Selected Public Health Programs (in millions)

Program	FY 2013 Final (including all cuts)	FY 2013 NFPRHA Request	FY 2014 President's Budget	FY 2014 Senate Labor-HHS Appropriations	FY 2014 House Labor-HHS Appropriations
Title X Family Planning	$278.3	$327.4	$327.4	$327.4	No Bill
Title V MCH Block Grant	$604.9	Increased Funding	$639	$643.8	No Bill
Teen Pregnancy Prevention Initiative (TPPI)	$98.1	$105	$105	$104.8	No Bill
TPPI Evaluation	$8.1	n/a	$4.2	$8.5	No Bill
Personal Responsibility Education Program (PREP) [mandatory]	$84	n/a	$82	n/a	No Bill
Title V Abstinence-Only-Until-Marriage (mandatory)	$38	n/a	n/a	n/a	No Bill
Competitive Abstinence Education (CAE) Grant Program	$4.7	$0	$0	$0	No Bill
CDC Division of Adolescent School Health (DASH)	$28.3	$40	$32.4	$29.8	No Bill
DASH Evaluation (new)	n/a	n/a	$3	n/a	No Bill
Title XX Social Services Block Grant	$1,613	n/a	$1,700	$1,700	No Bill
CDC HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	$1,045	Increased Funding	$1,177	$1,097	No Bill
CDC Division of STD Prevention (DSTDP)	$145.8	n/a	$161.7	$153.5	No Bill
HRSA HIV/AIDS Bureau (Ryan White AIDS Programs)	$2,220	n/a	$2,387	$2,393	No Bill
Community Health Centers	$1,390	n/a	$1,472 (discretionary)	$1,574 (combined with mandatory total is $3,774 – an increase of $700,000,000)	No Bill

Section II: The Affordable Care Act

As the October 1, 2013, beginning of open enrollment approached for the health insurance marketplaces, excitement about the possibilities of the law waned as the difficulty of executing such a challenging undertaking emerged. Federal regulators were under-resourced and trying to implement policies not yet finalized. Insurers and health care providers were adapting their businesses with limited information about the various marketplaces. The White House set a goal of enrolling seven million people into the marketplaces by March 31, 2014, and a majority of consumers reported knowing very little about the law, making this target seem unobtainable.[63]

The rollout of the Affordable Care Act (ACA) would ultimately prove to be more problematic than anyone could have initially predicted. However, the biggest challenge would manifest itself not in misunderstandings by insurers or providers, or limited interest on the part of consumers, but in the execution of creating, launching, and operating Healthcare.gov - the mechanism touted throughout the year as the main portal for consumers to enroll in health insurance.

Creating Health Insurance Marketplaces Proves Challenging for HHS

The US Department of Health and Human Services (HHS) was unprepared for the limited number of states that decided to create and run their own health insurance marketplace. The ACA was written with the expectation that states would want to govern how insurance companies, plans, consumers, and providers interact – as they have historically done for their health insurance markets.[64] Largely due to politics, a majority of states decided not to establish their own marketplaces but rely upon the federal government to create marketplaces. As a result, the federal government held responsibility for creating the insurance marketplace for consumers in 34 states while only 16 states and the District of Columbia were responsible for setting up their own.[65]

When it became clear at the end of 2012 that many states were deciding against establishing their own exchanges, HHS extended the decision deadline in an effort to entice additional states into taking on the task. At the beginning of 2013, the Centers for Medicare & Medicaid Services (CMS) released guidance for how states would implement partnership marketplaces, allowing states to have primary responsibility for many of the key marketplace functions including certification of the health plan offerings and conducting consumer assistance programs to help people learn about and enroll in comprehensive coverage.[66] Seven states (Arkansas, Delaware, Illinois, Iowa, Michigan, New Hampshire, and West Virginia) opted for the partnership marketplace, adding to federal responsibility.

Defining Appropriate Essential Community Provider Contracting Thresholds

Also included in the January 2013 guidance on state partnership marketplaces was a key NFPRHA priority - an appendix that briefly outlined HHS's intentions for requiring health plans to include safety-net providers in their networks.[67] Language in the ACA required health plans approved for participation in marketplaces – qualified health plans (QHPs) – to include in their networks essential community providers (ECPs) – providers that traditionally care for low-income and medically underserved individuals.[68] The limited guidance in the January letter restated statutory language that defines an ECP by using the eligibility for the 340B program as one definition. The guidance also briefly outlined their approach to certifying if a health insurance issuer had adequately contracted with ECPs. The guidance outlined three standards: a "safe harbor" standard that allows health insurance issuers to show that their networks included at least 20% ECPs; a "minimum expectation" standard that insurers' networks include at least 10% ECPs with a narrative justification explaining sufficiency; and a final standard that would allow health issuers to include fewer than 10% ECPs in their networks with a detailed narrative justification explaining how networks would provide access for low-income and vulnerable populations as well as a

63 Jennifer Haberkorn, "Kathleen Sebelius: Exchange enrollment goal is 7 million by end of March," *Politico*, June 24, 2013, http://www.politico.com/story/2013/06/kathleen-sebelius-says-exchange-goal-is-7-million-by-march-93301.html.

64 Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010).

65 Kaiser Family Foundation, *State Decisions for Creating Health Insurance Marketplaces*, May 28, 2013, http://kff.org/health-reform/state-indicator/health-insurance-exchanges/.

66 US Department of Health and Human Services, Center for Consumer Information and Oversight, *Affordable Insurance Exchanges Guidance: Guidance on State Partnership Exchange*, January 3, 2013, http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/partnership-guidance-01-03-2013.pdf.

67 Ibid.

68 Patient Protection and Affordable Care Act. "Establishment of Exchanges and Qualified Health Plans," *Federal Register* 76:136 (July 15, 2011) p. 41899.

plan to increase ECP participation in future years.[69] HHS also made clear that the contracting standard in the appendix was "transitional" and that additional guidance would be forthcoming because it rightfully anticipated a negative reaction to the very loose standard from both insurers and the safety-net community. Over the next several months, the lax standard and limited enforcement provisions would become a primary area of administrative advocacy for NFPRHA staff.

Following the transitional policy, HHS issued a letter with additional guidance on the requirement that QHP issuers contract with ECPs. The guidance gave issuers two ways they could satisfy the sufficiency standard for including ECPs in their networks. Option one (the "safe harbor") required the plan issuer to demonstrate that it included at least 20% of all available ECPs in its provider networks and at least one ECP of each ECP category "in each county in the service area, where an ECP in that category is available."[70] HHS designated six different categories of ECPs and "family planning providers" is considered one category. HHS defined family planning providers as Title X family planning health centers and Title X "look-alikes" to enable non-Title X organizations to be designated as ECPs. Option two allows a plan issuer to satisfy the network adequacy requirement by contracting with at least 10% of available ECPs in its service area, and issuing a narrative justifying that it is adequately meeting the needs of the area's medically underserved. HHS subsequently released a database of available ECPs to help QHP issuers identify potential partners.[71] While CMS made clear that the list of health agencies was not exhaustive and that health insurance issuers could and should contract with eligible agencies not in the database, the realization that the database did not include every provider that might qualify under the ECP standard, caused concern among ECPs that health insurance issuers would leave them out of their networks because they were not "official" ECPs.

NFPRHA and other safety-net advocates were displeased that the transitional standards outlined in guidance earlier in the year were not strengthened by the additional guidance. Initial advocacy for ECP standards had supported language requiring plans to issue a contract to any provider willing to contract with the health plan. Having lost that fight, they were dismayed that HHS would impose such a low threshold for ECP contracting on health plan issuers. Moreover, the way the guidance was written gave insurance companies the option to write a narrative justifying why they could not contract with any ECPs and allowed them to be nearly exempt from the statutory requirement altogether.

NFPRHA submitted comments outlining its concerns with the lax guidance and asking that the Center for Consumer Information and Insurance Oversight (CCIIO) clarify that a health plan issuer could not offer contracts to providers that satisfy multiple categories of ECP, which would allow QHP issuers to contract with even fewer ECPs. It was no secret that insurance companies – despite the ACA's intention - would remain hesitant to contract with the safety net. NFPRHA stressed to HHS that it should continue monitoring the contracting environment and take actions to remedy any efforts on the part of plan issuers to discriminate against family planning and other providers that millions of underserved people rely upon for care.

Throughout the spring, safety-net providers communicated about the QHP contracting problems they were experiencing with advocates, including NFPRHA, in Washington and with regional HHS staff. As a sign that CMS was aware of the scarce contracting between QHPs and ECPs, the agency released a frequently asked questions (FAQs) document directed at ECPs but with an eye towards strengthening the previous QHP-related guidance. In the FAQs, CMS confirmed that it reserved the right to monitor QHP issuers, post-certification in the marketplaces, to ensure they continued to comply with law and regulation. It also clarified that it was not too late to contract with an insurance plan despite the certification application deadline passing on April 30, 2013.[72]

CCIIO expressed a strong interest in getting real-time information about the QHP contracting experiences of publicly funded family planning providers and others. To help illuminate the contracting challenges experienced in the safety net, NFPRHA identified several of its members to participate in a group that would work together to advance ECP contracting. The group meets periodically to talk about their QHP contracting experiences and inform NFPRHA work designed to educate the entire membership about how to work best with commercial insurers.

69 US Department of Health and Human Services, Center for Consumer Information and Oversight, *Affordable Insurance Exchanges Guidance: Guidance on the State Partnership Exchange*.

70 US Department of Health and Human Services, Center for Consumer Information and Oversight, letter to issuers on federally facilitated and state partnership exchanges, April 5, 2013, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf.

71 "Non-Exhaustive List of Essential Community Providers," official website of the US Department of Health and Human Services, Centers for Medicare & Medicaid Services, https://data.cms.gov/dataset/Non-Exhaustive-List-of-Essential-Community-Provide/ibqy-mswq.

72 US Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Frequently Asked Questions on Essential Community Providers*, May 13, 2013, http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ecp-faq-20130513.pdf.

By mid-summer 2013, CCIIO began communicating regularly with NFPRHA and others about its concerns regarding QHP issuers' limited contracting with ECPs – most likely after they reviewed plan certification applications for marketplace participation. In June, NFPRHA along with its coalition of safety-net provider organizations, met with CCIIO to express shared concerns about QHP contracting and to share some anecdotal information from the field. CCIIO assured the group that it was in the best interest of both the administration and health plans to contract with ECPs and promised to help facilitate a dialogue between insurance companies and the safety-net community.

Problems with the Single Streamlined Application

Another challenge for administration officials involved how it would ensure that consumers were not overwhelmed with the process of choosing appropriate coverage. The ACA calls for the creation of a single, streamlined application to ensure that all individuals are screened for all insurance products for which they may be eligible, whether commercial or public. The single, streamlined application is one way that HHS tries to fulfill the commitment to a "no wrong door" approach to enrollment that ensures that regardless of the various coverage options authorized by the ACA, consumers would find no wrong door when trying to apply for insurance. The goal is that regardless of whether the application started at a Medicaid agency, on the marketplace, or at a family planning health center, consumers would have one start-to-finish application to enroll into health insurance. Combining the applications for Medicaid expansion populations, categorically eligible individuals, and individuals who would be enrolling into commercial health insurance with varying levels of financial assistance, proved to be a complex undertaking not fully anticipated by federal administrators.[73]

In the early part of 2013, HHS introduced proposed drafts of the application for use to apply for health insurance through the marketplaces. Three versions of the draft applications were unveiled in January and advocates were given about a month to propose changes.[74]

In response to the flood of comments HHS received, the agency began reaching out to NFPRHA and other partner organizations to discuss ways to collaborate on implementing the ACA effectively and educating people about the marketplaces. Early in the year, NFPRHA staff met with communication staff from CMS and began a regular check-in with them to share new materials and identify unmet needs in the field. CMS was aware that many of the tools it intended to rely upon for consumer education about the opening of the marketplaces may be less accessible or reliable for vulnerable populations because of their income, age, ethnicity, health status, or geographic region.

Administration Delays and Provision Rollbacks

Throughout the summer, administration officials began announcing decisions to delay implementation of certain provisions of the law. The most noteworthy delay came in July 2013, when the White House announced that it would give employers an additional year to comply with the mandate requiring that they cover their employees.[75] The employer mandate requires that all employers with 50 or more workers offer their employees affordable health insurance or face a penalty for each employee they fail to offer coverage.[76] As a result of the delay, employers now have until 2015 to comply with the law. The employer mandate delay was followed by an HHS decision to delay the requirement that marketplaces verify income or insurance status for employer-sponsored insurance, which was followed by a decision to allow states to delay opening the small business health options program – a marketplace open only to small businesses and their employees.[77]

Despite these delays, which signaled a larger concern with implementation, and some skepticism about the administration's readiness for the open enrollment period raised by a variety of health care stakeholders, HHS maintained its position that marketplaces would indeed be ready for consumer use on October 1, 2013.

73 For more on Medicaid family planning expansions, see the "Publicly Funded Family Planning: A Programmatic Look" section, starting on page 28.

74 "Agency Information Collection Activities: Submission for OMB Review." *Federal Register* 78:6109 (January 29, 2013) p. 6109 - 6111, https://www.federalregister.gov/articles/2013/01/29/2013-01770/agency-information-collection-activities-submission-for-omb-review-comment-request.

75 Dan Balz, "Delay of employer mandate in health-care law heightens stakes for Obama administration," *Washington Post*, July 3, 2013, http://www.washingtonpost.com/politics/delay-of-employer-mandate-in-health-care-law-heightens-stakes-for-obama-administration/2013/07/03/344b820e-e404-11e2-a11e-c2ea876a8f30_story.html.

76 Patient Protection and Affordable Care Act.

77 Sarah Kliff and Sandhya Somashekahar, "Health insurance marketplaces will not be required to verify consumer claims," *Washington Post*, July 5, 2013, http://articles.washingtonpost.com/2013-07-05/national/40390077_1_health-insurance-consumer-claims-federal-government.; Jason Millman and Jennifer Haberkorn, "Another Obamacare delay," *Politico*, September 26, 2013, http://www.politico.com/story/2013/09/obamacare-faces-new-delay-in-small-business-enrollment-97401.html.

To help its members get ready for the first open enrollment period under the ACA, NFPRHA focused its annual summer toolkit on ACA implementation. The materials in the toolkit ranged from tips on the "Top 5 Things Family Planning Providers Should Know About Open Enrollment" to a more hands-on document helping providers craft arguments to strengthen their negotiations with commercial payers. It also contained sample traditional and social media-focused items to help members publicize the importance of enrolling in ACA-sponsored coverage from the family planning perspective as well as through CMS-branded materials.

NFPRHA submitted comments to the proposed rule asking that Navigator funds be directed to family planning providers who have a long history of delivering care to the medically underserved. In addition, the comments supported HHS's efforts to prevent consumers from being cajoled by assistors into plans that may not be suitable for them and asked that those protections be strengthened in the final rule. Finally, NFPRHA stressed the importance of requiring entities that were awarded Navigator funds to build partnerships with family planning providers and others currently caring for the uninsured. HHS did strengthen the consumer protections in the final rule but did not require grantees to build connections to other social service organizations and community-based providers.[80]

Outreach and Enrollment: Conquering the Impossible

Compounding the infrastructure challenges HHS experienced building a multi-state health insurance market was the need to educate and enroll the millions of people who lacked coverage. In April, CMS published a proposed rule detailing a federal Navigator program that allows HHS to provide funds to agencies within federally facilitated marketplace (FFM) states to support the hiring and training of outreach and enrollment workers especially in population-dense areas of the country that would likely struggle to meet the coverage information and purchasing needs of its consumers.[78] HHS used the rules to also create a sub-category of the Navigator program, termed certified application counselors (CACs). Similar to Navigators, CACs are required to undergo formal training and certification processes, but without the same financial resources promised to Navigators. The proposed and final rule detailed the standards related to the ACA's patient Navigators and non-Navigator assistance personnel in federally facilitated and state marketplaces.[79] Recognizing that subsidizing individuals and organizations to assist with enrolling people in insurance could create perverse incentives, the guidance also established a variety of mechanisms to safeguard against predatory behavior by the assistors. In particular, HHS administrators wanted to guard against assistors being subject to incentives by insurers to enroll low-cost patients into their plans at the expense of those with increased health needs.

In the spring, HHS solicited applications for Navigator grants, and several family planning providers and even more community-based organizations ranging from church groups to senior support agencies applied for the funds. HHS initially announced it would grant $54 million in Navigator funds (later increased to $67 million) for groups operating in the FFMs. State-run marketplaces were responsible for organizing and funding their own Navigator-like programs. Health care stakeholders were quick to criticize what they considered an incredibly insufficient amount of money to meet the expected demand for support in the 34 FFM states.[81]

HHS then made a decision that infuriated some safety-net providers when it announced in the summer that it would grant $150 million in outreach funds solely to the federally qualified health center (FQHC) system.[82] The funds would support 1,159 community health centers to hire 2,900 outreach and eligibility assistance workers. Family planning providers and others, including Ryan White health centers and mental health centers, were stunned to hear that while all of the safety net was expected to help with consumer assistance functions, FQHCs were the only group guaranteed the resources to participate. HHS clarified that the resources were not in fact from new revenue sources, but were pulled from previously allocated FQHC funds. However, the explanations did little to lessen the frustration that some providers had about HHS asking them to do more with less.

78 "Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel, Proposed Rule." *Federal Register* 78:66 (April 5, 2013) p. 20581, http://www.gpo.gov/fdsys/pkg/FR-2013-04-05/pdf/2013-07951.pdf.

79 "Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel; Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors, Final Rule." *Federal Register* 78:137 (July 17, 2013), http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf.

80 Ibid.

81 Phil Galewitz and Jenny Gold, "Funding to Enroll Uninsured in New Markets Called 'Drop in a Bucket,'" *Kaiser Health News*, April 9, 2013, http://www.kaiserhealthnews.org/stories/2013/april/09/54-million-dollar-grants-for-exchange-enrollment-efforts.aspx.

82 US Department of Health and Human Services, "Health centers to help uninsured gain affordable health coverage," news release, July 10, 2013, http://www.hhs.gov/news/press/2013pres/07/20130710a.html.

At the end of July, just two months before the marketplaces were set to open, CMS announced initial training sessions for the CACs. While the trainings were expected to be similar for the Navigators, the grant awards were still unknown. NFPRHA alerted its members to this information recognizing that many of its members were anxious for some instruction and information on how to help their patients. Unlike the Navigator program, which required grantees to have far-reaching geographic and demographic capacity, the CAC program was accessible for many family planning health centers and staff.[83] CMS planned to list the CACs on its website, as entities where individuals could get help enrolling in the new marketplaces. CMS also directed its marketplace call-in center to refer consumers to CACs.

Non-governmental public and private organizations also started unveiling their plans for helping to promote open enrollment. Private for-profit companies ranging from Walgreens to professional sports teams began promoting the marketplaces.[84] For-profit companies also helped finance the work of a newly created nonprofit organization called Enroll America which has a sole mission of "maximizing the number of Americans who are enrolled in and retain health coverage."[85]

In early September, Enroll America hosted more than 150 events across the country to encourage enrollment into the marketplaces.[86] NFPRHA helped connect its members with the different days of action and encouraged them to attend and host events and engage with consumer assistance trainings. NFPRHA also became an HHS "Champion for Coverage" listed online among many other organizations that are sharing publicly available information to inform and educate providers and consumers about the ACA and its coverage options.

In mid-August, CMS finally announced that it would grant $67 million to 105 Navigator grantees.[87] Grants were awarded to a variety of organizations, including some family planning providers, which were charged with providing culturally competent, unbiased information on consumers' enrollment options. The announcement of the grants indicated that the Navigator program "builds upon the significant progress in outreach and enrollment made" throughout the summer. Few consumer advocates, however, agreed with HHS's assessment of this progress.

Contraceptive Coverage Benefit Caught in Religious, Legal Crosshairs

In 2013, ideologically driven attacks on the ACA's contraceptive coverage benefit – part of the ACA's preventive services provision – would continue.[88]

The Obama administration published a proposed rule in February 2013, reaffirming that all women should receive insurance coverage of contraception at no additional cost to them, regardless of where they work.[89] NFPRHA and other family planning and sexual health advocates hailed the rule as a victory for women's health. Under the proposed rule, women working for religious employers, with objections to paying for coverage, would still get access to the benefit. To accommodate religious organizations with outside health insurance coverage, the proposed rule would require insurers to cover the benefit at no cost to the woman and at no cost to the religious organization. Religious employers that are self-insured would notify their third-party administrator (TPA), which would then work with a health insurance issuer to provide separate health insurance policies at no cost for women accessing the coverage.

83 Gary Cohen, US Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Guidance on Certified Application Counselor Program for the Federally-Facilitated Marketplace Including State Marketplaces*, July 12, 2013, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CAC-guidance-7-12-2013.pdf.

84 Jennifer Haberkorn, "Blue Cross, Walgreens, team for Obamacare campaign," *Politico*, June 11, 2013, http://www.politico.com/story/2013/07/blue-cross-walgreens-obamacare-93983.html; Jason Millman, "Recruiting local sports for Team Obamacare," *Politico*, June 27, 2013, http://www.politico.com/story/2013/06/obamacare-sports-teams-health-insurance-93471.html.

85 "Our Mission," official website of Enroll America, accessed March 2014, http://www.enrollamerica.org/about-us.

86 Enroll America, "Get Covered America Prepares to Hit the Streets Across the Country for 'Get the Word out Weekend,'" news release, September 3, 2014, http://www.getcoveredamerica.org/pages/get-covered-america-prepares-to-hit-the-streets.

87 US Department of Health and Human Services, Centers for Medicare & Medicaid Services, "New resources available to help consumers navigate the Health Insurance Marketplace," news release, August 15, 2013, http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-08-15.html.

88 "Women's Preventive Services Guidelines," official website of the US Department of Health and Human Services, Health Resources and Services Administration, accessed August 2, 2013, http://www.hrsa.gov/womensguidelines/.

89 "Coverage of Certain Preventive Services Under the Affordable Care Act, Proposed Rule." *Federal Register* 78:25 (Feb. 6, 2013) p. 8456, http://www.gpo.gov/fdsys/pkg/FR-2013-02-06/pdf/2013-02420.pdf.

As NFPRHA prepared a response to the proposed rule on contraceptive coverage, it continued work begun in the previous year seeking additional guidance for insurers outlining the real-world application of the benefit. NFPRHA and several of its aligned organizations were enthusiastic about the women's preventive services benefit but concerned that without additional rules, insurers would take the most narrow approach to coverage as the law would allow – ultimately limiting patient access to care. To safeguard against this, NFPRHA and coalition partners engaged HHS in a series of meetings explaining how the use of certain medical management and utilization controls would contradict the intent of the coverage.

NFPRHA and its partners were pleasantly surprised in February when the Departments of Labor, HHS, and Treasury jointly published an FAQs document designed to help implement various sections of the ACA, including the contraceptive coverage requirement.[90] The FAQs provided additional information explaining how health plans were to cover preventive services, including those recommended for women.

Answering many of the coalition's outstanding questions, the FAQs stated that while guidelines from the Health Resources and Services Administration (HRSA) recommended at least one annual well-woman visit, additional visits could be needed to obtain all of the necessary recommended preventive services and that these visits should be covered with no co-pay. The FAQs also clarified that health plans could not limit contraceptive coverage to oral contraceptives. The FAQs stated that plans could have preferences for generics, but must have a process for waiving any applicable cost sharing for the branded or non-preferred version, if the woman's provider deemed the preferred drug unacceptable for her.[91] The FAQs document was an early sign that the Obama administration intended to stand behind its statement that all women should and would be able to access the benefits as intended in the law.

The strong signals coming from the White House did little to dissuade conservatives in Congress from introducing and working to pass legislation to weaken the women's health preventive services benefit. Representative James Sensenbrenner (R-WI) and 30 co-sponsors introduced H.R. 973, the "Religious Freedom Tax Repeal Act of 2013."[92] The bill would exempt any employer who refused to cover contraception in their health insurance plan for religious or moral reasons from facing penalties, including applicable taxes and possible lawsuits resulting from not providing the coverage. In short, the bill would create a loophole to the ACA's contraceptive coverage requirement.

In addition to the legislative attacks on the benefit, policymakers in Congress and dozens of for-profit and nonprofit companies sued the administration claiming the contraceptive coverage requirement imposed on various constitutionally protected freedoms. A group of congressional Republicans, led by Senator Orrin Hatch (R-UT), filed an amicus brief in support of Hobby Lobby, a for-profit craft store suing the federal government in opposition to the contraceptive coverage requirement.[93] At the time, the *Sebelius v. Hobby Lobby Stores, Inc.* suit was one of many against the requirement moving slowly through the legal system, most of which were meeting abrupt and unsuccessful ends. Very few court analysts and advocates anticipated that it would soon become the standard bearer for all other legal action against the benefit and would be one of the cases eventually accepted for review by the US Supreme Court.

NFPRHA submitted comments to the proposed rule and reiterated many of the concerns and principles stated in previous responses to the administration's guidance on the contraceptive coverage benefit. NFPRHA stressed the importance of keeping the universe of employers which are eligible for the accommodation very narrow. The comments also urged HHS to impose notification requirements for employees of accommodated religious organizations that would allow them to access the benefit and suggested several ways in which notice to the employees could be crafted to ensure that all women affected understand their coverage. NFPRHA again applauded the administration's overarching goal to ensure access to the benefit but urged HHS to be vigilant in its enforcement processes, particularly in the face of increasing congressional and legal scrutiny.

In the summer, HHS, the IRS, and the Employee Benefits Administration issued a final rule on the ACA's accommodation for nonprofit entities objecting to contraceptive coverage on religious grounds.[94] The final rule changed little from the previous version in which the insurance plan or TPA will directly cover contraceptives for employees of religiously affiliated

90 US Department of Labor, US Department of Health and Human Services, and US Treasury Department, *FAQs About Affordable Care Act Implementation (Part XII)*, February 20, 2013, http://www.dol.gov/ebsa/pdf/faq-aca12.pdf.

91 Ibid.

92 Religious Freedom Tax Repeal Act of 2013, H.R. 973, 113th Cong. (2013).

93 *Hobby Lobby Stores, Inc. v. Kathleen Sebelius*, No. 12-6994 (10th Cir. 2013).

94 "Coverage of Certain Preventive Services Under the Affordable Care Act, Final Rule." *Federal Register* 78:39869 (July 2, 2013) https://www.federalregister.gov/articles/2013/07/02/2013-15866/coverage-of-certain-preventive-services-under-the-affordable-care-act.

employers that object to the coverage. However, the administration took the liberty of extending the "safe harbor" period for those entities qualifying for the accommodation for six months. Thus employers that were subject to providing the coverage in August were given until January 2014 to adopt the benefit or face financial penalties.

While June 2013 marked what appeared to be the end of the regulatory back-and-forth over the contraceptive coverage benefit, the legal fight was just beginning. By the end of the year, there would be more than 60 cases challenging the contraceptive coverage requirement. The administration and supporters of the benefit would begin preparing to defend it in the US Supreme Court.[95]

By the end of the year, the 10th Circuit Court of Appeals reversed an Oklahoma district court's decision that had denied Hobby Lobby its preliminary injunction request - to temporarily forego adhering to the contraceptive coverage requirement while its legal suit against the federal government was pending.[96] The ruling, which came after a higher court asked the district court to reconsider its previous decision to deny Hobby Lobby an injunction, allowed the arts and crafts chain to be exempt from the contraceptive coverage requirement and its $1.3 million per-day penalty for non-compliance, which started July 1, 2012, while the case proceeded to trial. In its suit against the federal government, Hobby Lobby's owners argued that requiring their company health plans to cover contraceptives infringes on their religious liberty. The 10th Circuit's decision did not make a determination on the underlying merits of the lawsuit and instead remanded those questions back to the district court.

Although the 10th Circuit reversal was not a decision on the merits, NFPRHA and women's health coalition partners that submitted amicus briefs in the case were wholly disappointed by this development and concerned about what might come next. They would not have to wait long. In October, The Oklahoma-based craft store petitioned the US Supreme Court to review its case.[97] Although the company's current insurance covers most forms of birth control, the retailer objects to the requirement that it cover emergency contraception and intrauterine devices – two methods that the company considers abortifacients despite scientific evidence to the contrary.[98] In November, the Supreme Court announced it would examine the merits of requiring employers to provide coverage of contraception for its employees in its next docket.[99]

In a late-breaking order handed down on New Year's Eve, Supreme Court Justice Sonia Sotomayor temporarily blocked implementation of the contraceptive coverage mandate for the Little Sisters of the Poor Home for the Aged, in Denver, CO.[100] The temporary block only applies to the petitioner and other religiously affiliated organizations that maintain health insurance through the Christian Brothers Employee Benefit Trust. The federal government was given until Friday, January 3, 2014, to respond to the order.

NFPRHA's President & CEO Clare Coleman wrote on *The Huffington Post* and *The Hill's* political blogs about the historic importance of the contraceptive coverage benefit, birth control's wide acceptance, and the deep impact the benefit was already having on millions of women despite the legal conversations that were about to unfold about the case and religious freedom.

Open Enrollment Rollout Exposes Fault Lines in ACA Implementation

Leading up to the October 1, 2013, open enrollment period, NFPRHA, like many other organizations in the public health and provider communities, was asked to engage with several HHS agencies on how best to reach uninsured populations that stood to benefit from the ACA-sponsored coverage. Although ready to help with ACA implementation, NFPRHA was clear that reaching out to safety-net providers outside of the FQHC system, with less than two months before the opening of the marketplaces, would prove too late. While recognizing the extremely difficult task facing the administration, failure to adequately prepare the safety net would be one of the many missteps by HHS during the lead up to the implementation phase.

On October 1, health insurance marketplaces opened across the United States. Within minutes of Healthcare.gov going live, reports began to trickle in about technical glitches on the site.[101]

95 American Civil Liberties Union, *Challenges to the Federal Contraceptive Coverage Rule*, accessed October 28, 2013, https://www.aclu.org/reproductive-freedom/challenges-federal-contraceptive-coverage-rule.

96 Sam Baker, "Hobby Lobby wins temporary exemption from birth-control mandate," *The Hill*, June 28, 2013, http://thehill.com/blogs/healthwatch/legal-challenges/308541-hobby-lobby-wins-temporary-exemption-from-birth-control-mandate.

97 Traci G. Lee, "Hobby Lobby asks Supreme Court to hear contraception mandate challenge," *MSNBC*, October 22, 2013, accessed October 28, 2013, http://www.msnbc.com/msnbc/hobby-lobby-asks-supreme-court-hear.

98 For more on developments in emergency contraception and contraceptive devices and services, see the "Family Planning Services and Supplies" section, starting on page 34.

99 Bill Mears, "Supreme Court to take up Obamacare contraception case," *CNN*, November 26, 2013, http://www.cnn.com/2013/11/26/politics/obamacare-court/.

100 Steve Kenny and Robert Pear, "Justice Blocks Contraception Mandate on Insurance in Suit by Nuns," *New York Times*, December 31, 2013, http://www.nytimes.com/2014/01/01/us/politics/justice-sotomayor-blocks-contraception-mandate-in-health-law.html?_r=1.

101 Jason Millman and Brett Norman, "Glitches and recoveries: State exchanges run the gamut," *Politico*, October 2, 2013, http://www.politico.com/story/2013/10/obamacare-exchanges-glitches-recoveries-97689.html.

With millions of unique visitors trying to log on and shop for coverage, HHS and the White House were forced to explain that the site was not prepared to handle such volume. According to the US Chief Technology Officer, HHS expected Healthcare.gov to handle 50,000 – 60,000 users at a time but the site was experiencing 250,000 visitors at a time.[102] Few consumer advocates considered this a reasonable explanation.

While the federal Healthcare.gov website continued to have technical issues, the 16 states plus the District of Columbia that had chosen to create a state-based marketplace (SBM) had varying experiences with the launch of the marketplace websites in their respective states. Some, like Washington state, were immediately able to consistently enroll consumers and make eligibility determinations, while others, like neighboring Oregon, were not able to process applications at all through the website – forcing the use of paper applications for eligibility determinations.[103] The variance in the design and usability of marketplace websites was illustrated in reports by the HHS Assistant Secretary for Planning and Evaluation (ASPE) that showed enrollment numbers into QHPs in states with working websites were much higher than the states that continued to struggle with technology.[104] Overall, states that created their own marketplaces were having better initial enrollment success than the FFM.

To answer relentless requests for information about enrollment during the first difficult month of open enrollment, the Obama administration released preliminary figures during the second week in November. Not surprisingly, the numbers showed that only 106,185 people had completed the commercial insurance enrollment process and selected a health insurance plan.[105] That number represented 1.5% of the total expected enrollment into marketplace plans by the end of the open enrollment period.

In contrast, Medicaid enrollment for the same period proved to be a success - 396,261 individuals had enrolled in coverage. The information released by HHS tried to highlight that more than 800,000 applications had been submitted, translating to more than 1.5 million individuals applying for health insurance coverage. However, the low numbers were additional fuel for Republican legislators who were holding congressional hearings multiple times a week to point out what they considered irreparable flaws in the ACA.

The website problems were then overshadowed by a new and serious public relations problem, when health insurers began sending some policyholders cancellation notices.[106] Because the ACA requires that all health plans contain a certain amount of financial protections and level of benefits, plans were ending some existing policies and offering policyholders new and sometimes more expensive options. The action contradicted a phrase President Barack Obama used throughout the 2012 presidential campaign, "if you like your health insurance, you can keep it." The thousands of cancellation notices proved that statement to be incorrect. The administration and ACA supporters were panicked about the onslaught of negative attention focused on the health reform law.

Over the next several weeks, problems with the website and the growing difficulties consumers experienced as they attempted to sign up for coverage would dominate the news cycle and policy discussions about the ACA. Amidst calls for HHS Secretary Kathleen Sebelius to resign, and for extensions of the open enrollment period, administration officials would scramble to change the focus from the glitches in the website to evidence of mass interest in the marketplace based on high website hits. President Obama addressed the cancelled policies problem when he announced that health plans could continue offering coverage that did not meet the standards set by the ACA.[107] The transitional policy would allow the potentially cancelled plans to be sold in the 2014 plan year. Health insurance issuers would be required to tell consumers that they can continue with their current plans but that they may find more comprehensive coverage and take advantage of financial subsidies in the marketplace. Plans argued that it would undermine the rate settings the companies had created and destabilize the insurance market. Because insurance is regulated at a state level, several state insurance regulators refused to implement the concession and proceeded with the cancellations.[108] As a secondary response to congressional and public outcry about the cancellation notices, HHS published guidance describing options for consumers with cancelled health plans.[109] The guidance suggested three options for consumers. First, that they are able to purchase any plan for which they are eligible directly from their current health insurance issuer; second, that they can use the new health insurance

102 Tim Mullaney, "Obama adviser: Demand overwhelmed Healthcare.gov," *USA Today*, October 6, 2013, http://www.usatoday.com/story/news/nation/2013/10/05/health-care-website-repairs/2927597/.

103 Amy Snow Landa, "A Tale Of Two State Exchanges," *Kaiser Health News*, October 18, 2013, http://www.kaiserhealthnews.org/Stories/2013/October/18/Oregon-Washington-health-insurance-marketplace-exchanges.aspx.

104 US Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplace: November Enrollment Report*, November 13, 2013, http://aspe.hhs.gov/health/reports/2013/MarketPlaceEnrollment/rpt_enrollment.pdf.

105 Ibid.

106 Lisa Meyers, "Insurers, state officials say cancellation of health care policies just as they predicted," *NBC News*, November 15, 2013, http://investigations.nbcnews.com/_news/2013/11/15/21482622-insurers-state-officials-say-cancellation-of-health-care-policies-just-as-they-predicted.

107 US Department of Health and Human Services, Centers for Medicare & Medicaid, Center for Consumer Information & Insurance Oversight Director Gary Cohen, letter to insurance commissioners, November 14, 2013, http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF.

108 Lisa Myers, "Insurers, state officials say cancellation of health care policies just as they predicted."

109 US Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Consumer Information & Insurance Oversight, *Options Available for Consumers with Cancelled Policies*, December 19, 2013, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cancellation-consumer-options-12-19-2013.pdf.

marketplaces to shop for insurance and access premium tax credits; and third, that they can shop for a new policy outside their current issuer and the marketplace in their state's individual market. Plans purchased on the non-ACA regulated individual market would likely not have all the protections offered in the marketplaces. In addition, the guidance formalized a recommendation made by senators to HHS to allow consumers with cancelled plans to use the hardship exemption to avoid paying a penalty under the law's individual mandate. The exemption to the mandate penalty allows these consumers to purchase health insurance that may not meet minimum essential coverage requirements.

NFPRHA remained confident that its members would use additional tools to help them communicate about the law. In November, NFPRHA published an ACA Coverage Start Policy and Communications Toolkit to be used starting January 1.The toolkit contained links to tools and resources to educate family planning providers and their patients about open enrollment and changes coming to the Medicaid program. It also included sample communications materials, materials to encourage enrollment into comprehensive coverage, and advocacy messages to help certain states continue advocating for the Medicaid expansion.

Unsurprisingly, the Obama administration also announced that it would amend the deadlines for the ACA's initial open enrollment period and for the 2015 open enrollment period that would start in fall 2014. Citing the need to provide consumers an extension to apply for coverage as a result of ongoing technical issues with Healthcare.gov, the administration extended, by eight days, the deadline for consumers to be enrolled so they may start receiving coverage January 1. Originally, consumers had to sign up by December 15, and pay their premium by December 31, to have coverage January 1. Officials shifted that deadline to December 23.[110] The administration did not extend the 2014 open enrollment past March however; advocates continued to push in the hopes of giving people, particularly the young and healthy, more time to make a choice to participate.

The administration also moved the following year's open enrollment period from October 15, through December 7, to November 15, through January 15, 2015.[111] The goal of the change was to give states more time to ensure their marketplaces were fully operational. Republican politicians quickly jumped on this announcement, calling it a political maneuver by the administration to avoid bad news coverage during the election season in the fall of 2014.

Marketplace health insurance issuers responded to the administration's deadline extensions by extending payment deadlines, allowing consumers to make payments into the new year and retroactively providing health insurance coverage.[112]

The ACA's Bright Spot: 25 States Plus DC Expand Medicaid

One of the biggest decisions facing state officials and lawmakers as 2014 approached was whether they would choose to accept federal money to expand their Medicaid programs to people with incomes up to 138% of the federal poverty level (FPL) – approximately $15,856 in annual income for an individual in 2013.[113] Almost immediately after the US Supreme Court issued its 2012 decision on the ACA, which effectively made the law's Medicaid expansion optional for states, a number of state governors – particularly from states that had challenged the constitutionality of the ACA – announced that their states would not participate in the expansion. Other governors announced support for the provision, but the majority of states' leaders adopted a "wait-and-see" attitude at that time.

But by early 2013, several high-profile conservative governors began to rethink their opposition to Medicaid expansion. Republican governors, including Jan Brewer (AZ), John Kasich (OH), Rick Scott (FL), and Chris Christie (NJ) announced that they intended to pursue the Medicaid expansion – and the billions in federal dollars that come with it.[114]

110 Sarah Kliff, "Obamacare's deadlines are changing. Again," *Washington Post Wonkblog* (blog), December 12, 2014, http://www.washingtonpost.com/blogs/wonkblog/wp/2013/12/12/obamacares-deadlines-are-changing-again/.

111 Aaron Blake and Juliet Eilperin, "Obamacare 2015 open enrollment to be delayed one month, to after 2014 election," *Washington Post, Post Politics* (blog), November 22, 2013, http://www.washingtonpost.com/blogs/post-politics/wp/2013/11/22/obamacare-2015-open-enrollment-set-to-be-delayed-one-month/.

112 Brett Norman, "Obamacare consumers: Time to pay up," *Politico*, January 10,2014, http://www.politico.com/story/2014/01/obamacare-consumers-time-to-pay-up-102016.html.

113 Kaiser Family Foundation, *Quick Take: Who Benefits from the ACA Medicaid Expansion?*, June 14, 2012, http://kff.org/health-reform/fact-sheet/who-benefits-from-the-aca-medicaid-expansion/.; "Annual Update of the HHS Poverty Guidelines." *Federal Register* 78: 5182 (January 24, 2013) p. 5182-5183. For more information on Medicaid-funded family planning policies, see the "Publicly Funded Family Planning: A Programmatic Look" section, starting on page 28.

114 As of April 1, 2013; Kyle Cheney and Jason Millman, "For Republican governors, Medicaid expansion is hard sell," *Politico*, March 7, 2013, http://www.politico.com/story/2013/03/for-republican-governors-medicaid-expansion-is-hard-sell-88522.html.

Governors and legislators seemed to come to grips with the reality that the Medicaid expansion is a good deal for states. States will receive 100% federal funding for those newly eligible for Medicaid under the expansion for the first three years (2014-16). Starting in 2017, the federal match will be gradually reduced to 90%. If all 50 states and the District of Columbia implemented the Medicaid expansion, it is estimated that states could actually save $92-$129 billion between 2014 and 2019.[115] Part of this cost savings – an estimated $26-$52 billion – would come from freeing up state and local funds currently being used to help offset the cost of uncompensated care provided to uninsured patients who cannot afford to pay.[116]

At of the end of 2013, 25 states plus the District of Columbia chose to accept federal money to expand health insurance coverage to individuals with incomes up to 138% of the FPL.[117] Three of those states – Arkansas, Iowa, and Michigan – had expanded coverage through an alternative path to Medicaid expansion.[118] According to the Center on Budget and Policy Priorities (CBPP), more than 15 million adults could become newly eligible for Medicaid across all states, although the total number that actually enroll will be less since not all eligible adults will apply for and enroll in coverage.[119]

Yet even in non-expansion states, Medicaid enrollment is expected to increase. CBPP estimates more than four million "uninsured adults are currently eligible under existing state eligibility criteria but are not enrolled; many will likely [enroll] once the requirement to have coverage becomes effective in 2014." For example, in Texas, CBPP estimates that while an additional 1,805,000 newly eligible adults would enroll if the state expanded Medicaid, enrollment is expected to increase by 554,000 even if the state does not ultimately expand. This increase, known as the "welcome-mat" effect, stems from individuals already eligible for but not enrolled in coverage signing up because of increased outreach to enroll people through the health insurance marketplaces, improved and simplified eligibility procedures, and the individual mandate requiring people to have coverage or pay a penalty.[120]

A June 2013 *Health Affairs* study looked at Massachusetts's 2006 health reform efforts to examine the welcome-mat effect.[121] Researchers found that enrollment in Massachusetts among low-income parents who were previously eligible for Medicaid but not enrolled increased by 16.3%, in comparison to a group of control states.[122] The researchers noted that, since Massachusetts already had a high Medicaid participation rate, the welcome-mat effect in other states could be larger.[123]

The impact the ACA will have on Medicaid enrollment will not be known for some time, but the first month of the ACA's initial open enrollment period demonstrated just how important the Medicaid expansion could be for low-income Americans.[124] The first month of enrollment showed a major imbalance in Medicaid enrollment versus enrollment in commercial insurance plans, with Medicaid sign-ups far outpacing commercial insurance.[125] In some places, nine out of every 10 enrollees were Medicaid.[126]

CMS Works to Finalize Rules and Guidance on ACA Medicaid Expansion

CMS issued significant rules and guidance related to the ACA's Medicaid expansion in 2013. In January, the agency released a notice of proposed rulemaking (NPRM) implementing key provisions of the ACA relating to the Medicaid expansion and the

115 The Lewin Group estimates savings of $101 billion, while the Robert Wood Johnson Foundation and the Urban Institute estimate the Medicaid expansion's cost savings to states at $92-$129 billion. *See* The Lewin Group, *Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers*, June 8, 2010, http://www.lewin.com/~/media/Lewin/Site_Sections/Publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf. See also Matthew Buettgens, et al., the Robert Wood Johnson Foundation and the Urban Institute, *Consider Savings as well as Costs: State Governments Would Spend at Least $90 Billion Less with the ACA than Without It from 2014 to 2019, July 2011*, http://www.urban.org/uploadedpdf/412361-consider-savings.pdf.

116 Buettgens, et al., *Consider Savings as well as Costs: State Governments Would Spend at Least $90 Billion Less with the ACA than Without It from 2014 to 2019*.

117 Center on Budget and Policy Priorities, *Status of the ACA Medicaid Expansion after Supreme Court Ruling*, updated October 22, 2013, http://www.cbpp.org/files/status-of-the-ACA-medicaid-expansion-after-supreme-court-ruling.pdf.

118 For more information on alternative Medicaid expansion plans, see the "CMS Allows States to Pursue Alternative Path to Medicaid Expansion: 'Premium Assistance'" section, starting on page 26.

119 Center on Budget and Policy Priorities, *Status of the ACA Medicaid Expansion after Supreme Court Ruling*.

120 Center on Budget and Policy Priorities, "How Would the Medicaid Expansion Affect Texas?," http://www.cbpp.org/files/healthtoolkit2012/Texas.pdf, citing John Holahan, et. al., *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Results*, Urban Institute and Kaiser Family Foundation, November 2012. Enrollment estimates for your state are available by clicking on your state on the CBPP map at http://www.cbpp.org/cms/index.cfm?fa=view&id=3819. For more information on outreach and enrollment, see the "Outreach and Enrollment: Conquering the Impossible" section, starting on page 18.

121 Chris Fleming, "Massachusetts Data Suggests States May See Large Medicaid 'Welcome-Mat' Effect," *Health Affairs* (Blog), June 27, 2013, http://healthaffairs.org/blog/2013/06/27/massachusetts-data-suggests-states-may-see-large-medicaid-welcome-mat-effect/.

122 Julie Sonier, Michel H. Boudreaux, and Lynn A. Blewett, "Medicaid 'Welcome-Mat' Effect Of Affordable Care Act Implementation Could Be Substantial," *Health Affairs* 32:7 (July 2013): 1319-1325, http://content.healthaffairs.org/content/32/7/1319.

123 Chris Fleming, "Massachusetts Data Suggests States May See Large Medicaid 'Welcome-Mat' Effect."

124 For more on the start of open enrollment, see the "Open Enrollment Rollout Exposes Fault Lines in ACA Implementation" section on page 21.

125 Sarah Kliff, "In first month, the vast majority of Obamacare sign-ups are in Medicaid," *Washington Post Wonkblog* (blog), November 1, 2013, http://www.washingtonpost.com/blogs/wonkblog/wp/2013/10/31/in-first-month-the-vast-majority-of-obamacare-sign-ups-are-in-medicaid/.

126 Ibid.

health insurance exchanges.[127] The NPRM proposed to codify the ACA's eligibility provisions and laid out a structure and options for coordinating Medicaid, the Children's Health Insurance Program (CHIP), and exchange eligibility notices and appeals. It also proposed to modify existing benchmark benefits regulations for low-income adults and Medicaid premiums and cost-sharing requirements, including raising the maximum co-pay for services to a flat $4 maximum allowable for outpatient services. The proposed rule also allowed state-based exchanges to choose to rely on HHS for verifying whether an individual has employer-sponsored coverage and conducting some types of appeals.

NFPRHA submitted comments to CMS on a number of provisions of the proposed rule, addressing issues including the codification of ACA requirements related to Medicaid coverage of family planning and the elimination of barriers to low-income access to care.

CMS finalized the rule in July,[128] addressing some – but not all – of the proposals included in the January NPRM. The final rule codified statutory eligibility provisions – including the ACA's requirement that coverage provided to individuals of child-bearing age through Medicaid Alternative Benefit Plans include family planning services and supplies.[129] The rule also laid out a structure and options for coordinating Medicaid, CHIP, and exchange eligibility notices and appeals. Additionally, the final rule modified Medicaid benchmark benefits regulations as well as Medicaid premium and cost-sharing requirements. In the final rule, CMS indicated it intended to address the January NPRM's remaining provisions at a later date.[130]

On March 29, 2013, CMS issued a final rule codifying the enhanced federal medical assistance percentage (FMAP) rates that will be available beginning January 1, 2014, for newly eligible Medicaid patients up to 133% of the FPL.[131] The final rule implemented the enhanced FMAP rate for the Medicaid expansion population, which covers 100% of the costs for the first three years, gradually reducing to 90%. The rule also detailed the methodology states will use to claim the new rate.

The final rule was formally published in the April 2, Federal Register, and went into effect on June 3, 2013.

In addition to formal rulemaking, CMS also issued important sub-regulatory guidance in 2013. On February 6, the agency released an FAQs document that included information about the Basic Health Program – the ACA's optional coverage program that allows states to use federal tax subsidy dollars to offer subsidized coverage for individuals with incomes between 139-200% of the FPL.[132]

The FAQs also clarified that women who indicate on an initial application that they are pregnant should be enrolled in Medicaid coverage as pregnant women, rather than enrolled in the new adult group (the new eligibility group created by the ACA's Medicaid expansion). CMS further clarified that states are not required to track the pregnancy status of women already enrolled in the new adult group; women should be informed of the benefits afforded to pregnant women under the state's Medicaid program and if a woman becomes pregnant and requests a change in her coverage category, the state must make the change if she is eligible. Once the pregnancy is concluded, the state Medicaid agency will be required to re-evaluate the woman's eligibility for other coverage groups.

Also in February, CMS issued a State Medicaid Directors letter providing guidance on the ACA's 1% FMAP increase to states that elect to provide certain preventive services without cost-sharing in their standard Medicaid benefit package.[133] The services specified in the February 1, letter were those with an A or B rating from the United States Preventive Services Task Force (USPSTF), and vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). CMS acknowledged that the provision of the specified preventive services may overlap with other services eligible for enhanced or increased FMAP rates not identified in the letter, and used family planning services as the example of how the 1% FMAP would work.

For example, family planning services may include USPSTF preventive services and ACIP approved adult vaccines, and their administration, furnished during a family planning visit. Family planning services can be reimbursed at a 90% rate. In these cases, states should claim on the family planning line of the

127 "Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing." *Federal Register* 78:14 (January 22, 2013) p. 4594.

128 "Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, Final Rule." *Federal Register* 78:135 (July 15, 2013) p. 42160.

129 For more on family planning services and supplies, see the "Family Planning Services and Supplies" section starting on page 34.

130 The outstanding provisions of the January NPRM had not been finalized by CMS as of October 28, 2013.

131 "Medicaid Program; Increased Federal Medical Assistance Percentage Changes Under the Affordable Care Act of 2010, Final Rule." *Federal Register* 78:63 (April 2, 2013) p. 19918.

132 US Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, *Affordable Care Act Questions and Answers*, February 6, 2013, http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-02-06-13.pdf.

133 US Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, letter to State Medicaid Directors re: Affordable Care Act Section 4106 (Preventive Services), February 1, 2013, http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-002.pdf. For more on other preventive services, see the "Contraceptive Coverage Benefit Caught in Religious, Legal Crosshairs" section on page 19 and the "Family Planning Services and Supplies" section, starting on page 34.

CMS-64 form, which is reimbursed at the 90% rate. If a state ordinarily claims these preventive services and adult vaccines as a separate service from the family planning service, it should continue to do so.[134]

CMS Allows States to Pursue Alternative Path to Medicaid Expansion: "Premium Assistance"

While much of the country was focused on the "will-they-or-won't-they" decisions of states regarding the Medicaid expansion, an alternate path to expanding insurance coverage to low-income individuals emerged as a potential option for states.[135] A number of states already use Medicaid dollars to buy private insurance coverage or to help Medicaid-eligible residents buy into an employer-sponsored plan.[136] A December 2012 CMS FAQs document on the ACA sent by HHS Secretary Sebelius to state governors stated that "states can use federal and state Medicaid and CHIP funds to deliver Medicaid and CHIP coverage through the purchase of private health insurance"[137] under Section 1905(a) of the Social Security Act (SSA).[138] The FAQs indicated that insurance coverage purchased with Medicaid funds would be "subject to federal standards related to wrap-around benefits, cost sharing, and cost effectiveness."[139]

On February 26, Arkansas Governor Mike Beebe (D) announced that Secretary Sebelius had said the federal government would pay for Arkansas to purchase insurance coverage for low-income residents through the state's health insurance exchange rather than by expanding its Medicaid program.[140]

Such an arrangement would allow Arkansas to provide commercial coverage to residents with incomes up to 138% of the FPL with the federal government paying all the costs for the first 3 years, gradually decreasing to 90% in 2020, without actually expanding its Medicaid program.[141] More than 200,000 Arkansans would be expected to gain coverage under the deal – the same group that would receive coverage if the state were to expand Medicaid.[142] While the state would use federal Medicaid dollars to pay for the full insurance premium for the first three years, enrollees could have to pay some co-pays.[143]

Initially, not much was known about the "new" premium assistance option, but soon several state governors – particularly those in difficult political climates – expressed interest in the idea. On March 29, CMS released an FAQs document providing a few details about the premium assistance approach.[144] In August, Arkansas became the first state to formally apply for a waiver from CMS to implement the premium assistance option.[145] By the end of 2013, Iowa also had a premium assistance waiver approved by CMS. Michigan expanded its Medicaid program through a waiver that, while enrolling patients into Medicaid rather than private insurance coverage, makes some notable changes to Medicaid protections and benefits. Pennsylvania had released its premium assistance plan for public comment, but had not submitted a formal plan to CMS.

A number of advocacy groups expressed concern that states might try to use this option to get CMS to waive certain Medicaid requirements and protections. And indeed, despite CMS's stated guidance that premium assistance enrollees would be subject to the same rules and protections as other Medicaid beneficiaries, states did include in their waivers a number of requests to eliminate some existing Medicaid protections and add additional requirements for eligibility, including eliminating wrap-around benefits; imposing premiums, cost-sharing, and work requirements; waiving requirements to provide family planning services; and limiting beneficiaries' access to out-of-network providers. While CMS upheld many requirements – including those related to family planning – it did waive some.

134 US Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, letter to State Medicaid Directors re: Affordable Care Act Section 4106 (Preventive Services).

135 For information on Medicaid-funded family planning policies, see "Publicly Funded Family Planning: A Programmatic Look" starting on page 28.

136 Sarah Kliff, "Arkansas's unusual plan to expand Medicaid," *Washington Post Wonkblog* (blog), February 28, 2013, http://www.washingtonpost.com/blogs/wonkblog/wp/2013/02/28/arkansass-different-plan-to-expand-medicaid/.

137 US Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid*, December 10, 2012, http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf.

138 Sections 1905(a) of the SSA only applies to the use of Medicaid funds. The statutory authority for the use of CHIP funds for premium assistance is Section 2105(c)(3) of the SSA.

139 US Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid*. *See also* Sara Rosenbaum, "Using Medicaid Funds to Buy Qualified Health Plan Coverage for Medicaid Beneficiaries," *HealthReformGPS*, March 7, 2013, http://www.healthreformgps.org/resources/using-medicaid-funds-to-buy-qualified-health-plan-coverage-for-medicaid-beneficiaries/.

140 David Ramsey, "UPDATE Medicaid game-changer," *Arkansas Times*, February 26, 2013, http://www.arktimes.com/ArkansasBlog/archives/2013/02/26/medicaid-game-changer-feds-approve-putting-entire-expansion-population-on-exchange.

141 The Advisory Board Company, "Big deal in Arkansas: State gets OK on plan to circumvent Medicaid," *Daily Briefing*, February 27, 2013, http://www.advisory.com/Daily-Briefing/2013/02/27/Feds-OK-plan-to-cover-low-income-patients-through-exchanges.

142 David Ramsey, "UPDATE Medicaid game-changer."

143 Ibid.

144 US Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Medicaid and the Affordable Care Act: Premium Assistance*, March 2013, http://www.washingtonpost.com/blogs/wonkblog/files/2013/03/FINAL-Medicaid-premium-assistance-FAQ-3-29-13.pdf.

145 MaryBeth Musumeci, *Medicaid Expansion Through Premium Assistance: Arkansas and Iowa's Section 1115 Demonstration Waiver Applications Compared*, Henry J. Kaiser Foundation, September 18, 2013, http://kff.org/health-reform/fact-sheet/medicaid-expansion-through-premium-assistance-arkansas-and-iowas-section-1115-demonstration-waiver-applications-compared/.

One of the most notable waivers granted will allow Iowa to impose premiums on individuals earning as little as $5,745 a year (50% of the FPL).

NFPRHA commented on a number of these proposals and worked with its members and colleague organizations to urge CMS to uphold Medicaid's requirements and protections for family planning services, supplies, and providers. While NFPRHA was gratified that CMS did stand firm on family planning, it was disappointed with some of the program requirements CMS did waive, including those related to premiums that can serve as a significant barrier to care for low-income populations. The exceptions made by CMS in granting these waivers will be instructive as other states contemplate similar alternative means of implementing the ACA's Medicaid expansion.

Section III: Publicly Funded Family Planning: A Programmatic Look

A series of regulatory actions and legislative efforts in 2013 would significantly impact publicly funded family planning providers. NFPRHA worked hard to obtain a number of favorable policy decisions from the Centers for Medicare & Medicaid (CMS) that would allow patients to continue accessing services through Medicaid family planning expansions – not least of which was the ability to continue §1115 family planning waivers. Research and data efforts on the national level are examining how to best demonstrate the quality of the care and value of the services delivered in the safety net. NFPRHA, in partnership with federal agencies and coalition partners, has also started advocacy efforts designed to incorporate family planning services into national quality measurement efforts.

The positive policy developments to strengthen publicly funded family planning were balanced with several developments that would reduce access to care for the most vulnerable individuals living in the United States. Some states continued implementing laws designed to weaken the family planning network and prevent women and men from accessing services. Congress advanced immigration reform policy that barred undocumented women and men from accessing comprehensive health coverage until after the completion of more-than-a-decade-long citizenship process.

CMS Grants One-Year Extensions to Medicaid Family Planning Waivers

For two decades, states have broadened eligibility for their Medicaid programs to provide family planning services and supplies to individuals who are not otherwise eligible for Medicaid, in their state.[146] Originally these expansions were authorized through a Medicaid demonstration waiver authorized by §1115 of the Social Security Act, an important tool that allows states to test out innovative ideas in the administration of their Medicaid programs. Recognizing the effectiveness of these programs, Congress included in the Affordable Care Act (ACA) a provision giving states the option to amend their state Medicaid plans to expand eligibility for family planning services and supplies to individuals who are not pregnant and who have an income that does not exceed the income-eligibility level set by the state for coverage for pregnancy-related care.[147]

Entering 2013, however, states faced significant uncertainty about the future of their Medicaid family planning waivers. Following the passage of the ACA, CMS began shortening the length of Medicaid family planning waiver initial terms and renewals. Instead of approving initial waiver applications and renewals for their traditional five- and three-year terms, respectively, CMS shortened the timeframe so that all new or renewed waivers had scheduled end dates of December 31, 2013. In 2012, CMS began including language in waiver renewals directing states to prepare transition plans detailing how they plan to move waiver enrollees into more comprehensive coverage under the ACA.

Good news came in 2013. The first indication that waivers would continue past 2013 came at NFPRHA's 2013 National Conference, where Julia Hinckley, Deputy Director of the Children and Adults Health Programs Group, at the Center for Medicaid and CHIP Services within CMS, indicated that CMS was open to continuing waivers. In July, word came down that CMS was in fact allowing states to continue their family planning waivers, granting one-year extensions to states.[148]

146 For more on family planning services and supplies, see the "Family Planning Services and Supplies" section starting on page 34.

147 Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010). For more information on the Affordable Care Act, see the "Affordable Care Act" section starting on page 15.

148 The full list of current Medicaid family planning expansion end dates is available on the Guttmacher Institute website. Guttmacher Institute, *State Policies in Brief: Medicaid Family Planning Eligibility Expansions*, http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf.

Since 2012, NFPRHA, its members, and its allies routinely communicated the continuing need for Medicaid family planning waivers to CMS. In 2013, NFPRHA, along with the Guttmacher Institute, strongly urged administration officials to extend the family planning waivers into 2014. The one-year extension was a significant victory for publicly funded family planning, ensuring that women and men in family planning expansion states will continue to receive critical health care services as the ACA gets fully underway. NFPRHA will continue to work with its partners to ensure that CMS understands the continuing need for these important programs beyond 2014.

In 2013, many states understood the continuing importance of Medicaid family planning programs and looked to implement or improve their own family planning expansions. Some other states, however, began looking for ways to streamline eligibility standards and cut costs. One of the paths states examined was the possibility of eliminating their current limited-benefit Medicaid programs, including their expansions of Medicaid eligibility for family planning through state plan amendments (SPA) and waivers.

As with other public health programs and limited-benefit Medicaid coverage, some policymakers at the federal and state levels argued that the ACA would solve the problem of the uninsured and therefore America no longer needed a safety net or funding for it. Interestingly, this was a view put forth both by supporters of the law as well as its opponents in their ongoing efforts to undermine the law and slash funding for essential public health programs like Title X.[149]

In 2013, NFPRHA actively engaged with family planning providers and administrators in a number of states on the continuing need for Medicaid family planning expansions. NFPRHA developed a fact sheet, "Medicaid Family Planning Expansion Programs: Essential Coverage Post-ACA Implementation," to help family planning providers, administrators, and supporters in their efforts to maintain or secure Medicaid family planning expansion programs.

In March, NFPRHA staff testified at a Nebraska Legislature Health and Human Services Committee hearing in support of the state pursuing a Medicaid family planning SPA. Staff also traveled to other states, including Pennsylvania, Maine, and Ohio, to help educate advocates and legislators about the important role Medicaid family planning expansions could play in their states.

NFPRHA continued to emphasize that Medicaid family planning expansion programs remain a cost-effective means of providing essential health services and will be important to states' efforts to implement the ACA. The health reform experience of Massachusetts shows that even with "universal" coverage, there will be significant coverage gaps for millions in need of family planning. Many of these patients will turn to safety-net settings, such as publicly funded family planning centers, for care. Medicaid family planning expansion programs help to ensure that women can access the services they need where and when they need them. Ending Medicaid family planning expansion programs would serve only to limit access to care and limit states' ability to meet the requirements of the ACA, and would increase – not decrease – state and federal spending.

Ultimately, the number of states which have expanded Medicaid coverage of family planning services stayed the same in 2013. By the end of the year, a total of 31 states had sought and received approval from CMS to expand Medicaid coverage of family planning through either a waiver or a SPA. Twenty-one states had expanded family planning access via a waiver. Connecticut became the newest family planning SPA state, bringing the total number of SPA states to 10 at the end of 2013 (joining California, Indiana, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Virginia, and Wisconsin).

NFPRHA continues to work to help state officials understand why Medicaid family planning expansion programs are good for public health and good for state budgets.

149 For more information on the Title X family planning program, see the "Publicly Funded Family Planning: Budget and Appropriations" section starting on page 6.

Medicaid Changes Affect Medicaid Family Planning Expansions

The ACA brings a number of changes to Medicaid that potentially impact family planning providers and their patients. One of those changes involves the way income is counted for the purposes of determining Medicaid eligibility.

In February, CMS released a frequently asked questions (FAQs) document that included information about transitioning to the ACA's new Medicaid income standards, known as modified adjusted gross income (MAGI).[150] This more uniform counting methodology – instead of the varied ways states had been assessing income and household size for public insurance programs – will be used for the health insurance marketplaces and most of Medicaid. Beginning in 2014, the ACA's MAGI rules require that states move away from income "disregards" – which allow states to exclude certain income for groups or subgroups of Medicaid applicants – and convert to using MAGI counting rules.

Unfortunately, this conversion created a potential problem for Medicaid family planning expansion programs, some of which allow for certain individuals to have their eligibility assessed using only their individual income. This allows state Medicaid agencies to enroll individuals into their family planning expansion programs who, if their parents', spouse's, or other household members' income was counted, might not otherwise qualify for the family planning expansion. This means of disregarding certain income has been especially important for ensuring that individuals seeking confidential services are able to access family planning services and supplies through Medicaid.

Another challenge for Medicaid family planning programs was in the ACA's requirement that states move to a single, streamlined application, which will be used by the state insurance marketplaces to gather and assess information necessary to determine the insurance coverage and assistance for which a person is eligible.[151] However, as with the transition to MAGI, there were particular concerns about this transition with respect to Medicaid family planning expansion programs.

In the 23 states with Medicaid family planning expansions where the health insurance marketplace was being run by the federal government (federally facilitated marketplaces, or FFMs), it was not actually possible for the FFM to assess or determine eligibility for the state's Medicaid family planning expansion.[152] Medicaid family planning expansions were not included on the FFM single, streamlined application, and eligibility for these programs therefore could not be assessed and/or determined by the FFM.[153] There were also concerns that the longer applications required for full-benefit coverage could be a deterrent for some patients to get enrolled in coverage (such as through same-day, on-site enrollment).

NFPRHA brought together coalition partners to assess and strategize solutions related to MAGI and the single, streamlined application. NFPRHA and its partners had productive conversations with CMS in December 2013. NFPRHA continues to work to resolve these issues and ensure they do not act as a barrier to care for people seeking family planning services through Medicaid family planning expansion programs.

CDC Publishes New STD Prevention Funding Opportunity Announcement

In June 2013, the Centers for Disease Control and Prevention's (CDC) Division of STD Prevention (DSTDP) published a new funding opportunity announcement (FOA) entitled *Improving Sexually Transmitted Disease Programs through Assessment, Assurance, Policy Development, and Prevention Strategies* (STD AAPPS).[154] This FOA formally adopted a much-anticipated, new approach to CDC's STD prevention efforts. While this new FOA had similar features to the previous STD FOA, there are some major differences, most notably the elimination of separate funding for the infertility prevention project (IPP) and syphilis elimination project. It also required programs to develop work plans, performance measures, and evaluation

150 US Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, *Affordable Care Act Questions and Answers*, February 6, 2013, http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-02-06-13.pdf. See also US Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, *Medicaid and CHIP FAQs: MAGI Conversion*, originally released February 2013 and August 2013, http://medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-Implementation/Downloads/FAQs-by-Topic-MAGI-Conversion-2013.pdf.

151 Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010). For more information on the single streamlined application, see the "Problems with the Single Streamlined Application" section on page 17.

152 Alice Weiss, National Academy for State Health Policy, "Family Planning & the Single Streamlined Application," NFPRHA Medicaid Peer-to-Peer Meeting PowerPoint, October 1, 2013, http://www.nationalfamilyplanning.org/document.doc?id=1206.

153 Ibid.

154 Centers for Disease Control and Prevention, Division of Sexually Transmitted Disease Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention Director Gail Bolan, MD, letter to colleagues, June 14, 2013, http://www.cdc.gov/Std/dstdp/DearColl-June-14-2013.pdf. For information on STD prevention and treatment funding, see the "Publicly Funded Family Planning: Budget and Appropriations" section, starting on page 6.

activities that highlight program efficiency, cost effectiveness, and scalable interventions with high health impact. Prior to this FOA, DSTDP provided funding in 50 states, seven cities, and two territorial health departments to assist in local STD prevention efforts - these existing agreements expired at the end of 2013. The anticipated award date for these new projects is January 2014, and each project will last five years.

Immigrant Access to Family Planning: Policymakers Erect Additional Barriers to Care

In 2012, the administration made the decision to deny a new class of lawfully residing individuals' access to the ACA.[155] The policy, Deferred Action for Childhood Arrivals (DACA) – which allows the US to defer immigration actions against undocumented immigrants brought to the US as children – was widely supported by the public. The administration quickly blunted any enthusiasm immigrants' rights advocates had around the policy when they implemented a rule that barred these same individuals from ACA-related coverage.[156] The administration's decision, considered politically motivated to draw attention away from the lack of comprehensive immigration reform legislation and the unpopular health reform law, frustrated supporters of access to health care.

In 2013, the White House hoped to move quickly on comprehensive immigration reform legislation using the political capital it acquired from a decisive electoral win in 2012. After months of closed-door negotiations, in mid-April, a bipartisan group of senators, referred to as the "Gang of Eight," released a nearly 850-page immigration reform bill.[157] The proposal included a pathway to citizenship for the approximately 11 million undocumented individuals living in the United States. Glaringly absent from the bill were any resources to help those seeking citizenship obtain access to health services. The bill, as in past immigration reform policy efforts, would require that undocumented immigrants wait at least 10 years before allowing them to access programs designed to help them obtain public or private insurance coverage. It further maintained an additional wait time for immigrants who would be eligible for Medicaid – in effect forcing some undocumented individuals to wait up to 15 years for such coverage.

Eager to help advance immigration reform, immigrant rights groups were put in the difficult position of having to support a bill that fell far short of what they envisioned. Several advocacy groups expressed disappointment with the lack of health care policy in the bill yet refused to dismiss the bill outright for fear of losing any momentum to address the immigration challenges that frequently involved millions of US residents. Two weeks after the bill was introduced, the Senate Judiciary Committee began marking up S. 744, the "Border Security, Economic Opportunity, and Immigration Modernization Act."[158] To allow the bipartisan group of sponsors to maintain unity throughout the legislative process, the bill would have to remain relatively unchanged throughout the markup process despite the more than 300 amendments that were filed to change the bill.[159] Health care advocates, including NFPRHA, worked with Senator Mazie Hirono (D-HI) to try to advance several amendments that would open up small health care access points for undocumented immigrants. Those amendments failed with the bipartisan drafters voting against them.[160]

After a two-week markup, S. 744 passed the Senate Judiciary Committee by a vote of 13-5.[161] Three Republican authors of the bill, Senators Lindsay Graham (SC), Orrin Hatch (UT), and Jeff Flake (AZ), joined all 10 Democrats on the committee to advance the bipartisan legislation to the Senate floor.

While the Senate was moving quickly on its bill, the House was trying to identify a path it could take to advance immigration reform. A significant number of the House Republicans were opposed to the Senate's immigration reform bill, which put House Speaker John Boehner (R-OH) in the familiar position of not being able to coalesce his caucus around any specific initiative.[162] Recognizing that the Senate bill would not be brought for a vote on the House floor, House Democrats were able to publicly oppose it on the grounds that it lacked sufficient health care supports. The growing public divisions in the House prompted reform advocates to worry that any viable legislation was doomed.

155 For more information on the Affordable Care Act, see the "Affordable Care Act" section starting on page 15.

156 "Pre-existing Conditions Insurance Plan Program; Amendment to Interim Final Rule", Federal Register 77:169 (August 30, 2012).

157 Staff Report, "Senators aiming for 70 votes on immigration bill," *USA Today*, April 25, 2013, http://www.usatoday.com/story/news/politics/2013/04/25/schumer-mccain-immigration-bill/2112059/.

158 Border Security, Economic Opportunity, and Immigration Modernization Act, S. 744, 113th Cong. (2013).

159 Elise Foley, "Immigration Bill Faces Hundreds Of Amendments, Including On LGBT Rights," *Huffington Post*, May 7, 2013, http://www.huffingtonpost.com/2013/05/07/immigration-bill-amendments_n_3232641.html.

160 "Immigration," official website of Senator Maize Hirono (D-HI), accessed March 2014, http://www.hirono.senate.gov/issues/immigration.

161 "Comprehensive Immigration Reform," official website of the United States Senate Committee on the Judiciary, accessed March 2014, http://www.judiciary.senate.gov/legislation/immigration/.

162 Alexander Bolton, "Conservatives declare opposition to Senate immigration bill," *The Hill*, May 21, 2013, http://thehill.com/homenews/senate/300891-conservatives-declare-opposition-to-senate-immigration-bill.

In June, by a vote of 68-32, the Senate passed S. 744.[163] Fourteen Republicans joined all of the Democrats in the Senate to advance the legislation. Under the proposal, undocumented immigrants would be eligible for citizenship after approximately 13 years of living and working in the US.

The Senate hoped that its strong bipartisan vote would force House Speaker John Boehner (R-OH) to bring the bill up for a vote. That day never came. House negotiations slowed to a stop. President Barack Obama tried to jumpstart the discussion following the resolution of the government shutdown but the need to focus on the rollout of health care reform distracted the administration from making substantive efforts at the end of 2013.[164]

However, the administration did issue a policy designed to improve immigrant access to health care. In October, Immigration and Customs Enforcement (ICE), the legal enforcement agency of the US Department of Homeland Security, confirmed that immigrant parents could enroll their children in ACA-related health insurance coverage without fear of triggering immigration enforcement actions.[165] Mixed-status families frequently forego applying for benefits for which they might be eligible for fear of subjecting undocumented family members to enforcement actions. This is a substantial barrier to coverage and care for children in those families. Public health advocates were eager to educate immigrant communities about this policy and hoped the clarification would encourage eligible individuals to seek out health services.

Protecting Patient Confidentiality: Seeking Solutions for a Growing Concern

In 2013, concerns about protecting patient access to confidential services grew as more health insurance coverage options became available under the ACA. In particular, there was apprehension about increased numbers of patients with commercial health insurance who could be at risk of having their health information disclosed through explanation of benefits forms (EOBs). With little instruction from the federal government on how to approach this issue, as insurance is generally regulated by states, many in the health care community and several states took steps to address the problem.

In California, on October 1, 2013, Governor Jerry Brown (D) signed Senate Bill 138, the "Confidential Health Information Act," into law.[166] This bill will ensure that health plans honor confidential communications requests and seek ways to communicate directly with patients rather than sending information, such as EOBs, to the main policyholder.[167] This protection will support patients seeking confidential services - including family planning services such as contraception, STD testing, and cancer screening.[168]

NFPRHA assembled a small group of family planning and sexual health organizations to draft pilot legislative and regulatory language protecting confidentiality for sensitive services.

Policymakers in Colorado and Massachusetts undertook similar actions towards protecting access to confidential services. In Colorado, advocates were able to successfully add regulatory language to EOB standards that require the protected health information of adult children, insured as dependents, to remain confidential.[169] The regulations state that a separate means of communication may be required to safeguard this information. Massachusetts was also working with regulatory agencies to address the confidentiality of insured dependents' EOBs. A coalition of health care advocates in Massachusetts, including the state department of health, participated throughout the year in the Division of Insurance's process to write regulations implementing newly passed legislation requiring health insurance plans to send a common "summary of payments" form (similar to an EOB). Family planning advocates in the state partnered with a wide variety of health care advocacy stakeholders to craft a comprehensive set of recommendations to both implement the summary of payments form and protect confidentiality.

In contrast, in North Carolina, proposed legislation was defeated that tried to curtail the provision of confidential services by requiring that minors provide notarized parental consent from parents before being treated for sexually transmitted diseases, mental health counseling, pregnancy care, or substance abuse

163 Vote 168, US Senate Roll Call Votes, 113th Cong. (2013), June 27, 2013, http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=113&session=1&vote=00168.

164 For more on health care reform and the rollout of open enrollment, see the "Affordable Care Act" section starting on page 15.

165 US Department of Homeland Security, US Immigration and Customs Enforcement, *Clarification of Existing Practices Related to Certain Health Care Information*, October 25, 2013, http://www.ice.gov/doclib/ero-outreach/pdf/ice-aca-memo.pdf.

166 S.B. 138, 2013-2014 Leg., Reg. Sess. (Cal. 2013), http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140SB138.

167 California Family Health Council, "Governor Signs Confidential Health Information Act Into Law As California Moves Forward With Health Reform," news release, October 2, 2013, http://cfhc.org/about/press/governor-signs-confidential-health-information-act-law-california-moves-forward-health.

168 For more on family planning services and supplies, see the "Family Planning Services and Supplies" section, starting on page 34. For more on how they are funded, see the "Publicly Funded Family Planning: Budget and Appropriations" section starting on page 6.

169 3 Code Colo. Regs. § 702-4.

treatment.[170] In Montana, county commissioners voted to reject Title X funds appropriated by the state because some of the commissioners took issue with the requirement that adolescents be able to access services confidentially.[171] Despite local protests and positive recommendations from the public health commission, county commissioners did not restore funding and the funding had not been redistributed at print time.

Demonstrating Value: Moving Towards a Contraceptive Quality Measure

The shift in the US health system away from paying for quantity, towards financing tied to quality, has significant consequences for the safety net. It will be increasingly important that family planning, its services and providers, be able to demonstrate their value in terms of achieving positive health outcomes and reducing health care costs. Fortunately, family planning services and providers, as research has repeatedly shown, achieve both aims. Yet few authorities that review and endorse formal quality measures have examined the quality contributions of family planning.

In an effort to promote greater recognition about the benefits of family planning, NFPRHA ramped up its focus and work on quality improvement and measurement. In June, NFPRHA responded to a draft from the National Committee for Quality Assurance (NCQA) on their Patient-Centered Medical Home (PCMH) standards. NFPRHA's comments asked NCQA to understand the varying levels of PCMH readiness within the safety-net community and encouraged the accrediting body to adopt a more flexible approach to its PCMH-qualifying standards.

NFPRHA, along with the Family Planning Councils of America (FPCA), hosted a Capitol Hill briefing on the work they have done to achieve high-quality clinical and other benchmarks within their Title X programs. Representative Krysten Sinema (D-AZ) hosted the briefing, and the featured speakers included Brenda L. Thomas, MPA, CEO of the Arizona Family Health Partnership, and Cindy Stewart, CEO of the Family Health Council of Central PA, as well as NFPRHA President & CEO Clare Coleman.

Federal and non-governmental stakeholders were also beginning to examine ways to advance a family planning quality measure, specifically, a contraceptive measure. NFPRHA joined a group of experts assembled by Planned Parenthood Federation of American (PPFA) to work towards identification of a contraceptive quality measure and advocate for the development of a national measure. Working on a parallel and coordinated track, the Office of Population Affairs and the Centers for Disease Control and Prevention began the process of preparing a contraceptive measure for submission to an accrediting body for review. All of the stakeholders were working towards the same goal – identifying a way to elevate the importance of family planning in health care delivery. As health care financing becomes more entwined with quality reporting, the existence of a family planning measure could help support the viability of the family planning network.

170 Travis Fain, "Some bills die; others get new life," *News & Record*, May 20, 2013, http://www.news-record.com/news/government/article_864800d4-c102-11e2-ba3e-0019bb30f31a.html.

171 Perry Backus, "Title X: Ravalli County commissioners eliminate women's health services," *Ravalli Republic*, September 9, 2013, http://ravallirepublic.com/news/local/article_3c2bded0-1972-11e3-83bb-0019bb2963f4.html.

Section IV: Family Planning Services and Supplies

Perhaps the greatest achievement for increasing access to and improving the quality of family planning services and supplies in 2013 was a US district court's decision that finally lifted age restrictions on the sale of Plan B One-Step emergency contraception (EC). The decision would make the branded product available over the counter without any purchasing restrictions. This victory came after long legal and regulatory battles that, to some extent, pitted the Obama administration against the family planning and sexual health community.

Also in 2013, despite the failure to release the widely anticipated, Title X guidance revision that would include best practice recommendations on family planning care delivery, two new sets of guidelines for providers were released that further strengthened the model for comprehensive care.

At the other end of the spectrum, the 340B drug discount program became a significant point of scrutiny by opponents in Congress and some corporate interests as poorly regulated. Additionally, a long-awaited and highly necessary bill that would provide additional funding incentives to safety-net family planning providers to implement electronic health records (EHR) stalled in Congress after its introduction.

Emergency Contraception Available Over the Counter, Without Restrictions

In one of most crucial gains for family planning and sexual health in 2013, on April 5, the US District Court for the Eastern District of New York's decision in *Tummino v. Hamburg* lifted age restrictions on EC products available over the counter.[172] Filed in February 2012, the lawsuit was a response to US Department of Health and Human Services (HHS) Secretary Kathleen Sebelius's decision in December 2011 that the Food and Drug Administration (FDA) had not provided enough evidence that EC was safe for women under the age of 17, despite robust data to the contrary. The plaintiffs included the Center for Reproductive Rights and other women's health advocates, arguing against Secretary Sebelius's restriction of over-the-counter EC to only women 17 years of age and older. Judge Edward Korman ruled that the FDA's data provided sufficient evidence to expand over-the-counter EC access to women of all ages. However, he added that the FDA could choose to apply the ruling to only one-pill products if the agency decided that there was a significant difference.

Not only did the decision expand access to EC to younger women, but it also secured access for women who do not have government-issued identification. However, before the promise of access was completely fulfilled, the FDA approved the sale of Plan B One-Step without a prescription for women 15 years of age and older on April 30, despite the court ruling that the over-the-counter availability of EC drugs cannot be restricted by age.[173] Futhermore, the Department of Justice (DOJ) announced soon after that the administration would appeal the decision, claiming that the court did not have the jurisdiction over the FDA to issue its order to remove age restrictions.[174]

In June, the 2nd US Circuit Court of Appeals, which was set to consider the EC appeal, ruled in favor of expanding the over-the-counter availability of two-pill EC methods to women of any age. By June 10, the Obama administration dropped the original appeal on the condition that the lift-of-age restrictions applies to only the brand Plan B One-Step.[175] The court accepted the proposal.[176] Although the court ruling was a victory in terms of EC access, the higher cost of Plan B-One Step as compared to generic brands may hinder access for low-income and other vulnerable populations. NFPRHA is continuing to work with

172 Jodi Jacobson, "Court Orders FDA to Make Emergency Contraception Available Over-the-Counter for All Ages," *RH Reality Check* (blog), April 5, 2013, http://rhrealitycheck.org/article/2013/04/05/court-orders-fda-to-make-emergency-contraception-available-over-the-counter-for-all-ages/.

173 US Department of Health and Human Services, Food and Drug Administration, "FDA approves Plan B One-Step emergency contraceptive without a prescription for women 15 years of age and older," news release, April 30, 2013, http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm350230.htm.

174 Sarah Kliff, "Obama administration plans to appeal Plan B ruling," *Washington Post Wonkblog* (blog), May 1, 2013, http://www.washingtonpost.com/blogs/wonkblog/wp/2013/05/01/obama-administration-plans-to-appeal-plan-b-ruling/.

175 Brady Dennis and Sarah Kliff, "Obama administration drops fight to keep age restrictions on Plan B sales," *Washington Post*, June 10, 2013, http://www.washingtonpost.com/national/health-science/obama-administration-drops-fight-to-keep-age-restrictions-on-plan-b-sales/2013/06/10/a296406e-d22a-11e2-a73e-826d299ff459_story.html.

176 Ben Wolfgang and Tom Howell Jr., "Obama administration drops its appeal of Plan B ruling, will widen access to drug," *Washington Times*, June 11, 2013, http://www.washingtontimes.com/news/2013/jun/11/obama-administration-drops-its-appeal-plan-b-rulin/.

other women's health advocates to support the unrestricted sale of EC products to ensure access to all women. Nonetheless, the ruling was a substantive victory for public health.

New Research and Guidelines Improve and Advance Family Planning Services

In 2013, two new sets of guidelines and recommendations were released with the intention to improve and standardize care for the millions of women who seek contraceptive services every year.[177]

In January, the US Preventive Services Task Force (USPSTF) released a report recommending that clinicians should screen their female patients of childbearing age for Intimate Partner Violence (IPV), and offer additional services to address related concerns.[178] The report followed studies indicating that 31% of women experience IPV in their lifetime, and one in four women are victims of severe IPV. The USPSTF found the most effective screening assessments to be the Hurt, Insult, Threaten, Scream (HITS) tool; Ongoing Abuse Screen/Ongoing Violence Assessment Tool (OAS/OVAT); Slapped, Threatened, and Throw (STaT) tool; Humiliation, Afraid, Rape, Kick (HARK) tool; Modified Childhood Trauma Questionnaire–Short Form (CTQ-SF); and Woman Abuse Screen Tool (WAST). Following the detection of IPV, the USPSTF recommends follow-up services including counseling, home visits, and referrals to community services, with supporting evidence that screening and intervention lead to a moderate net benefit in health and no significant harms. However, the USPSTF noted gaps in existing research on computerized screening and interventions for middle-aged women, as well as men of all ages. In addition, it noted that the development of assessment standards would improve evaluation of screening instruments. With the addition of this recommendation, IPV screening has been added to the list of preventive health care services for women that should be covered by insurance without a co-pay under the Affordable Care Act (ACA).[179]

On June 14, the Centers for Disease Control and Prevention (CDC) released highly anticipated recommendations for clinical providers on contraceptive management.[180] Adapted from the Selected Practice Recommendations (SPRs) issued by the World Health Organization (WHO), the US SPRs provided clinical guidance on a number of complex issues including the use of contraceptive patches and vaginal rings, regular contraception commencement after the use of emergency contraceptive pills, bleeding as a side effect of extended hormonal contraceptive use, female sterilization, and avoiding pregnancy after discontinuing contraceptive use. In addition, the CDC's SPRs provided updated information on decision making for contraceptive method recommendations, pregnancy testing, and specific guidelines on timing, risks, and efficacy for each contraceptive.

In honor of the 48th anniversary of the June 7, 1965, *Griswold v. Connecticut* Supreme Court decision, which paved the way to legalizing all contraception, NFPRHA published a toolkit for members to educate their communities on access to family planning and sexual health services and advocate for the Title X program. The toolkit included a list of talking points for media interviews, a sample letter to the editor, a sample press release, and sample social media posts. Also in honor of *Griswold*, NFPRHA hosted a well-attended Capitol Hill press briefing on the recent attacks on family planning, co-sponsored by Senator Richard Blumenthal (D-CT). Policy experts from the Guttmacher Institute and American Civil Liberties Union joined NFPRHA President & CEO Clare Coleman on a panel and Senator Blumenthal also addressed the attendees.

To support its members in meeting the contraceptive needs of women and men, NFPRHA offered $12,000 in grants to five family planning providers to establish a pilot program for use of the copper intrauterine device (IUD) ParaGard as emergency contraception (EC). This initiative, funded by the William and Flora Hewlett Foundation, was the result of clinical research suggesting that when inserted within five days after unprotected intercourse, ParaGard is 10 times as effective as standard EC pills. Members that received the grants were charged with piloting ParaGard as an EC method for six months.

177 For more information on policy developments around contraceptive coverage, see the "Contraceptive Coverage Benefit Caught in Religious, Legal Crosshairs" section on page 19.

178 Virginia A. Moyer, MD, MPH, on behalf of the US Preventive Services Task Force, "Screening for Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults: U.S. Preventive Services Task Force Recommendation Statement," *Annals of Internal Medicine* 158 (January 2013): 478-486, http://www.uspreventiveservicestaskforce.org/uspstf12/ipvelder/ipvelderfinalrs.pdf.

179 For more information on the Affordable Care Act, see the "Affordable Care Act" section starting on page 15.

180 US Department of Health and Human Services, Centers for Disease Control and Prevention, "U.S. Selected Practice Recommendations for Contraceptive Use, 2013 Adapted from the World Health Organization Selected Practice Recommendations for Contraceptive Use, 2nd Edition," *Morbidity and Mortality Weekly Report* 62 (June 14, 2013), http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6205a1.htm.

340B Drug Pricing Program Continues Amid Criticism

In late 2012, several congressional Republicans took aggressive action to limit the 340B drug discount program's reach. These actions included letters from House and Senate Republicans requesting information about the program and pushing legislation designed to reduce access to 340B drugs. These efforts continued to gain traction in 2013 but by the year's end, congressional leaders who had been publicly hostile to 340B tempered their negative comments about the program's value to the safety net. Congress's changed posture did little to deter other opponents of 340B from criticizing the program – namely, the pharmaceutical industry.

In February, the Pharmaceutical Research and Manufacturers of America (PhRMA) and the Community Oncology Alliance, among other organizations with a strong interest in drug pricing, commissioned a white paper on 340B by Avalere Health, a for-profit research and consulting organization.[181] The paper claimed that there were negative consequences to health care access as a result of the 340B program. It further stated that a lack of thorough and specific regulations have led to "unintended and potentially harmful consequences for patients," particularly in cases in which providers were making clinical decisions based on their 340B discount, and due to evidence of displacement of non-340B providers that are essential for access in underserved areas. In its findings, Avalere Health recommended increased funding for improved regulation and evaluation of the program.

To refute the study, advocates of the 340B program emphasized that the research included only hospitals which left out many safety-net systems that benefit from the program, including family planning health centers. In an effort to counterbalance the negative attention and incomplete information about the program, NFPRHA and other safety-net provider organizations turned to Congress for help. In July, Senators Tammy Baldwin (D-WI) and John Thune (R-SD) and Representatives Shelley Moore Capito (R-WV) and Kathy Castor (D-FL) circulated letters demonstrating broad bipartisan support for the drug discount program.[182] The bipartisan letters signed by 29 Senators and 84 members in the House, signaled to opponents that it would not be easy to dismantle the important program.

On the regulatory side, the Health Resources and Services Administration (HRSA) continued taking steps to clarify the role of the program and provide support for 340B-eligible entities. In response to questions about the eligibility process and requirements, the Office of Pharmacy Affairs released a document addressing frequently asked questions (FAQs).[183] The FAQs confirmed that safety-net organizations that receive in-kind resources such as STD testing kits and other STD prevention products, as well as those that receive direct funding, qualify for the 340B program. The announcement was welcomed by many family planning agencies that were in limbo about their eligibility for the program. The reduction in federal and state resources necessitates that family planning and other safety-net systems maximize their participation in other public health supports including the 340B program. In the last quarter of 2013, opponents took their fight to the courts. In late September, PhRMA filed a lawsuit to block an HHS regulation that would allow providers that were newly eligible for 340B certification under the ACA to purchase discounted outpatient orphan drugs - drugs often used for rare diseases – as long as they are used to treat common conditions.[184] In December, the American Hospital Association filed an amicus curie brief disputing PhRMA's claims.[185]

MITECH Bill Would Bridge Technological Divide

On July 11, Senator Jay Rockefeller (D-WV) and Representative Lois Capps (D-CA) introduced the "Medicaid Information Technology to Enhance Community Health Act" (MITECH, S.1286, H.R. 2676). Congressional champions and safety-net advocates had spent a long time crafting the legislation. By expanding the types of providers eligible for funding incentives to implement an EHR system, MITECH would increase opportunities for safety-net health care providers, such as family planning providers, to modernize and upgrade their medical records systems.[186] Because these providers, including family planning health centers, often do not have the funds to invest in EHR systems, the bill would facilitate improvements in health

181 Biotechnology Industry Organization (BIO) et. al., *The 340B Drug Discount Program: A Review and Analysis of the 340B Program*, Winter 2013, http://www.ncpanet.org/pdf/leg/feb13/340b_white_paper.pdf.

182 Senator John Thune (R-SD), Senator Tammy Baldwin (D-WI), et. al., letter to Senator Tom Harkin (D-IA) and Senator Lamar Alexander (R-TN) supporting the 340B drug discount program, August 2, 2013, http://www.snhpa.org/files/senate_signon_letters.pdf.; Representative Shelley More Capito (WV-R), Representative Cathy Castor (D-FL), et. al., letter to Speaker John Boehner and Minority Leader Nancy Pelosi (D-CA) supporting the 340B drug discount program, August 2, 2013, http://www.snhpa.org/files/340B_draft_052313.pdf.

183 US Department of Health and Human Services, Health Resources and Service Administration, *340B Drug Pricing Program & Pharmacy Affairs: FAQs*, accessed 2013, http://www.hrsa.gov/opa/faqs/index.html#3.

184 Helen Adamopoulos, "PhRMA Files Lawsuit to Stop 340B Drug Discount Regulation," *Becker's Hospital Review*, October 2, 2014, http://www.beckershospitalreview.com/news-analysis/phrma-files-lawsuit-to-stop-340b-drug-discount-regulation.html.

185 Joe Carlson, "Hospitals push back against PhRMA orphan-drug lawsuit," *Modern Healthcare*, December 17, 2013.

186 Medicaid Information Technology to Enhance Community Health Act of 2013, S. 1286; H.R. 2676, 113th Cong. (2013).

care quality, efficiency, and coordination with other providers.[187] The bill was referred to the House Committee on Energy and Commerce with no co-sponsors and to the Senate Committee on Finance with two co-sponsors; no further action took place in 2013.

NFPRHA asked its members and the public to take action by urging their members of Congress to co-sponsor the MITECH bill, vital to the future of publicly funded family planning organizations.

187 Office of Senator Jay Rockefeller (D-WV), "Rockefeller, Whitehouse, Franken, Capps Introduce Bill to Encourage Low-income Health Clinics to Adopt Electronic Health Records," news release, July 11, 2013, http://www.rockefeller.senate.gov/public/index.cfm/press-releases?ID=0f96528a-c1a3-4c93-b898-35e7e2524c6c. For more information on how family planning providers are measuring quality in the new health care economy, see the "Demonstrating Value: Moving Towards a Contraceptive Quality Measure" section on page 33.

Section V: Access to Abortion Care

Despite public and media backlash against anti-reproductive rights legislation and policy in 2012, conservative legislatures and organizations at the state and federal levels continued to push abortion restrictions in 2013. Some members of Congress re-introduced bills that were seen in previous sessions, while others found new ways to attempt limiting access to family planning and sexual health care. As in 2012, there were continued attempts to use the Affordable Care Act (ACA) as a vehicle to restrict abortion access. Although several anti-abortion bills made their way through the House of Representatives, the Democratic-controlled Senate and President Barack Obama continued to stand against or oppose measures that sought to restrict women's access to abortion.

Opponents Use Publicly Funded Family Planning Network to Attack Abortion Service Providers

In January, Representative Marsha Blackburn (R-TN) introduced H.R. 61, the "Title X Abortion Provider Prohibition Act."[188] This bill contained similar language put forth in previous sessions by former Republican House member Mike Pence (elected Governor of Indiana) and would bar Title X funds from being distributed to entities that provide abortion services or refer for abortion services – even though Title X dollars are already prohibited from being used for abortions and Title X programs, by law, must provide a woman with a referral for abortion services if she wishes it.[189] The bill was referred to the Energy and Commerce Committee, of which Rep. Blackburn was the Vice Chair. Representative Diane Black (R-TN) introduced a nearly identical bill, H.R. 217, which was also referred to the House Energy and Commerce Committee.[190] Even though the bills, combined, gained nearly 300 co-sponsors, they did not receive committee consideration.

Another bill targeting publicly funded family planning providers was H.R. 1122, the "Protecting Life in Funding Education Act" or PRO-LIFE Act introduced by Representative Randy Neugebauer (R-TX).[191] The PRO-LIFE Act would prohibit School-Based Health Centers (SBHCs) from contracting with any health center that provides abortion, abortion-related materials or refers for abortion services. Since entities that receive Title X funds must refer for abortions, this measure would have disqualified the entire Title X network from contracting with SBHCs. The bill was referred to the Committee on Education and Workforce's Subcommittee on Early Childhood, Elementary, and Secondary Education, but never received a hearing. In February, led by Rep. Black, Representative Pete Olson (R-TX), and Senator David Vitter (R-LA), several anti-choice Republican members of Congress sent their annual letter to the Government Accountability Office (GAO) requesting a study of how Planned Parenthood Federation of America, the International Planned Parenthood Federation, the Population Council, the Guttmacher Institute, Advocates for Youth, and the Sexuality Information and Education Council of the United States (SIECUS) use federal dollars for health-related activities.[192] These members claimed to be seeking more information about publicly funded programs - including Medicaid and Title X - that direct federal resources to these organizations. The request also asked that the GAO provide the number and type of family planning services provided by community health centers and FQHCs. The GAO did not respond to these requests.

Anti-Abortion Legislators Seek to Limit Abortion Access

At the outset of the first session of the 113th Congress, abortion opponents in Congress introduced numerous bills to limit access to abortion. In addition to bills that were designed to dismantle the Title X network (H.R. 61 and H.R. 217), congressional proposals included attempts to block multi-state insurance plans in the health insurance exchanges from providing abortion coverage despite the fact that many consumers will purchase these plans with their own money ("Stop Abortion Funding in Multi-State Exchange Plans Act"/H.R. 346 and "Preventing the Offering of Elective Coverage of Taxpayer-Funded Abortion Act of 2013"/S. 154).[193] Other measures, such as the "Hyde Amendment Codification Act" or S. 142, would single out

188 Title X Abortion Provider Prohibition Act, H.R. 61, 113th Cong. (2013).

189 For more information on the Title X family planning program, see the "Publicly Funded Family Planning: Budget and Appropriations" section, starting on page 6.

190 Title X Abortion Provider Prohibition Act, H.R. 217, 113th Cong. (2013).

191 Protecting Life in Funding Education Act, H.R. 1122, 113th Cong. (2013).

192 Representative Diane Black (R-TN), Representative Pete Olson (R-TX) and colleagues, letter to the Honorable Gene L. Dodaro, Comptroller General of the United States, US Government Accountability Office, February 21, 2013, http://black.house.gov/sites/black.house.gov/files/GAO%20Report%20Request%202013_letter%20FINAL_0.pdf.

193 Stop Abortion Funding in Multi-state Exchange Plans (SAFE) Act, H.R. 346, 113th Cong. (2013). Preventing the Offering of Elective Coverage of Taxpayer-Funded-Abortion (PROTECT) Act of 2013, S. 154, 113th Cong. (2013). For more information on the ACA's health insurance exchanges, see the "Affordable Care Act" section starting on page 15.

abortion providers and apply cumbersome restrictions on prospective patients.[194] Specifically, opponents sought to permanently codify the Hyde Amendment, which is not permanent law but rather a rider attached to annual appropriations bills. The legislation introduced by Senator Bob Casey (R-PA) would limit access to abortion for women who receive Medicaid. The bill had no co-sponsors, and after being referred to the Committee on Health, Education, Labor and Pensions (HELP), did not see any further action.

Also in January, Representative Paul Broun (R-GA) introduced H.R. 23, the "Sanctity of Human Life Act."[195] This bill would declare that life begins at the point of fertilization, therefore making abortion, some types of contraception, and Assisted Reproductive Technology (ART) illegal. This bill's "personhood" framework had been seen on the state level, making national headlines when introduced in states like Ohio and Virginia, but had not yet been introduced in Congress until 2013. Given its controversial nature, the bill only attained 40 co-sponsors and saw no congressional action after being referred to the Committee on the Judiciary's Subcommittee on the Constitution and Civil Justice. Representative Jim Jordan (R-OH) and Senator Rand Paul (R-KY) introduced their own version of a "personhood" bill, H.R. 1091/S. 583, the "Life at Conception Act."[196] This bill also sought to give full legal protections to "preborn human persons"; it saw no action past committee referral.

As in 2012, 2013 saw more legislation that would allow health care providers and others working in the health care field to refuse to provide certain services, especially abortion, family planning, and sexual health services. S. 143, the "Health Care Provider and Hospital Conscience Protection Act," introduced by Sen. Casey, took so-called "conscience provisions" a step further by also allowing entities, such as hospitals and insurance companies, to refuse to recommend, refer for, provide coverage for, pay for, or participate in abortion services in any capacity.[197] A similar bill, H.R. 940/S. 1204, the "Health Care Conscience Rights Act," was introduced by Senator Tom Coburn (R-OK) and Rep. Black.[198] This bill would have amended the ACA so that entities, including insurance companies, could deny coverage of abortion for religious or moral reasons. Similar to the Blunt Amendment in 2012, these bills were targeting reproductive health services but had far-reaching implications as they would allow employers and insurance companies to deny coverage for anything to which they objected on religious or moral grounds.[199]

Another returning bill was H.R. 447/S. 138, the "Prenatal Nondiscrimination Act" or PRENDA, an anti-"sex-selection" bill to prohibit providers from performing an abortion if they have reason to believe a woman is seeking an abortion based on the sex of the fetus.[200] The bill, introduced by Representative Trent Franks (R-AZ) and Sen. Vitter, received praise among the anti-abortion base but did not see any movement beyond committee referrals in both chambers.

The 113th Congress again saw a bill to ban DC women from having an abortion after 20 weeks, as well as a national iteration. H.R. 1797/S. 886, the "Pain-Capable Unborn Child Protection Act," was originally introduced as the "District of Columbia Pain-Capable Unborn Child Protection Act" by Rep. Franks and Senator Mike Lee (R-UT).[201] The original bill, introduced in April, would have prohibited abortion in the District of Columbia at 20 weeks and beyond. The bill only included the narrow exceptions for rape, incest, and the life of the woman. There was no exception for health or fetal anomalies. In June, there was a hearing on the bill in the Judiciary Committee's Subcommittee on the Constitution and Civil Justice during which Rep. Franks introduced an amendment to make the bill applicable to the entire country, not just DC.[202] The amendment passed along party lines and the bill was modified to ban abortions at 20 weeks and after in all states. The new bill then went to the full Judiciary Committee, passed along party lines (20-12), and was sent to the floor for a vote - despite opposition from leading medical organizations. The bill passed the House, and a Senate companion, S. 1670, was introduced by Senator Lindsay Graham (R-SC) in November.[203] In a "Statement of Administration Policy" the Obama administration strongly opposed H.R. 1797, stating that if presented with the bill, the president's advisors would recommend he veto it.[204] The bill

194 Hyde Amendment Codification Act, S. 142, 113th Cong. (2013).

195 Sanctity of Human Life Act, H.R. 23, 113th Cong. (2013).

196 Life at Conception Act, H.R. 1091, 113th Cong. (2013); Life at Conception Act of 2013, S. 583, 113th Cong. (2013)

197 The Health Care Provider and Hospital Conscience Protection Act, S. 143, 113th Cong. (2013).

198 Health Care Conscience Rights Act, H.R. 940, 113th Cong. (2013); Health Care Conscience Rights Act, S. 1204, 113th Cong. (2013). For more on refusal policies, see the "Contraceptive Coverage Benefit Caught in Religious, Legal Crosshairs" section on page 19.

199 In 2012, Senator Roy Blunt (R-MO) offered an amendment to allow any employer or insurance company to refuse to offer, provide, or cover any essential health care service - including birth control coverage - if the employer or insurance company opposed the service on religious or moral grounds.

200 Prenatal Nondiscrimination Act (PRENDA) of 2013, H.R. 447, 113th Cong. (2013); Prenatal Nondiscrimination Act, S. 138, 113th Cong. (2013).

201 Pain-Capable Unborn Child Protection Act, H.R. 1797, 113th Cong. (2013); District of Columbia Pain-Capable Unborn Child Protection Act, S. 886, 113th Cong. (2013).

202 "Markup of: H.R. 1797, the 'District of Columbia Pain-Capable Unborn Child Protection Act'; and, H.R. 1944, the 'Private Property Rights Protection Act of 2013'," official website of the United States House of Representatives Committee on the Judiciary, last modified June 2013, http://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=100990.

203 Vote 251, US House of Representatives Roll Call Votes, 113th Cong., June 18, 2013, http://clerk.house.gov/evs/2013/roll251.xml. Pain-Capable Unborn Child Protection Act, S. 1670, 113th Cong. (2013).

204 Executive Office of the President, Office of Management and Budget, *Statement of Administration Policy: H.R. 1797 – Pain-Capable Unborn Child Protection Act*, June 17, 2013, http://www.nrlc.org/uploads/fetalpain/AdminPolicyStatement061713.pdf.

did not move further in 2013. Similar bans on later abortion procedures have passed in several states; however, a 20-week abortion ban law in Arizona was challenged in court and found unconstitutional by a federal appeals court in May.[205]

Representative Chris Smith (R-NJ) introduced H.R. 7, the "No Taxpayer Funding for Abortion Act," in May. Rep. Smith's bill would have banned federal funds for any health coverage that includes abortion care, effectively taking away insurance coverage that millions of people already have.[206] A Senate companion bill (S. 946) was introduced by Senator Roger Wicker (R-MS).[207] The bill received a lot of attention from Congress, the media, and the public when it was originally introduced in 2011 because of its far-reaching implications. However, the bill did not move by the end of the year.

Champions Introduce Legislation, Elevate Efforts to Broaden Abortion Access and Protections

Despite a strong presence of anti-abortion activity in the 113th Congress, abortion rights champions introduced a cadre of legislation, including new bills, to protect and expand abortion access. Representative Louise Slaughter (D-NY) and Senator Kirsten Gillibrand (D-NY) introduced H.R. 1389/S. 777, the "Military Access to Reproductive Care and Health (MARCH) for Military Women Act."[208] In previous versions, this bill sought to ensure insurance coverage for military women and their dependents who wanted an abortion due to rape or incest and to repeal current restrictions on abortion care performed at Department of Defense facilities. However, since the Shaheen Amendment passed in 2012 - guaranteeing military women and military dependents access to insurance coverage of abortion in the cases of rape or incest - this bill would complement that victory by eliminating the prohibition on abortion in military medical facilities. The bill saw no further action.

Senator Frank Lautenberg (D-NJ) introduced S. 813, the "Peace Corps Equity Act of 2013," which would have provided abortion coverage for Peace Corps volunteers in cases of rape, incest, or life endangerment.[209] Women who work for the federal government, including those who work in the national Peace Corps office, receive coverage for abortion under these exceptions, and this bill would have extended that coverage to volunteers serving in other countries. Senator Lautenberg died in June and the bill was not re-introduced in 2013.

In mid-November, two proactive efforts were launched to protect abortion services and expand abortion access in the United States. The "Women's Health Protection Act" (S. 1696/H.R. 3471) was new legislation introduced by Senators Richard Blumenthal (D-CT), Barbara Boxer (D-CA), and Tammy Baldwin (D-WI) in the Senate and Representatives Judy Chu (D-CA), Marcia Fudge (D-OH), and Lois Frankel (D-FL) in the House.[210] The legislation would prohibit state laws that impose restrictions on access to women's health, including medically unnecessary tests and procedures that are often meant to erect barriers to abortion access. More specifically, the bill would require states to prove that the measures they propose do not undermine access to these services nor do they single out abortion providers as compared to providers that offer similar medical procedures.[211] The "All Above All" campaign, organized by sexual and reproductive health coalition groups, held a November day of action on Capitol Hill, during which supporters educated members of Congress about the Hyde Amendment legislation, which bars federal funding for abortion, except in the cases of rape, incest, and life of the mother.[212] Participants discussed how these restrictions bar many poor and low-income women from accessing publicly funded abortion and that a woman's financial position should not prohibit her from having an abortion if she needs one. Neither of these proactive bills received a hearing.

NFPRHA, along with many national partners, signed a letter supporting the Women's Health Protection Act and was an official "supporting organization" of the All Above All campaign.

On the 40th anniversary of the *Roe v. Wade* Supreme Court decision that legalized abortion in the US, President Obama released a statement affirming "its historic commitment to protect the health and reproductive freedom of women across this country" continuing that he would "stand by its guiding principle: that government should not intrude on our most private family

205 Fernanda Santos, "Arizona Law on Abortions Struck Down as Restrictive," *New York Times*, 5/21/13, http://www.nytimes.com/2013/05/22/us/arizonas-ban-on-abortions-struck-down-in-federal-court.html?_r=0.

206 No Taxpayer Funding for Abortion Act, H.R. 7, 113th Cong. (2013).

207 No Taxpayer Funding for Abortion Act, S. 946, 113th Cong. (2013).

208 Military Access to Reproductive Care and Health (MARCH) for Military Women Act, H.R. 1389, 113th Cong. (2013); Military Access to Reproductive Care and Health (MARCH) for Military Women Act, S. 777, 113th Cong. (2013).

209 Peace Corps Equity Act of 2013, S.813, 113th Cong. (2013).

210 Women's Health Protection Act, S. 1696, 113th Cong. (2013); Women's Health Protection Act, H.R. 3471, 113th Cong. (2013).

211 For more on state-level attacks on abortion and family planning, see the "State Level Anti-Abortion Activity Focused on Title X Providers" section starting on page 41 and the "Other State-Level Attacks by Anti-Choice Opponents" section on page 42.

212 Emily Crokett, "Advocates Push to End Federal Abortion Funding Bans," *RH Reality Check* (blog), November 13, 2013, http://rhrealitycheck.org/article/2013/11/14/advocates-push-to-end-federal-abortion-funding-bans/.

matters, and women should be able to make their own choices about their bodies and their health care."[213]

In January, NFPRHA published a policy and communications toolkit to commemorate the 40th anniversary of the *Roe v. Wade* Supreme Court decision, citing the right to privacy in legalizing abortion services in the United States. The toolkit contained sample press statements, letters to the editor, social media posts, and talking points to help members educate their patients and communities about the importance of the decision in protecting women's access to safe and legal abortion care.

Anti-Abortion Policy Attached to the Budget

In March, during early budget and appropriations negotiations for the fiscal year (FY) 2014 budget, several policymakers introduced abortion-related amendments in the hopes that they would succeed where stand-alone bills had failed. Senators Vitter, Lee, and Marco Rubio (R-FL), each introduced amendments, including a 20-week abortion ban for DC and a bill to criminalize individuals who help minors cross state lines to obtain an abortion.[214] None of these amendments were called for a vote. In April, President Obama's FY 2014 budget proposal called for bringing the current abortion ban for Peace Corps volunteers in line with the Hyde-permissible exceptions of rape, incest, and life of the woman, but failed to delete the harmful Hyde language which prohibits the use of federal Medicaid funds for abortion, except in those limited circumstances.[215]

Gosnell Trial Incites Abortion Opponents to Act

In the spring of 2013, legal proceedings took place against Kermit Gosnell, a Philadelphia physician found guilty of murder for performing illegal abortion procedures. The story gained national attention, and anti-abortion advocates in and out of Congress seized on this rare occurrence. Representative Stephen Fincher (R-TN) and Senator Lee introduced resolutions calling on lawmakers to target abortion providers with medically unnecessary regulations and investigations (H. Res. 206, S.Res. 133).[216] Other Republicans in the House sent letters to every state health department asking for information about how states regulate and monitor abortion providers. Abortion access proponents took the opportunity to sharply rebuke criminal acts by abortion providers, reinforce their rarity, and stress the importance of safe, legal access to abortion. Senator Blumenthal responded with a resolution condemning all illegal health care practices (S. Res. 134).[217]

State-Level Anti-Abortion Activity Focused on Title X Providers

After losing several family planning and sexual health battles on the 2012 national stage, abortion opponents once again took to the state level, many with an agenda to advance their anti-choice policies by focusing on dismantling the family planning network. These harmful policies ranged from local, municipal governments voting to prohibit Title X funding for local providers, to states "tiering" the types of providers that could receive public funds - effectively cutting out stand-alone family planning providers, abortion providers, and Planned Parenthood affiliates.[218]

While differing slightly in each of the states, through tiering, legislatures in Kansas, Ohio, Oklahoma, and Texas mandated that public funding, including Title X, should first be distributed to public facilities like county health departments, followed by federally qualified health centers (FQHCs) or other primary health care providers, and only then to stand-alone family planning providers.[219] In fact, in Kansas and Oklahoma, family planning providers are excluded from the funding priority system entirely. Statutes in both states requires that family planning

213 White House, "Statement by the President on Roe v. Wade Anniversary," news release, January 22, 2013, http://www.whitehouse.gov/the-press-office/2013/01/22/statement-president-roe-v-wade-anniversary.

214 Fiscal Year 2014 Senate Budget Resolution, S. Con. Res. 8, 113th Cong. (2013).

215 Executive Office of the President of the United States, Office of Management and Budget, *Fiscal Year 2014 Budget of the U.S. Government*, 2013, http://apps.washingtonpost.com/g/page/politics/president-obamas-2014-budget-proposal/94/.

216 Expressing the sense of the House of Representatives that Congress and the States should investigate and correct abusive, unsanitary, and illegal abortion practices, H. Res. 206, 113th Cong. (2013).; Expressing the sense of the Senate that Congress and the States should investigate and correct abusive, unsanitary, and illegal abortion practices, S. Res. 133, 113th Cong. (2013).

217 A resolution expressing the sense of the Senate that all incidents of abusive, unsanitary, or illegal health care practices should be condemned and prevented and the perpetrators should be prosecuted to the full extent of the law, S. Res. 134, 113th Cong. (2013).

218 For more on federal funding for the Title X family planning program, see the "Publicly Funded Family Planning: Budget and Appropriations" section, starting on page 6.

219 Elizabeth Nash et. al., *Laws Affecting Reproductive Health and Rights: 2013 State Policy Review* (Washington DC: Guttmacher Institute, accessed March 2014), https://www.guttmacher.org/statecenter/updates/2013/statetrends42013.html.

funds be given instead to health centers providing primary care, such as hospitals or FQHCs.[220]

Texas augmented an already-hostile environment for family planning and sexual health providers by passing legislation that adds additional requirements to family planning provider systems that provide abortion. The state law now requires these family planning agencies to separate their finance and administrative functions, like governing structure and incorporation, between the two service areas.[221] Almost all of these Texas laws are facing legal challenges.

Legislators in Arkansas and North Dakota proposed language that would have made it increasingly difficult to administer family planning funds in these states. The Arkansas proposal would have prohibited the state from awarding public funds to entities that provide abortion services or referrals and would have extended to organizations that contract with abortion providers as well. The legislature adjourned without the bill moving forward. North Dakota's state legislature proposed language that would have prohibited the state from contracting with any organizations that provide or counsel for abortions from receiving money that goes through the state treasury. This would have excluded abortion providers from receiving state and federal money. The language was removed before the bill was signed by the governor.[222]

In Arizona, legislators tried to attach language defunding Planned Parenthood health centers to legislation expanding Medicaid. The 11th hour attempt came as a result of division within the Arizona Republican party. Governor Jan Brewer (R) surprised the country and many in her political party when she announced her support for expanding Medicaid as intended under the ACA.[223] To block her effort to adopt the Medicaid expansion, her Republican colleagues tried to muddy the waters by adding the anti-Planned Parenthood provision to the bill in the hopes of forcing Democrats and women's health providers to block the bill's advancement.[224] After realizing the legal and political traps such a policy would bring, the legislators backed off and passed the Medicaid expansion legislation without including the language.[225]

Some States Defeat Attacks, Strengthen Provider Protections

Although several of the anti-sexual health policies became law in the states, advocates were able to beat back a handful of the legislative and regulatory proposals. In May, the South Carolina Senate amended its annual appropriations bill to create a priority system for family planning funding in the state – similar to other tiering systems, federal family planning dollars would first be given to health departments, and then FQHCs and other providers offering primary care before granting to traditional family planning providers. The provision was deleted in the final appropriations bill.[226]

In a proactive move, in October, California passed the only legislation in the nation to broaden access to abortion care by changing scope-of-practice laws to allow certified nurse midwives, nurse practitioners, and physician assistants to perform first-trimester abortions.[227] This legislation will broaden access to abortion throughout the state and in health centers that were previously unable to provide the service because of their provider mix. Health care providers performing the procedures will need to undergo specific training procedures and comply with medical standards, set out in the law.

Other State-Level Attacks by Anti-Choice Opponents

Several states also saw movement on bills aimed directly at limiting access to abortion with a few actually passing into law. Arkansas passed the most extreme of these and now bans abortion at 12 weeks after a woman's last period. Twenty-week bans (22 weeks after the woman's last period) were also passed in Arkansas, North Dakota, and Texas.[228] Kansas, North Carolina, and North Dakota all passed laws to prohibit sex-selective abortions.[229] The North Dakota legislature also passed legislation that banned abortion providers from performing abortions where they have reason to believe the woman is seeking the abortion due to fetal impairment.[230] The bill was signed into law in

220 S.B. 171, 2013-2014 Leg., Reg. Sess. (Kan. 2013).; S.B. 900, 54th Leg., 1st Sess. (Okla. 2013).

221 Guttmacher Institute, *Monthly Update: Major Developments in 2013*, accessed October 1, 2013, http://www.guttmacher.org/statecenter/updates/index.html.

222 Ibid.

223 For more information on Medicaid expansion see, "The ACA's Bright Spot: 25 States Plus DC Expand Medicaid" section on page 23.

224 Mary K. Reinhart, "Abortion enters Arizona debate on Medicaid expansion," *Arizona Republic*, March 28, 2013, http://www.azcentral.com/news/politics/articles/20130327abortion-enters-arizona-debate-medicaid.html.

225 Katie McDonough, "Jan Brewer blocks anti-Planned Parenthood provision of Medicaid bill," *Salon*, April 11, 2013, http://www.salon.com/2013/04/11/jan_brewer_blocks_anti_planned_parenthood_provision_of_medicaid_bill/.

226 Guttmacher Institute, *Monthly Update: Major Developments in 2013* accessed October 1, 2013.

227 Patrick McGreevy, "Brown signs bill to let nurse-practitioners, others perform abortions," *Los Angeles Times*, October 9, 2013, http://articles.latimes.com/2013/oct/09/local/la-me-pc-gov-brown-allows-nursepractitioners-to-perform-abortions-20131009.

228 Guttmacher Institute, *State Legislation and Policies Enacted in 2013 Related to Reproductive Health*, accessed October 2013, http://www.guttmacher.org/statecenter/updates/2013Newlaws.pdf.

229 Ibid.

230 Ibid.

March.[231] In an attempt to shut down one of the few providers of later abortion, a city-level ballot initiative to ban abortion after 20 weeks was introduced in Albuquerque, New Mexico. Voters defeated the measure by nearly a ten-point margin.[232] A number of these abortion bans are being challenged in the courts as unconstitutional.[233]

Eight states, including Indiana and Wisconsin, passed "Targeted Regulations of Abortion Providers" or TRAP laws.[234] These laws require facilities to meet certain requirements, including having certain hallway sizes or a specific number of water fountains. Some of the laws passed in 2013 required abortion providers to have admitting privileges at a local hospital, which are sometimes impossible for providers to attain. Due to these over-burdensome, unnecessary, and arbitrary requirements, some health centers in states like Virginia and Texas have been forced to close, leaving hundreds of thousands of women without access to abortion. A women's health center in Virginia is challenging the new restrictions in court.[235]

In Ohio, anti-choice politicians included several provisions that will limit access to reproductive health care in the state budget.[236] These provisions tier reproductive health funds; direct money from the Temporary Assistance for Needy Families (TANF) block grant to crisis pregnancy centers; require physicians to perform a medically unnecessary ultrasound for any patient seeking an abortion; require all ambulatory surgical centers to have admitting privileges to a local hospital while also banning public hospitals from having agreements with abortion providers; and ties funding for rape crisis programs to a prohibition on counseling for or referring to abortion care. The ACLU of Ohio has filed a lawsuit on behalf of a Cleveland health center that provides birth control and abortion services.[237]

State legislatures also limited women's access to abortion in 2013 by attacking medication abortion.[238] With the intention of creating barriers to the service, several states passed laws that require a physician to provide the medication to the woman, others required the woman to go to the health center for each dose, while others prohibited the use of telemedicine as a way to provide medication abortion – resulting in a lack of services to those in rural or frontier communities. In Iowa, the Board of Medicine passed a rule that would have effectively banned the use of telemedicine for provision of abortions in the state. However, in November, a district judge ordered a temporary stay on the rule, allowing providers to continue the practice.[239] Insurance coverage was another way policymakers restricted abortion access. Ten states enacted laws that in some way limit access to insurance coverage of abortion, including barring coverage in the new health care marketplaces and restricting coverage for state or local employees.[240] A handful of states also added restrictions in the form of mandatory counseling or waiting periods.[241]

Anti-Abortion Measures in Texas Grab National Spotlight

Texas has remained a hotbed of anti-choice activity since passing its highly publicized 2012 law barring abortion providers from receiving both state and federal funding for family planning services. In 2013, the Texas legislature further attacked women's access to health care by hotly debating and eventually passing a bill to impose strict requirements on abortion providers, effectively shutting a majority of them down and almost fully restricting access for Texas women.[242] During Senate debate, Texas State Senator Wendy Davis (D-10) inspired pro-choice Texans and supporters nationwide when she led an 11-hour filibuster of the bill.[243] The eventually passed Texas Senate Bill 5 requires doctors in the state to have admitting privileges at a hospital within 30 miles of where they provide abortions; imposes strict restrictions on medication abortions; bans abortions at 20 weeks of pregnancy, with exceptions for the life of the mother; and requires that all abortions take place in an ambulatory surgical center – a move that forces the majority of abortion-providing health centers to meet onerous and unnecessary requirements. The law

231 Nick Smith, "North Dakota governor signs abortion bills," *Bismarck Tribune*, March 26, 2013, http://bismarcktribune.com/news/local/govt-and-politics/article_803a58ca-962f-11e2-a12e-0019bb2963f4.html#.UVHLhdWSi8s.twitter.

232 Niraj Chokshi, "The abortion ban defeated Tuesday in Albuquerque has passed in 13 states," *Washington Post*, November 20, 2013, http://www.washingtonpost.com/blogs/govbeat/wp/2013/11/20/the-abortion-ban-defeated-tuesday-in-albuquerque-has-passed-in-13-states/.

233 Andrea Grimes and Jessica Mason Pieklo, "Texas Abortion Providers Challenge Omnibus Anti-Abortion Bill in Federal Court," *RH Reality Check* (blog), September 27, 2013, http://rhrealitycheck.org/article/2013/09/27/texas-abortion-providers-challenge-omnibus-anti-abortion-bill-in-federal-court/.

234 Elizabeth Nash et. al., *Laws Affecting Reproductive Health and Rights: 2013 State Policy Review*.

235 Tara Culp-Ressler, "Women's Health Advocates Fight Back Against Virginia's New Abortion Clinic Restrictions," *Think Progress* (blog), June 14, 2013, http://thinkprogress.org/health/2013/06/14/2162011/fight-back-virginia-trap/.

236 Kim Palmer, "ACLU sues Ohio for including abortion restrictions in its budget," *Reuters*, October 9, 2013, http://www.reuters.com/article/2013/10/09/us-usa-abortion-ohio-idUSBRE9980OS20131009.

237 Ibid.

238 Elizabeth Nash et. al., *Laws Affecting Reproductive Health and Rights: 2013 State Policy Review*.

239 Tony Leys, "District judge suspends ban on telemedicine abortions," *Des Moines Register*, November 6, 2013.

240 Elizabeth Nash et. al., *Laws Affecting Reproductive Health and Rights: 2013 State Policy Review*. For more information on the health insurance marketplaces, see the "Affordable Care Act" section starting on page 15.

241 Ibid.

242 "Perry signs Texas abortion bill into law," *Washington Post*, July 18, 2013, http://www.washingtonpost.com/blogs/post-politics/wp/2013/07/18/perry-signs-texas-abortion-bill-into-law/.

243 Staff Report, "Texas abortion bill fails after Sen. Wendy Davis' filibuster," *CBS News*, June 26, 2013, http://www.cbsnews.com/news/texas-abortion-bill-fails-after-sen-wendy-davis-filibuster/.

has faced a number of legal challenges that unfortunately left it intact at the end of the year after the Supreme Court rejected a bid by Planned Parenthood and other women's health providers to block the law while it is under appeal.[244] The appeals court was expected to hear arguments in January 2014, providing little respite for the health centers that had already closed their doors or are expected to if the appeals fail.

244 Mark Sherman, "Supreme Court Rejects Bid to block Texas abortion law," *Associated Press*, November 19, 2013, http://www.sltrib.com/sltrib/world/57154115-68/court-abortion-texas-appeals.html.csp.

A Look Ahead

With the 2014 midterm elections in sight, advocates for family planning and sexual health care rely heavily on the Obama administration. The current danger to women's health at the federal level lies primarily in the ongoing erosion of resources rather than in any immediate capability of anti-choice opponents. Although the December budget agreement demonstrated some bipartisanship, the likelihood that Washington could become a functional environment before the midterm elections is slim. The truncated legislative calendar will dissuade lawmakers yet again from tackling entitlement reform or other critical elements that could make long-term progress on the partisan impasse that has immobilized the budget and appropriations process in recent years.

Instead, family planning and sexual health advocates should cast their eyes towards the states as the stage where the most progress and setbacks will occur. States with heavily conservative legislatures have already indicated interest in offering and replicating successful "tiering" bills that would destabilize the publicly funded family planning network by carving out certain family planning providers from access to funding; other states have committed to revitalizing efforts to restrict access to abortion through 20-week abortion bans and other provider restriction measures. The year will also hold significant possibility for changes to Medicaid as states offer, and the Centers for Medicare & Medicaid Services accepts, alternative plans to expand Medicaid. These incremental adjustments in Medicaid could have either a beneficial or detrimental domino effect on the ways that states opt to run their Medicaid programs. Family planning proponents also have plans to advance proposals in states that would strengthen confidentiality protections for Title X-funded health systems, particularly as those systems adjust to a new payer mix with additional private insurance contracts.

Also in 2014, the Supreme Court decision on contraceptive coverage could have far-reaching implications for family planning access, not only for those who have employer-sponsored insurance coverage, but for the safety net: upholding access to contraceptive coverage would help the family planning network offset the cost of caring for those who remain uninsured or who cannot use their insurance coverage. Furthermore, with health reform in effect, the administration may be able to shift its focus from defending Healthcare.gov to evaluating early experience and making regulatory corrections that better fulfill the goal of helping Americans gain coverage and access health care services. These adjustments could come in the form of fine-tuning the essential community provider regulation or through modifications to the next open enrollment season beginning in the fall.

As Congress grapples with how to return to functional order, in 2014 NFPRHA will make every effort to help the publicly funded family planning network strategize and execute sustainability plans that reflect the strained fiscal environment and the new health care law fully in effect.

While 2013 was a toss up when evaluating the policy successes for family planning and sexual health, 2014 represents a new opportunity for progress and NFPRHA, working with its members, will do all it can to advance its important mission of support to the publicly funded family planning and sexual health provider network.

About NFPRHA

Founded in 1971 and located in Washington, DC, the National Family Planning & Reproductive Health Association (NFPRHA) is a 501(c)3 non-profit membership organization representing the broad spectrum of family planning administrators and providers who serve the nation's low-income, under-insured, and uninsured women and men.

As the only national membership organization in the United States dedicated to increasing family planning access, NFPRHA is committed to advocacy, education, and training for its members. NFPRHA works to help ensure access to voluntary, comprehensive, and culturally sensitive sexual and reproductive health care services and supplies, and to support reproductive freedom for all.

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