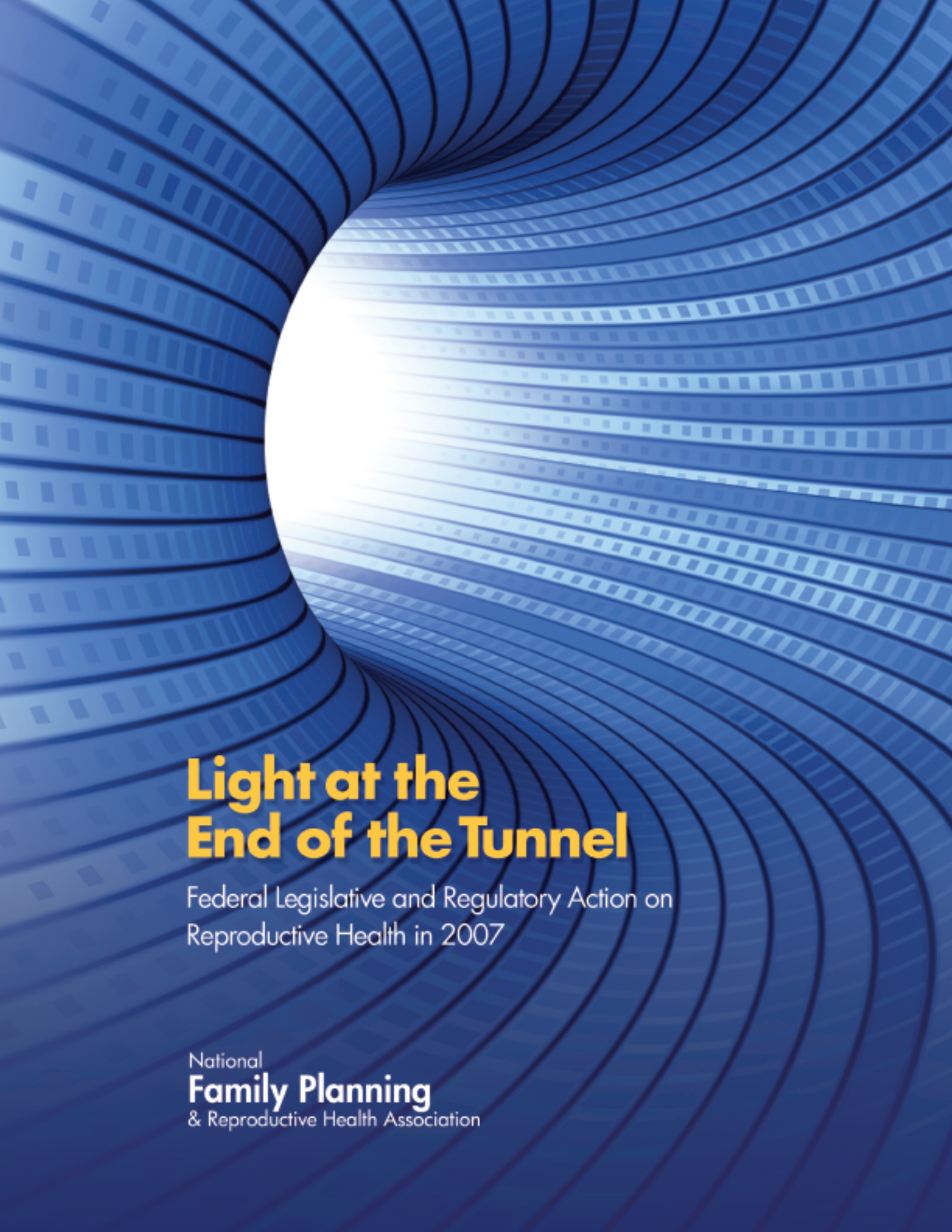

Light at the End of the Tunnel

Federal Legislative and Regulatory Action on Reproductive Health in 2007

National
Family Planning
& Reproductive Health Association

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& Reproductive Health Association

The National Family Planning & Reproductive Health Association (NFPRHA) is a vital membership organization of dedicated family planning service providers – public health departments, hospitals, general health providers and community based reproductive health caregivers.

Our goal is to prevent unwanted pregnancies and reduce the need for abortion by providing the education, contraception, counseling and preventive health services low-income and uninsured people need to act responsibly, stay healthy and plan their families.

This publication is made possible with the generous support of the Robert Sterling Clark Foundation. It was prepared by the NFPRHA Public Policy Division, under the leadership of Robin Summers and in consultation with Eleanor Allen, editor.

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Executive Summary

Thanks to years of hard work by our members, staff and coalition partners on the front lines and behind the scenes, 2007 was an outstanding year for family planners; a year that is hopefully a sign of light at the end of the tunnel.

The 2006 mid-term elections brought more family planning advocates to Congress. For the first time in years, pro-family planning Members are in leadership positions in both the House and the Senate. NFPRHA anticipated a more proactive agenda from Democratic leadership. However, a fiercely anti-family planning Administration, a slim Democratic majority in the Senate, and extremist opponents of family planning in Congress hindered the advancement of our agenda.

The crowning achievement in 2007 was an increase in Title X funding, the third largest increase for the program in the last 25 years. While small in comparison to the funding truly needed to provide high-quality, comprehensive family planning services to the 17.5 million women in need, it is still an important, positive step in achieving a new level of understanding among policymakers about the importance of family planning.

NFPRHA faced its most significant change in the last 15 years – in February 2007, a new CEO & President, Mary Jane Gallagher, was chosen by the board to lead the organization. Her directive was to reengage the membership and implement her vision for NFPRHA and the future of family planning in the United States. This vision includes a renowned policy shop paired with an effective communications operation to bolster NFPRHA's efforts to educate policymakers as well as to train and activate our membership. NFPRHA is equipping and readying our members for challenges now and in the future – namely, health care reform, a new presidential administration, the rising costs of drugs, and an expansion of available sources of funding for family planning, specifically Medicaid.

NFPRHA's 2007 National Conference held in Washington, DC revolved around the theme, "Family Planning: The Cornerstone of Public Health." A number of Members of Congress demonstrated their support for family planning by attending the conference. A reception at the Library of Congress welcoming new NFPRHA President & CEO Mary Jane Gallagher also honored Congresswoman Nita Lowey (D-NY) as a recipient of NFPRHA's Title X Champion Award. The reception, sponsored by Wyeth, was also attended by Reps. Tim Ryan (D-OH), Jim Moran (D-VA), Russ Carnahan (D-MO), Christopher Shays (R-CT) and Ron Klein (D-FL).

At NFPRHA's annual Capitol Hill luncheon, Congresswoman Diana DeGette (D-CO) received NFPRHA's Outstanding Public Servant Award for 2007. The Congresswoman made clear to all in attendance that the advocacy conducted by NFPRHA and its members is critical to securing additional Title X funds. Her enthusiasm energized the crowd, which dispersed after the luncheon to meet with and educate their Members of Congress.

Key legislative and policy accomplishments relating to family planning in 2007:

- **Millions more for family planning.** Congress increased Title X funding by $17 million to $300 million for FY 2008. The legislation also delinked Title X funding from the Community-Based Abstinence Education (CBAE) program, which was level-funded at $113 million. Our members and staff reached out to Members of Congress through visits, calls and e-mails to make the case, which paid off in more Title X funding.

- **Blocked harmful legislation.** NFPRHA staff, members and allies worked diligently to ensure that several poisonous amendments to restrict the use of Title X funds failed. For example, the Pence Amendment to the FY 2008 Labor, Health and Human Services and Education Appropriations Act would have prevented Planned Parenthood clinics from receiving Title X funding. Many members and friends of the organization made calls to their elected officials and used NFPRHA's

new web-based congressional contact tool to oppose such onerous amendments.

- **Created workgroup on the future of Title X.** NFPRHA brought together an experienced group of members representing each of the Title X federal regions to serve on our Title X Advisory Council. This group of dedicated frontline family planning providers will help us determine the changes that need to be made to the program, including increased funding and additional flexibility. The Council will develop an "Action Plan" for maintaining Title X's effectiveness as a federally funded family planning program.

- **Continued to ensure access to preventive health care.** NFPRHA led efforts to reintroduce the Prevention First Act, a comprehensive family planning package designed to provide the tools necessary to curb unintended pregnancies and thereby reduce the need for abortion. The bill challenges the federal government to live up to its goal, set in 2000, of reducing unintended pregnancies by 40 percent by 2010. Though passage of Prevention First is unlikely with the current Congress, the number of sponsors has continued to rise to almost 200. This bill remains the gold standard for addressing the high rate of unintended pregnancy in America.

- **Funding family planning through Medicaid.** NFPRHA worked tirelessly to expand Medicaid coverage of family planning services. The Unintended Pregnancy Reduction Act, sponsored by Senate Majority Leader Harry Reid (D-NV) and Senator Hillary Rodham Clinton (D-NY) in 2007, would have required states to expand Medicaid eligibility for family planning services and supplies to women that would have otherwise qualified for pregnancy-related care under Medicaid if they had become pregnant. While Congress failed to vote on the bill, the House of Representatives did pass a version of the legislation that gave states the option to provide family planning services for this population, validating our belief that passage of this measure is within our grasp. Securing this expansion is at the top of NFPRHA's priority list in 2008.

- **Working to keep contraception affordable.** NFPRHA joined Planned Parenthood to support the Prevention Through Affordable Access Act, also known as the nominal drug pricing bill. Senator Barack Obama (D-IL) and Representatives Joseph Crowley (D-NY) and Tim Ryan (D-OH) sponsored the legislation, which was designed to fix an inadvertent effect of the Deficit Reduction Act of 2005. That law sought to curb pharmaceutical manufacturers from misusing nominal pricing as a marketing tool to hospitals, but mistakenly created havoc for some of our members who experienced significant increases in the cost of contraception as a result. NFPRHA advocated for the Crowley/Obama bill; however, Congress did not act in 2007. NFPRHA continues to press on this critical issue.

- **Halted expansion of abstinence-only programs.** Thanks to extensive coalition work, NFPRHA and others succeeded in convincing Congress to flat-fund federal abstinence-only education programs, despite heavy pressure from the White House to increase abstinence-only funding by $28 million. One factor in securing the level funding for abstinence-only programs was the well-publicized congressional impact study of Title V, prepared by Mathematica Policy Research. The research found that students who participated in abstinence-only programs were just as likely to have sex as students who did not participate in the programs.

With the appointment of Dr. Susan Orr as Acting Deputy Assistant Secretary for Population Affairs, and the veto of the reauthorization of the State Children's Health Insurance Program, the President continues to exert his authority to challenge programs and spending that improve the health of women, men and children in the United States.

However, because of our combined tenacity and research, we have begun to effectively paint the picture for our elected officials of the social and economic benefits of family planning. Eighty-nine percent of Americans of all political stripes support family planning, and it is time that the policymakers embrace the will of the people.

NFPRHA's members are engaged in our mission like never before - as a result of our new branding, programming and technological tools to support these improvements, we have increased advocacy by our membership to Members of Congress from several dozen to hundreds of letters sent to policymakers in response to our Action Alerts.

NFPRHA's policy staff has established a list of more than two dozen Members of Congress with whom we will be meeting within the coming months to better examine ways in which we can work together.

Through our research, we developed better and easier ways to talk to Members of Congress about family planning issues – new ways to explain what Title X funds and comprehensive family planning services mean. We have worked with our members and our allies in Congress to help them spread the message that with education, counseling, contraception and preventive health services, people in this country can act responsibly, stay healthy and plan their families.

In 2008, we are hopeful that our national election will produce a pro-family planning Administration and a larger pro-family planning majority in Congress. We are poised to work with the next presidential administration to make sure that executive orders and regulatory changes, as well as federal appointments, advance our pro-family planning agenda, and we will continue to press the Administration and Congress for funding increases for family planning programs.

Family Planning Appropriations – Title X

Historic Increase in Family Planning Funding

Through increased outreach and education efforts to Members of Congress and their staffs, NFPRHA, in coordination with our coalition partners, secured a $28 million increase to Title X when Congress approved the conference report for the FY 2008 Labor, Health and Human Services, and Education spending bill in November 2007. However, that bill was then promptly vetoed by President Bush.

With NFPRHA's assistance, Congresswoman Nita Lowey and other members of the House Appropriations Committee continued to press Chairman David Obey and House Speaker Nancy Pelosi to maintain the $28 million increase for Title X. As Congress sought to finalize Fiscal Year 2008 spending by year's end, NFPRHA's public policy staff and CEO worked closely with Members of Congress to ensure that Title X received an increase.

In addition to NFPRHA's members, who placed dozens of calls to congressional leadership, NFPRHA's CEO reached out to our coalition partners (including NARAL, National Partnership for Women and Families, National Women's Law Center, and Planned Parenthood Federation of America) and requested their strategic assistance on Title X. NFPRHA's CEO also placed a call to Speaker Pelosi reiterating the importance of her leadership in maintaining an increase for Title X.

The President and Congress ultimately approved an omnibus spending bill that contained a $17 million increase for Title X, bringing overall funding to approximately $300 million. While this increase is small in comparison to the overall need for publicly-subsidized family planning services, it was historic: it was the third largest that the program has received in the last twenty-five years.

THE APPROPRIATIONS PROCESS AND TITLE X FUNDING

For the first time in several years, NFPRHA was chosen to testify before the House Appropriations Subcommittee on Labor, Health and Human Services, and Education in support of a funding increase for Title X. NFPRHA Board member Barbara Parker of the Virginia Department of Health's Division of Women's and Infants' Health delivered our testimony on March 27.

Requesting that Title X be funded at $385 million in FY 2008, a $102 million increase, Barbara detailed the urgent need for additional funding: "Today, more than 17 million women need publicly supported contraceptive care—a number which continues to grow. For Title X service providers this is not an abstract concept. They are on the front line every day, struggling to address the growing demand for subsidized family planning services. Medical inflation, combined with improvements in contraceptive technologies, dramatic price increases for contraceptives, improved and expensive screening and treatment for STDs, including new costly pap test technology, and the increased cost of retaining qualified health care personnel in an era of rising salaries and nursing shortages have eaten away at clinic budgets."

When it came to a vote in the House subcommittee, family planning advocates won the largest increase in Title X funds in the last 25 years. In June, the House Labor, Health and Human Services, and Education Appropriations Subcommittee approved the FY 2008 Labor-Health and Human Services Appropriations bill, which contained a $28 million funding increase for Title X, bringing total funding for the program to $311 million.

Unfortunately, the bill included a $28 million funding increase for the Community-Based Abstinence Education (CBAE) program, despite overwhelming evidence that abstinence-only education programs are ineffective.

Action then shifted to the Senate, when the Senate Labor-HHS Appropriations Committee marked up its version of the FY 2008 Labor, Health and Human Services, and

Education appropriations bill, increasing funding for Title X by $17 million. While this represented a significant increase for Title X, it fell short of the $28 million previously approved by the House appropriations subcommittee. The Senate committee, however, did cut funding for the CBAE program by $28 million, setting up a potential showdown with House appropriators, who approved a $28 million increase for the program.

In July, family planning providers won a significant victory upon passage of the House bill, which included the $28 million increase for Title X. The House passed the FY 2008 Labor, Health and Human Services, and Education appropriations bill (H.R. 3043) by a vote of 276-140 (Roll Call Vote 686). Unfortunately, the bill also included the $28 million increase for the ineffective CBAE program. The bill, however, included report language requiring that information provided by abstinence-only programs be medically accurate.

In addition to protecting the $28 million increase, family planning advocates won another important victory by defeating an amendment that would have prevented Planned Parenthood clinics from receiving Title X funds. Representative Mike Pence (R-IN) introduced the amendment, which would have effectively defunded 13 percent of Title X family planning clinics and threatened access to family planning services for millions of low-income women and men. Appropriations Chairman David Obey (D-WI), and Reps. Rosa DeLauro (D-CT), Lois Capps (D-CA), Christopher Shays (R-CT), and Tim Ryan (D-OH) made floor statements in opposition to the Pence Amendment. Reps. Jim Moran (D-VA), Rush Holt (D-NJ), Nita Lowey (D-NY), and Carolyn Maloney (D-NY) also submitted statements against the Pence amendment for the Congressional Record. Thanks to the tremendous efforts of our congressional champions, the family planning community, and NFPRHA members, the Pence amendment was defeated 189-231 (Roll Call Vote 684).

Two other amendments designed to undermine access to contraception and women's health were also considered by the House. The first amendment, offered by Representative Jean Schmidt (R-OH), would have prohibited Title X clinics from receiving Title X funding if they were found to have violated state laws with respect to reporting child abuse, molestation, rape, or incest. The amendment was withdrawn after Chairman Obey raised a point of order against it. The second amendment, introduced by Representative Phil Gingrey (R-GA), would prohibit federal funds from being used to establish or implement mandatory HPV vaccination laws (H. Amdt. 569). The amendment was accepted by voice vote. This provision has the potential to limit access to the HPV vaccine for many low-income families should states go forward with vaccine mandates. To date, however, only one state has a mandate in place.

THE FIRST CONTINUING RESOLUTION

In late September, in anticipation of the fiscal year beginning without all twelve appropriations bills having been signed into law, Congress passed a continuing resolution (H.J. Res. 52) to keep the government operating until November 16 (404-14 in the House, 94-1 in the Senate). The continuing resolution also temporarily extended the State Children's Health Insurance Program (SCHIP), set to expire September 30, given President Bush's pledge to veto the reauthorization bill passed by Congress.

At the time, the House had passed all twelve of the Fiscal Year 2008 appropriations bills. The Senate, however, had yet to pass eight of the twelve bills, including the FY 2008 Labor, Health and Human Services, and Education (Labor-HHS) Appropriations bill. President Bush threatened to veto individual spending bills, including the Labor-HHS appropriations bill, because the twelve bills in total contained $23 billion more in discretionary spending than the President requested for FY 2008.

PASSAGE OF THE CONFERENCE REPORT

In late October, the Senate approved its version of the FY 2008 Labor-HHS Appropriations bill by a veto-proof majority of 75-19. It included a $17 million increase for FY08 Title X funding, instead of the House's $28 million, setting the stage for negotiations between House and Senate appropriators during conference.

On November 1, the conferees approved the bill, with the $28 million increase for Title X intact.

Just two weeks later, President Bush vetoed the Labor-HHS Appropriations bill, based on his opposition to the overall spending level. The House vote to override the veto fell just two votes shy of the necessary two-thirds majority. Before the House vote, Senate Majority Leader Harry Reid (D-NV) announced that Democrats would consider splitting the difference between the Congressionally-passed appropriations bills and the Administration's requests. This would mean reducing the overall funding in the remaining appropriations bills by $11 billion.

FURTHER CONTINUING RESOLUTIONS

As of early December, Congress had yet to approve 11 of its spending bills, including the Labor-HHS Appropriations bill, and the government was operating under a series of continuing resolutions. At year's end, lawmakers worked to put together an omnibus spending package with all 11 remaining bills. Democrats agreed to include Iraq war funding in exchange for higher domestic spending levels, including programs such as Title X. Leaders in both the House and Senate indicated support for the $28 million increase for Title X that was included in the Labor-HHS bill that Congress passed and the President vetoed earlier this year.

In mid-December, the House passed another short-term continuing resolution, (H. J. Res. 69), to keep the government operating until December 21. Another short-term continuing resolution (H. J. Res. 72) was passed on December 19 to keep the government operating until December 31.

In late December, Congress finally passed the omnibus appropriations bill, which was signed into law by the President on December 26. (P.L. 110-161) Included in the omnibus was the Labor-HHS Appropriations bill, which contained the increase of $17 million for Title X.

Harmful Legislation

On October 17, the Senate rejected an amendment (S. Amdt. 3330) to the FY08 Labor-HHS Appropriations bill (H.R. 3043) that would have prevented an entity from receiving federal health funding if it or any of its sub-grantees performed abortion services. The amendment, offered by family planning opponent Senator David Vitter (R-LA), was defeated by a vote of 41-52 (Roll Call Vote 379). The amendment went even farther than the Pence Amendment that was soundly defeated in the House in July. Prior to the vote on the Vitter amendment, Senators were presented with an alternative offered by Senate Majority Leader Harry Reid (D-NV) that restated current law concerning the funding of abortion. The Reid amendment passed 68-25 (Roll Call Vote 378). The defeat of the Vitter amendment was a great victory for family planning supporters.

During consideration of the bill, Senators Sam Brownback (R-KS) and Jim DeMint (R-SC) introduced amendments that would have threatened health and education funding for schools where school-based health centers provide contraceptives to minors. Fortunately, none of these amendments was called to a vote.

In November, Congressman Mike Pence (R-IL) introduced the Title X Abortion Provider Prevention Act (H.R. 4133). This bill is similar to the amendment he proposed to the Labor-HHS bill in the House, and would amend Title X to prohibit funds from being granted to any entity that uses separate, non-federal funding to provide abortion services. This bill would effectively preclude funding for hundreds of current Title X grantees, and would hinder access to family planning services for hundreds of thousands of women. As of the end of 2007, the bill had 42 cosponsors, but no further action has since taken place on this bill.

Representative Todd Akin (R-MO) has introduced a number of parental consent bills since 1999. In May, Akin introduced a bill which would require parental notification and consent before a Title X-funded clinic can provide contraception to a minor (H.R. 2134). No action has been taken on this bill.

FY 2008 Funding for Selected Public Health Programs ($ in millions)

PROGRAM	FY 2008 FINAL	PRESIDENT'S FY 2008 BUDGET REQUEST	FY 2007 ACTUAL
Title X Family Planning	$300[1] (+$17)	$283	$283
Adoption Awareness Training	$13 (0)	$13	$13
Social Services Block Grant	$1,700 (0)	$1,200	$1,700
MCH Block Grant	$666 (-$27)	$693	$693
Abstinence-Unless-Married Education Programs (total)	$176 (0)	$204	$176
1. Community-Based Abstinence Programs (ACF)[2]	$113[3] (0)	$141	$113
2. State Abstinence Grants (ACF)	$50 (0)	$50	$50
3. Adolescent Family Life Abstinence Earmark (OPA)	$13 (0)	$13	$13
CDC HIV/AIDS, Viral Hepatitis, STD and TB Prevention (total)[4]	$1,002 (0)	$1,057 (+$47)	$1,002
HIV/AIDS	$692 (-$3)	$745 (+$47)	$695
Viral Hepatitis	$18 (-$1)	$18 (0)	$17
STD	$152 (-$3)	$157	$155
TB	$140 (+$5)	$137 (0)	$135
Ryan White	$2,142 (+$30)	$2,158	$2,112
Community Health Centers	$2,022 (+$79)	$1,988	$1,943

1All FY08 Title X funding levels reflect 1.747% across-the-board rescission.

2 Includes $4.5 million for evaluation. Up to $10 million of total can be spent on a national abstinence education campaign.

3 The FY08 CBAE funding level reflects a 1.747% across-the-board rescission.

4 Individual program numbers for CDC HIV/AIDS, Viral Hepatitis, STD and TB Prevention are rounded up to nearest million, and may not reflect the total funding. The total funding level provided reflects the amount detailed in the budget.

DASPA Appointment

NFPRHA kept the spotlight on family planning in the wake of personnel changes at the federal office which oversees the nation's family planning program.

In March 2007, Dr. Eric Keroack resigned as the Deputy Assistant Secretary for Population Affairs (DASPA) at the Department of Health and Human Services (HHS). Keroack was a controversial choice to oversee the Title X family planning program, based on a record showing him to be an ardent anti-choice ob-gyn, a vocal supporter of abstinence-only education, and even an opponent of contraception. His unexpected resignation came only five months after his selection for the post and appeared connected to an allegation by the Massachusetts Medicaid office against his private practice. Evelyn Kappeler, a long-time staffer at the Office of Population Affairs, was appointed as the Acting DASPA.

NFPRHA organized a campaign to urge HHS Secretary Michael Leavitt to appoint a person with a demonstrated commitment to family planning as the new DASPA. Despite our efforts, Dr. Susan Orr, a vocal opponent of expanded access to contraception and accurate sex education, was named as the Acting DASPA in October.

Prior to joining the Bush Administration, Dr. Orr was the Senior Director for Marriage and Family Care at the Family Research Council, an organization that is well-known for its efforts to limit access to contraception. Dr. Orr cheered Bush's proposal to remove contraceptive benefits for federal employees. In fact, she told the *Washington Post*, "We're quite pleased because fertility is not a disease. It's not a medical necessity that you have [contraception]."

Orr's oversight of Title X could make it even more difficult for family planning service providers across the country.

NFPRHA worked with the *Washington Post* to break the story on October 17, and the news was quickly picked up by dozens of blogs and mainstream news organizations, including the *Wall Street Journal,* CBS News, *Seattle Post Intelligencer,* Huffington Post, *The Nation, Ms. Magazine* and RH Reality Check. Senators Hillary Rodham Clinton (D-NY) and Patty Murray (D-WA), along with Congresswomen Louise Slaughter (D-NY) and Diana DeGette (D-CO) and Planned Parenthood President Cecile Richard joined NFPRHA President & CEO Mary Jane Gallagher on an October 18 conference call with reporters. Following the call, nineteen Senators and seven Representatives sent letters to Secretary Leavitt urging him to withdraw the appointment.

Numerous public health advocates also wrote Secretary Leavitt in opposition to the appointment, including the American Public Health Association, the Association of Reproductive Health Professionals, the National Partnership for Women and Families, the National Women's Law Center, and the National Association of Nurse Practitioners in Women's Health.

Preventing Unintended Pregnancy

NFPRHA continues to work with congressional leaders to pursue a broad agenda to reduce unintended pregnancy, particularly among those who are low-income or uninsured, by expanding Title X funding, providing greater access to contraception, and funding teen pregnancy prevention programs.

Prevention First Legislation

NFPRHA, in close coordination with our coalition partners, helped to orchestrate the reintroduction of the Prevention First Act (S. 21) - a comprehensive bill intended to reduce unintended pregnancy by expanding access to contraception.

Prevention First was one of the first bills introduced in the Senate by Majority Leader Harry Reid (D-NV) on the opening day of the 110th Congress. Similar to the measure introduced in the last Congress, Prevention First would increase funding for Title X to $700 million, expand eligibility for family planning services under Medicaid, require private health plans to cover prescription contraceptives to the same extent they cover other prescription drugs, provide funding for an emergency contraception (EC) education campaign, require emergency rooms to provide EC access to victims of sexual assault, and provide funding for teen pregnancy prevention programs.

Representative Louise Slaughter (D-NY) followed suit in the House, introducing the companion bill (H.R. 819) on February 5 with 100 cosponsors. In 2007, we had more co-sponsors than ever before, in the House (160 compared to 136 in 2006) and in the Senate (33 compared to 25 in 2006).

New to the package this Congress is the Responsible Education About Life (REAL) Act, which provides for comprehensive sex education. Original cosponsors of the Senate bill are Senators Clinton (D-NY), Murray (D-WA), Boxer (D-CA), Akaka (D-HI), Kerry (D-MA), Leahy (D-VT), Obama (D-IL), Schumer (D-NY), Lautenberg (D-NJ), Kennedy (D-MA), Harkin (D-IA), Menendez (D-NJ), and Inouye (D-HI).

Recognizing the Importance of Access to Contraception

Representative Nita Lowey (D-NY) continued to highlight the importance of preventing unwanted pregnancies with the re-introduction of a resolution (H. Con. Res. 177) in June, expressing the sense of the Congress concerning contraceptives for women. The resolution supports a national campaign to help all women, regardless of income, avoid unintended pregnancy and abortion through access to contraception, and supports programs and policies that improve access to contraception and help women to use them consistently and correctly.

Access to and greater use of contraception, in fact, has an overall positive impact on women's health. A study published in the British Medical Journal found that women who take birth control pills have a reduced risk of developing cancer. Researchers from the University of Aberdeen in Great Britain found that the risk of cancer was up to 12 percent less among pill users than non-users, and that the protective effect of taking the pill can last for as many as 15 years after stopping. Women taking the pill were at significantly reduced risk of ovarian, uterine, and large bowel cancer, although those taking the pill for more than eight years had an increased risk of developing cervical and central nervous system cancer. Researchers concluded that oral contraception was "not associated with an overall increased risk of cancer; indeed it may even produce a net public health gain."

Other Legislation Aimed at Reducing Unwanted Pregnancies

Access to contraception, including emergency contraception (EC), is a key component of a larger agenda to reduce unwanted pregnancies. Although social conservatives and abortion critics have sought to curb the availability of EC, a

recent study concluded that EC is not in widespread use, and has not impacted pregnancy and abortion rates.

In December 2006, *Obstetrics and Gynecology* magazine released a review of eleven studies on the population-level impact of emergency contraception. None has shown any effect of increased access to EC on the rates of pregnancy or abortion, according to the study. The article examined four potential explanations for this lack of population-level impact and concluded that the major problem is insufficient use. While in each study, increased access to EC led to increased use of EC (with no increase in risk-taking), repeated use was uncommon, many unprotected acts remained uncovered by EC, and in most pregnancy cycles, EC was not used.

In 2007, several bills were introduced which acknowledged and addressed problems created by restrictions on contraceptive availability.

- In April, Senator Hillary Rodham Clinton (D-NY) introduced the Compassionate Assistance for Rape Emergencies Act of 2007 (S. 1240), a bill that would require any hospital receiving federal funds to make emergency contraception available for survivors of rape and incest.

- In June, Representative Carolyn Maloney (D-NY) and Senator Frank Lautenberg (D-NJ) introduced a bill designed to address the growing problem of pharmacy refusals. The Access to Birth Control Act guarantees women timely access to birth control, including over-the-counter emergency contraception, at the pharmacy counter. If the requested product is not in stock but the pharmacy stocks other forms of contraception, the bill mandates that the pharmacy help the woman access the medication without delay by the method of her preference: order, referral, or transfer. The bill is based on the Access to Legal Pharmaceuticals Act from the 109th Congress.

- In May, Representative Rosa DeLauro (D-CT) introduced the FDA Scientific Fairness for Women Act (H.R. 2503). The bill requires the FDA to convene a "scientific workshop" within six months to review current data and examine the scientific concerns that contributed to the age-restriction imposed on Plan B emergency contraception's over-the-counter (OTC) approval. The bill also provides explicit authorization for the FDA Office of Women's Health, elevating the status of the office within FDA, and requires research on the safety of breast implants. The bill had twenty cosponsors at year's end.

SETBACK ON EC ACCESS FOR ACTIVE MILITARY

Despite our collective efforts, the amendment offered by Representative Michael Michaud (D-ME) to ensure that EC is stocked at each military health care facility was withdrawn from the Defense Authorization bill just minutes after it was offered. The bipartisan amendment would have added Plan B® emergency contraception (EC) to the military's Basic Core Formulary, the list of medications that must be stocked at every military health care facility. Currently, the decision to stock EC is left up to individual military base commanders, an ad-hoc system that leaves many servicewomen at risk for unintended pregnancy. The amendment was similar to Representative Michaud's Compassionate Care for Servicewomen Act (H.R. 2064) introduced earlier this year.

States Provide Opportunities to Expand Access to Contraception

Given the near universal acceptance of pre-marital sex, everyone must have access to family planning services, including education and contraception, so they have the information and resources they need to be sexually and socially responsible. More than nine out of ten American men and women have had premarital sex, according to research from the Guttmacher Institute published in the Jan./Feb. 2007 issue of Public Health Reports, a journal of the U.S. Public Health Service published by the Association of Schools of Public Health. The study examined how sexual behavior before marriage has changed over time from 1982-2002 using data from the federal National Survey of Family Growth - finding that rates of premarital sexual activity have changed little over time. Even for women born in the 1940s, nearly nine out of 10 had had premarital sex. According to

the study, by age 44, 99 percent of respondents had had sex, and 95 percent had done so before marriage. Even among those who abstained from sex until age 20 or older, 81 percent had had premarital sex by age 44.

Several states enacted laws to expand access to contraceptive and preventive reproductive health services in 2007. The good news, according to the Guttmacher Institute, was that most of the activity around contraception and prevention was aimed at expanding access to reproductive health services. Arkansas, Colorado, Connecticut, Minnesota and Oregon enacted new laws in 2007 requiring hospitals to provide information on EC to women who have been sexually assaulted; there are now fourteen states that require hospitals to provide EC information. The new laws in Connecticut, Minnesota and Oregon go a significant step further, and require the hospital to provide the medication, if requested by the woman. With these new laws, ten states require hospitals to provide EC upon request.

ACCESS TO EMERGENCY CONTRACEPTION (EC)

Connecticut was one of three states to enact a law in 2007 requiring that emergency contraception (EC) be provided to rape survivors upon request. The other two were Minnesota and Oregon, according to the Guttmacher Institute. In May, the Connecticut House of Representatives overwhelmingly approved the bill (113-36) requiring hospitals to provide EC to rape survivors, which then passed in the State Senate. The bill passed despite vocal objections from Catholic leaders, who wrongly argued that EC causes abortion. The measure included compromise language that requires a pregnancy test be administered before the drug is provided, and allows an independent, third-party provider to distribute the drug. Church leaders failed to sign off on the compromise. Connecticut Governor M. Jodi Rell (R) signed the bill, which became law as of October 1.

Illinois legislators approved a bill to give women greater access to EC, however, the bill remains stuck in committee. The Illinois House Human Services Committee approved legislation (HB 1077) in March that would allow pharmacists to enter into a collaborative practice agreement with a physician, which would essentially allow women to obtain EC without first visiting a physician. Although Plan B was approved for over-the-counter sales last year, girls under the age of 18 and women without identification must still see a physician before obtaining EC.

In January 2007, the New York State Department of Health announced that it will cover the over-the-counter version of Plan B emergency contraception for adult Medicaid recipients without a fiscal note or prescription requirement as of February 1. Coverage will be limited to six courses of therapy in a 12-month period for any Plan B prescription and non-prescription combination.

A federal court upheld a minor's access to EC in 2007. In September, the 3rd Circuit Court of Appeals ruled that a city health clinic which provided EC to a 16-year-old girl without notifying her parents did not violate the rights of either the parents or the girl. In 2004, a girl visited a health center run by Philadelphia's Department of Public Health for a pregnancy test, which was unavailable that day. The girl returned to the clinic later and requested EC, which she was given by a nurse. The girl later experienced severe abdominal pain and vomiting, told her parents that she had taken EC, and was taken to the hospital. The parents, who oppose abortion and objected to the clinic's actions, sued, claiming that the clinic violated the family's rights. In *Anspach v. The City of Philadelphia,* the court unanimously held that "The Constitution does not impose an affirmative obligation on (the) defendants to ensure that children abide by their parents' wishes, values or religious beliefs." The court found that the clinic had not coerced the girl into taking the medication, having given the pills to the girl because she had requested them.

PHARMACIES MUST FILL VALID PRESCRIPTIONS

New Jersey enacted a law which mandates that pharmacies fill valid prescriptions, which was designed to prohibit them from refusing to dispense medication based on the philosophical, moral, or religious beliefs of their employees. The law, signed by Governor Jon Corzine (D) in November, establishes a pharmacy's duty to fill prescriptions for in-stock drugs or devices without delay (S-1195). If a pharmacy does not carry a particular drug, a patient may

chose to have the prescription transferred to a reasonably accessible pharmacy or have the prescription returned to the patient.

The measure is similar to one that was adopted in California in 2005, which protects a pharmacist's right to object to filling a prescription, as long as it doesn't interfere with a patient's timely access to needed medication. Health care professionals must notify their employers in writing regarding any moral objection to filling certain prescriptions and employers must then make reasonable accommodations.

In October, the State of Illinois reached a settlement in a lawsuit over a 2005 Illinois rule requiring pharmacies that sell contraceptives to fill prescriptions for birth control without delay. The rule required that if the contraceptive or a suitable alternative is out of stock, the pharmacy must order or obtain the contraceptive or, if the patient prefers, transfer the prescription to another local pharmacy or return the prescription to the customer. The American Center for Law and Justice, founded by evangelist Pat Robertson, filed suit against the State, saying that the rule violates a pharmacist's right to refuse on religious and moral grounds. Although the rule specifically required pharmacies – not individual pharmacists – to fill birth control prescriptions, the settlement clarifies how pharmacists can opt out of providing birth control without preventing women from getting their prescriptions filled. Under the settlement, pharmacists who object to providing birth control can stay out of the process of filling the customer's order, and customers can receive their prescription from the pharmacy owner or another employee after an off-site pharmacist approves the prescription by phone or fax. The settlement gives the state until March 3, 2008, to enact the proposed rule change, which must be reviewed by a legislative panel before it can take effect. A separate lawsuit against Walgreens, filed by four pharmacists who were suspended after objecting to dispensing Plan B emergency contraception, is still pending.

The Washington State Board of Pharmacy in April ruled unanimously that pharmacies have a duty to fill lawful prescriptions, even if individual pharmacists object to the medication. Pharmacists or drug stores that violate the rule could face disciplinary actions from the board, possibly including having state licenses revoked. The move came after complaints by state residents that pharmacists were not providing customers with Plan B. Under the new rule, pharmacists with objections to a drug could opt out of providing it by getting a co-worker to fill the order, but the opt-out provision would only apply if the customer is able to get the prescription filled in the same pharmacy visit. The rule also forbids pharmacists from destroying prescriptions or harassing patients. Its implementation has been delayed pending resolution of a legal challenge filed by a pharmacy and its pharmacists supported by conservative religious groups on whether they may refuse based on religious belief.

HEALTH PLAN COVERAGE OF CONTRACEPTIVES

On the federal level, Representative Nita Lowey (D-NY) reintroduced the Equity in Prescription Insurance and Contraceptive Coverage Act (H.R. 2412), which would require health plans to cover FDA-approved prescription contraceptives and related medical services to the same extent that they cover prescription drugs and other outpatient medical services. The measure is also included as part of the Prevention First (H.R. 819, S. 21) legislative package.

Oregon was the only state in 2007 to enact a law requiring contraceptive coverage. In March, the Oregon House of Representatives approved a bill (HB 2700) that would require insurance companies to cover prescription contraceptives. The Access to Birth Control bill (also known as the "ABC" bill) also ensures that hospital emergency rooms provide access to emergency contraception for victims of sexual assault. The ABC bill was approved on a bipartisan 49-9 vote and signed into law by Governor Ted Kulongoski (D) in May. According to the Guttmacher Institute, 27 states now have a contraceptive coverage mandate.

The nation's highest court let stand a state law which required insurance companies to cover contraceptives. On October 1, the Supreme Court of the United States declined to hear a case regarding a New York state law requiring insurance coverage of contraceptives. Catholic Charities

challenged the law, which requires employers who choose to cover prescription drugs to also cover prescription contraceptives for women, on the grounds of religious freedom. The law exempts religious organizations whose main purpose is to promote a particular faith, but it does not exempt church-affiliated organizations that provide nonreligious services to the public. In 2004, the Supreme Court refused to hear a similar case about a California law.

However, family planning advocates suffered a setback in a lower court which found that a company insurance policy did not have to include contraceptive coverage. In March, the Eighth Circuit Court of Appeals ruled that Union Pacific Railroad's policy of not covering contraceptives in its health plan does not discriminate against women. The Eighth Circuit held in *Standridge v. Union Pacific* that the company had not violated the federal Civil Rights Act because the health policy did not cover any form of contraception, for either men or women. The ruling overturns an Omaha lower court decision that the company did discriminate against women by denying contraceptive coverage. A dissent by one of the three appellate court judges said that since men cannot become pregnant, the policy only affects women, which makes it discriminatory even though it is officially gender neutral.

Targeting Young Adults

The National Campaign to Prevent Teen Pregnancy, which has worked to reduce the rate of teenage pregnancy in the United States since 1996, is expanding its mission to address the issue of unplanned and unwanted pregnancy among young adults. The National Campaign, as it will now be called, received a financial commitment from the William and Flora Hewlett Foundation in order to undertake this expanded mission. The provider community will be critical to achieving the goals of this initiative, and NFPRHA will work with The National Campaign staff as they further develop their plans.

Two studies were released by Child Trends at the end of 2007 which addressed the teen birth rate. In October, a Child Trends study showed that even though the teenage birth rate has declined over the past fifteen years, in 2004, one in five teen births were repeat births. Twenty percent of teenage mothers were having more than one child while still in their teens. The research brief, titled "Repeat Teen Childbearing: Differences Across States and by Race and Ethnicity" provides new information on the phenomenon. Findings include that Texas, which has the highest overall teen birth rate (63 births per 1,000 females ages 15-19) also has the highest percentage of repeat teen births (24 percent).

In November, Child Trends released "Trends in Hispanic Teen Births: Differences Across States," which identified two groups of states that are addressing teen pregnancy in the Hispanic community. States with a high percentage of teen births to Hispanics and those with especially rapid growth in the number of teen births to Hispanics both have unique issues that create implications for state agencies and local program providers. The report examined some possible explanations for these trends.

CONDOM USE AMONG ADOLESCENTS EFFECTIVE AGAINST STDs

A study found that adolescents who use condoms at first intercourse have the same number of sexual partners, but fewer sexually transmitted diseases (STDs), than those who do not use condoms the first time. The study, published in the June issue of The American Journal of Public Health, found that nearly 62 percent of teenagers studied used a condom the first time they had sex. Condom users and non-condom users both reported an average of five sexual partners, but those who used a condom at first intercourse were half as likely to have an STD seven years later.

Medicaid Funding for Family Planning

Preserving and expanding Medicaid, which provides the main source of funding for family planning services, is essential to the health of low-income women and their families. Studies show that increasing numbers of women of reproductive age are eligible for Medicaid, and that many of their family planning needs are still unmet.

NFPRHA advocated for the inclusion of a provision to allow states to provide family planning services through Medicaid for all women eligible for pregnancy-related care in the bill to reauthorize the State Children's Health Insurance Program (SCHIP). SCHIP is a popular government program which covers more than 6 million low- and moderate-income children. Although this provision was passed by the House of Representatives, it was ultimately dropped in negotiations with the Senate, and was not included in the final bill ultimately vetoed by the President. Expansion of Medicaid coverage of family planning continues to be one of our top legislative priorities.

Currently, 26 states have obtained Medicaid waivers to offset the costs of family planning services at the state level and several other states are following their example with NFPRHA's support and expertise.

STUDIES SHOW CONTINUING NEED FOR MEDICAID COVERAGE OF FAMILY PLANNING

A report in the Guttmacher Policy Review concluded that between 2000 and 2005, the number of women of reproductive age covered by Medicaid increased by nearly two million women, up from 9 percent to 12 percent. This increase, however, was matched by an increase in the proportion of reproductive age women who were uninsured, from 18 percent to 21 percent. The dual increase in Medicaid coverage and the number of uninsured was likely caused in part by the continuing decline of employer-sponsored health insurance and by the recession that followed the 2000 stock market crash. The report includes state-by-state information on Medicaid coverage and the number of uninsured.

In October, the Kaiser Family Foundation and the Guttmacher Institute released an Issue Brief that outlines the role of Medicaid funds in providing family planning services to the low-income and the uninsured. Though there are increased federal funds being spent through Medicaid to provide family planning services to the uninsured, there is still an unmet need.

In "Stronger Together: Medicaid, Title X Bring Different Strengths to Family Planning Effort," author Rachel Benson Gold analyzes the ways that Medicaid family planning waivers are changing how contraceptive services for low-income individuals are financed in the United States, and how Title X and Medicaid can be used together to better serve family planning clients. This article appeared in the Spring 2007 issue of the Guttmacher Policy Review.

Expanding Medicaid Coverage of Family Planning

UNINTENDED PREGNANCY REDUCTION ACT

In March, Senator Hillary Rodham Clinton (D-NY), along with Majority Leader Harry Reid (D-NV) and Senators Frank Lautenberg (D-NJ), Robert Casey (D-PA), John Kerry (D-MA), and Charles Schumer (D-NY), introduced the Unintended Pregnancy Reduction Act (S. 1075). The bill would require states to cover family planning services through Medicaid for all women who would be entitled to Medicaid-funded pregnancy-related care if they became pregnant, resulting in significant savings to both states and the federal government. The measure would also clarify that family planning services are mandatory benefits under Medicaid, an entitlement called into question by the Deficit Reduction Act (DRA).

A companion bill (H.R. 2523) was introduced in the House by Representative Nita Lowey (D-NY), along with Representatives Rosa DeLauro (D-CT), Mark Kirk (R-IL), and Henry Waxman (D-CA).

EXPANSION LANGUAGE INSERTED IN SCHIP REAUTHORIZATION

The House's original bill to reauthorize the State Children's Health Insurance Program (H.R. 976), marked up in July in the House Energy and Commerce Committee, which would expand health coverage for an additional four million children, included an expansion of Medicaid coverage of family planning. The Children's Health and Medicare Protection (CHAMP) Act of 2007 (H.R. 3162) included language that would give states the option of expanding Medicaid coverage of family planning services for women eligible for coverage of pregnancy-related services. This provision would bring an end to the lengthy and burdensome Medicaid family planning waiver process.

On August 1, the House voted 225-204 (Roll Call Vote 787), in favor of reauthorizing SCHIP, including the provision to expand Medicaid coverage of family planning services. The House bill also included a reauthorization of the Title V abstinence-only program that includes provisions on medical accuracy, effectiveness, and state flexibility. For the first time, states would be able to use federal funding to deliver good, comprehensive sexuality education. On August 3, the Senate passed its version of the bill (68-31, Roll Call Vote 307), which did not include the family planning-related provisions.

Prior to the final vote, the Senate narrowly defeated an amendment (49-50, Roll Call Vote 302) by Senator Wayne Allard (R-CO) which would have codified the unborn child rule finalized by the Department of Health and Human Services in October 2002 revising the definition of "child" to include unborn children.

In September, Congress passed a final bill to reauthorize SCHIP. The final bill did not include the expansion of Medicaid coverage of family planning services passed by the House, which was included in the bill until late in House and Senate negotiations. The bill also did not include the "fixes" to the Title V state abstinence-only grant program that included provisions on medical accuracy, effectiveness, and state flexibility.

The proposed expansion of the SCHIP program, which had strong bipartisan support, gave the Administration an opening to score a political point about increased spending amidst its claim that high income families would drop private coverage in favor of expanded government coverage. On October 3, President Bush vetoed the SCHIP reauthorization bill. The Senate had passed the measure by a vote of 67-29, providing the two-thirds needed to overturn a presidential veto. The House's 265-159 vote, however, fell short of a veto-proof margin and the House ultimately failed to override the veto. The program, which expired in September, was continued through temporary funding extensions through March 31, 2009.

NFPRHA is continuing to work to attach the provision expanding Medicaid coverage of family planning services to other suitable legislation.

PROOF OF CITIZENSHIP REQUIREMENT

As we feared, the citizenship documentation requirement enacted as part of the Deficit Reduction Act (DRA) in 2006 has proved burdensome to low-income women in need of publicly funded family planning services. In July, a review by the Government Accountability Office found that the citizenship documentation requirement is creating substantial enrollment declines among people eligible for Medicaid, but not among illegal immigrants. The review, which surveyed 44 states on the impact of the requirements, found that 22 states saw enrollment declines, largely due to delays in coverage or loss of coverage for eligible citizens. Twelve states said the requirements had not affected enrollment, while ten other states said they did not know how the requirements had affected enrollment.

NFPRHA supported efforts to remove the documentation requirement. The Senate Finance Committee addressed the issue in its July draft of the bill to reauthorize the SCHIP program. The bill included language that would amend the citizenship documentation requirement of the DRA to allow a state to verify a patient's name and Social Security number with the Social Security Administration (SSA). If a name or number is found to be invalid, patients would have 90 days to present evidence of citizenship.

Congress approved the SCHIP reauthorization in September, which included language giving states an alternative method of complying with the Medicaid citizenship documentation

requirements. A state could apply the documentation requirement as enacted in 2006, or the state could choose to verify each Medicaid applicant's and recipient's name and Social Security number with the SSA. States would provide to the SSA the Social Security numbers of individuals applying for Medicaid and SCHIP, and if the information provided by the applicant does not match SSA records, the applicant would have up to 90 days to prove their citizenship. Applicants who were unable to provide appropriate documentation would then be denied coverage.

However, as discussed above, President Bush vetoed the SCHIP reauthorization and the House failed to override the veto. The program, which expired in September, was continued through temporary funding extensions through March 31, 2009.

Earlier in the year, Representative Corrine Brown (D-FL) introduced a bill that would eliminate the citizenship documentation requirement. The bill (H.R. 1878) would restore citizenship verification as a state option, clarify federal law to ensure that children born in the United States are not denied coverage because of citizenship verification requirements (regardless of the child's parents' immigration status), and allow children and adults denied coverage because of citizenship verification requirements to potentially receive retroactive Medicaid eligibility for the coverage they were denied. A Senate version of the bill (S. 909) introduced by Senator Jeff Bingaman (D-NM) on March 15, is pending.

Medicaid Waivers

First implemented in the early 1990s, waivers have been used as an innovative way for states to use federal Medicaid funding to test new approaches to expanding coverage eligibility. Under the process, states must secure approval (known as a "waiver" of federal policy) from the Centers for Medicare and Medicaid Services (CMS). Applicants must make the case that waivers are budget neutral, and since 2001, family planning waivers have been required to facilitate access to primary care services. An August 2006 Guttmacher Institute study found that expanding Medicaid coverage for contraception to equal that of pregnancy related care would save $1.5 billion in annual federal and state expenditures.

Just over half of all states (26) have used the waiver process to secure expanded eligibility for Medicaid coverage of family planning services. Some states have obtained approval to continue Medicaid coverage of family planning services for women who would otherwise lose Medicaid coverage. Other states have granted coverage solely on the basis of income to individuals not previously covered under Medicaid.

In 2007, five states made progress to expand eligibility for Medicaid-covered family planning services. In Virginia and Wisconsin, legislators directed the state to expand existing programs. In Virginia, which already had expanded coverage for family planning services postpartum, the state was directed to seek federal approval to extend eligibility to women with incomes up to 200% of the federal poverty level. In Wisconsin, the legislature directed the state to extend coverage to women with an income up to that same level, an increase from the state's current ceiling of 185% of poverty. CMS approved both of these proposals, along with a third proposal submitted by Pennsylvania to extend coverage to women with an income up to 185% of the poverty level, during the course of the year. This brings to 20 the number of states with broad, income-based Medicaid family planning expansions and to 26 the total number of states with any type of expansion.

Two other states took action which did not result in the submission of proposals to CMS. The New Hampshire legislature directed the state to apply for an expansion and the Missouri legislature directed the state to broaden its existing expansion.

Drug Pricing Fix

In July, the Centers for Medicare and Medicaid Services (CMS) issued its final rule on implementation of provisions to the DRA pertaining to prescription drugs under the Medicaid program. Family planning advocates had hoped CMS would take the opportunity to correct a DRA provision that unintentionally prevents non-Title X family planning providers from accessing low-cost birth control for their low-income, uninsured and underinsured patients. Unfortunately, CMS did not define "safety net provider" in the final rule, thereby leaving the problem unresolved.

Case for Comprehensive Sex Education/ Ineffectiveness of Abstinence-Only Programs

Family planning extends beyond providing contraception, counseling and health services to include age-appropriate education. Comprehensive sexuality education programs provide people the information they need to make good decisions and to be socially responsible.

Currently, there is no federal funding for comprehensive sex education, while there were three separate federal funding streams totaling $176 million in FY 2007 for abstinence-only programs: the Abstinence Education Grants to States program (Title V, also referred to as Section 510 funding); the Community-Based Abstinence Education (CBAE) program; and the Adolescent Family Life Act (AFLA) abstinence program. Since 1982, more than $1.5 billion in federal funds has been spent on abstinence-only education programs that often teach false, misleading, and inaccurate information.

In April, a long-awaited, federally funded study of abstinence-only education programs revealed that students who participated in sexual abstinence programs were just as likely to have sex a few years later as those who did not participate in the programs. Conducted by Mathematica Policy Research, the study looked at students in four abstinence-only programs nationwide, as well as students from the same communities who did not participate in the programs. In total, 2,057 students in four cities (Miami, FL; Milwaukee, WI; Powhatan, VA; and Clarksdale, MS) were surveyed. The study found that the average age of first intercourse was the same for both the abstinence-only students and those in the control group: 14 years and nine months.

The Mathematica study is a blow to the Bush Administration, which had long-argued that the report would support its view that abstinence-only programs are effective. Following the release of the study, abstinence-only proponents tried to downplay its significance. In December, U.S. News & World Report wrote that researchers are cautioning against making any link between the teen birth rate and the Mathematica research saying that it's simply too soon to know. However, the study's findings only bolster reproductive health advocates' efforts to defund these dangerous programs.

For many years, extreme conservatives have tried to use federal funding for family planning through Title X as justification for the need to increase funding for abstinence-only programs. Family planning opponents have argued that federal funding for family planning is the same as funding comprehensive sex education, despite the fact that comparing Title X (a health service delivery program) and abstinence-only (allegedly an "education" program) is like trying to compare apples and oranges. Thanks, however, to strong education efforts by NFPRHA and its coalition partners, Congress finally de-linked Title X and the Community-Based Abstinence Education (CBAE) program, and CBAE received no increase for FY08 while Title X received an additional $17 million.

Comprehensive Sex Education

Family planning advocates strongly supported federal legislation to create a nationwide, comprehensive sex education program. In March, Representative Barbara Lee (D-CA) and Senator Frank Lautenberg (D-NJ) introduced the Responsible Education About Life (REAL) Act. The bill would create a grant program administered by the Department of Health and Human Services (HHS) to fund comprehensive sexuality education programs that include medically accurate information about abstinence, contraception, and disease prevention.

Federal Funding for Title V

After the failure of the SCHIP reauthorization, which included significant changes to the Title V abstinence-only education program that were dropped from the final bill, Congress granted a set of extensions to the program. The program which was set to expire at the end of June 2007 now expires on March 31, 2009.

The debate began in May, when House Energy and Commerce Chairman John Dingell (D-MI) announced his intention to let the $50 million Title V state abstinence-only program expire on June 30. Chairman Dingell called the Title V program "a colossal failure," citing the Mathematica study, which showed Title V-funded programs to be ineffective. In light of Chairman Dingell's remarks, supporters of abstinence-only programs responded by saying they would work harder to maintain the program.

In June, as the expiration of the program neared, the Senate approved a three-month reauthorization of the Transitional Medical Assistance program (TMA) and Title V state abstinence-only grant program, which have been historically linked. The short-term extension was designed to give congressional leaders time to develop a strategy to address the possibility of de-linking Title V from TMA and potential fixes to the abstinence-only program. Funding for both TMA and Title V programs had already been dispersed through the end of the current fiscal year, so neither program was expected to be immediately affected.

The House failed to approve the temporary extension after Representative Dennis Hastert (R-IL) objected to passing it by unanimous consent due an offset that was included in the bill. In July, however, the House followed the Senate and reauthorized the TMA program and Title V state abstinence-only grant program until September 30.

The July draft of the bill to reauthorize the State Children's Health Insurance Program (H.R. 976) marked up in the House Energy and Commerce Committee, which would expand health coverage for an additional four million children, included significant changes to Title V. The Children's Health and Medicare Protection (CHAMP) Act of 2007 included a two-year reauthorization of the TMA without a reauthorization of the Title V state abstinence-only grant program.

However, when Congress voted to reauthorize SCHIP in September, the final bill did not include the "fixes" to the Title V state abstinence-only grant program that included provisions on medical accuracy, effectiveness, and state flexibility.

Given than the Title V provisions did not make it into the final bill, Congress once again granted a short-term extension to the Title V state abstinence-only grant program which was set to expire September 30. The House and Senate approved the extension without objection (H.R. 3668), which extended both Title V and TMA until December 31. In late December, Congress granted Title V yet another temporary extension, along with TMA, as part of the temporary SCHIP funding extension. Title V is now set to expire on June 30, 2008.

Community-Based Abstinence Education

At the end of the year, the President signed the omnibus bill which included the Labor, Health and Human Services, and Education appropriations bill. Family planning opponents who claim that Title X is akin to sex education had insisted that Title X and the Community-Based Abstinence Education (CBAE) program receive the same increase in funding. Family planning advocates won an increase of $17 million for Title X, which meant a similar increase was on the table for the CBAE program. However, under pressure to make deeper cuts, legislators de-linked the two programs, resulting in no increase for CBAE programs in FY2008.

GUIDELINES FOR CBAE

The Department of Health and Human Services released the FY 2007 grant announcement for the CBAE program in March. One of the major changes to the grant announcement is the inclusion of a "medical accuracy" requirement, which requires only that applicants "ensure that all data in their applications are true and correct." No

further definition is provided. While the grant announcement requires that "information on contraceptives, if included, must be medically accurate and should include information on the effectiveness or lack of effectiveness of the type of contraception discussed in the curriculum," the requirement is only applicable to mass-produced materials that are specifically about sexually transmitted diseases (i.e. more than 50 percent of the content is related to STDs), which presents applicants with a very large loophole.

High-profile Resignation

Dr. Wade Horn, the Bush Administration's point man for abstinence education, resigned in April. As Assistant Secretary for Children and Families at the Department of Health and Human Services (HHS), Horn ran the Administration for Children and Families (ACF), which administers both the Abstinence Education Grants to States program (Title V) and the CBAE program. During Horn's tenure, the CBAE program saw major funding increases, bringing the current total for federally funded abstinence-only-until-marriage education programs to $176 million per year. Horn also oversaw a dramatic tightening of HHS restrictions on how abstinence-only funds can be used, and promoted an increased emphasis on marriage and faith-based initiatives. Horn, who was confirmed as Assistant Secretary in 2001, is now a Director at Deloitte Consulting LLP.

Education Programs in the States

COMPREHENSIVE SEX EDUCATION

In 2007, three states took steps to improve access to comprehensive sex education. As of the end of the year, 14 states require that contraception be included in the sex education provided to public school students, according to the Guttmacher Institute.

New laws in Washington and Colorado, as well as a similar measure adopted in Iowa, require that all sex education instruction be medically accurate. Laws adopted in Washington and Colorado also require that any sex education offered in public schools include instruction on contraception as well as abstinence.

In Washington, Governor Christine Gregoire (D) signed a bill to require the teaching of comprehensive sex education in state schools. The state House of Representatives passed the Healthy Youth Act by a vote of 63-34, and the state Senate approved it by a vote of 30-19 (ESSB 5297). The law requires that any sex education taught by school districts be medically accurate and comprehensive, as defined by the Washington Department of Health and the Office of the Superintendent of Public Instruction.

In May, Colorado Governor Bill Ritter (D) signed a bill into law that requires all but one school district in the state to teach comprehensive sex education courses. Under the new law, courses can still include discussion of abstinence, but must also include instruction on the health benefits and possible side effects of contraception. Schools can also choose not to teach a sex education course. The single exception to the law is the school district in Center, Colorado, which will be allowed to continue teaching its abstinence-only curriculum in order to meet its federal grant obligations.

Missouri, however, moved in the opposite direction. Since 1999, the state had required information on abstinence and contraception in sex education programs; it had also required that any instruction provided be medically accurate. A measure adopted in 2007, however, abolished both requirements by allowing abstinence-only education that meets the federal eight-point definition, which asserts, among other things, that "sexual activity outside the context of marriage is likely to have harmful psychological and physical side effects."

REFUSAL OF FEDERAL FUNDING

Federal action to curtail the use of funds for abstinence education caused several states to reject such funds entirely. In November 2006, the Department of Health and Human Services (HHS) put new rules into place requiring strict adherence to all elements of the Title V abstinence-only-until marriage education program, including requiring

teaching that sex within marriage is the "expected standard of human sexual activity," and that sex outside of marriage is likely to have "harmful psychological and physical effects." Teachers are also prohibited from discussing contraception except failure rates.

Accepting federal money with new restrictions in some cases violated state law because the Title V program prohibits states receiving such funds from providing complete and accurate information about contraception and sexually transmitted diseases (STDs). During 2000-06, New Jersey, California, and Maine had rejected the Title V funding. But after HHS announced the new rules in 2006, numerous other states decided to opt out of the program.

Significantly, Ohio made an important shift away from abstinence-only education. Ohio has long been a leader in abstinence-only-until-marriage education, even passing a law in 1999 requiring school districts to develop health curriculum emphasizing that abstinence is the only surefire way to avoid pregnancy, sexually transmitted diseases, and HIV. Abstinence-only groups in the state received $23.7 million in federal dollars from 2004-07. In March, however, Ohio Governor Ted Strickland (D) decided not to re-apply for federal abstinence-only funds once the state's $1.6 million grant ended in September. Additionally, Strickland's proposed budget eliminated the $500,000 that has been routinely set aside each year in state matching funds for the federal Title V abstinence-only program.

Following the April release of a federal study conducted by Mathematica Policy Research, which found abstinence-only programs to be ineffective, Massachusetts Governor Deval Patrick (D) chose to reject the Title V federal abstinence-only funding. Massachusetts had received $700,000 annually in federal funding for state abstinence-only programs since 1998. The Patrick Administration cited the Mathematica study, as well as federal restrictions requiring that the discussion of birth control be limited to failure rates. The Massachusetts House of Representatives passed an amendment affirming the Governor's decision and calling for a study evaluating the effects of abstinence only programs in Massachusetts.

In March, Wisconsin Governor Jim Doyle (D) announced that the state would turn down approximately $600,000 in federal abstinence education funding for FY 2007. Colorado also decided not to seek a grant of $450,000. In November, Virginia Governor Timothy M. Kaine (D) also announced plans to reject $275,000 in federal funds.

As of December 2007, fifteen states had either rejected Title V funds outright or announced their intention not to participate in the program, leaving nearly $18 million in unspent funds in federal coffers.

Reducing the Need for Abortion: Successes and Setbacks

NFPRHA's family planning agenda places a strong emphasis on preventing unwanted pregnancies and reducing the need for abortion. In fact, federally funded, comprehensive family planning services prevent an estimated 1.3 million unplanned pregnancies and 630,000 abortions each year.

While congressional leaders struggle to find a consensus approach on abortion, introducing numerous positive measures to address pregnancy and health, some conservative legislators continue to find ways to raise divisive issues. The Supreme Court, however, dealt a major blow to supporters of women's health by affirming the constitutionality of the abortion ban, which has now been enacted in 14 states. Numerous state legislatures actively sought to restrict access to abortion in several other ways, but abortion opponents made limited gains.

Congress Addresses Abortion, With Success on Federal Funding

FEDERAL FUNDING

President Bush warned the new Democratic-led Congress not to relax any restriction on federal funding for abortion. Democratic leaders issued a strong response and invited the President to support pregnancy prevention efforts put forth by family planning advocates.

In May, President Bush sent a letter to House Speaker Nancy Pelosi (D-CA) and Senate Majority Leader Harry Reid (D-NV) threatening to veto any legislation that would weaken federal policies or laws on abortion. In the letter, Bush wrote, "The standing pattern is that appropriate conscience protections must be in place for health care entities and that taxpayer dollars may not be used in coercive or involuntary family planning programs." House and Senate Republicans then wrote President Bush urging him to make clear that any weakening of anti-choice restrictions would be unacceptable. Senator Reid's office responded to the veto threat by encouraging President Bush to get behind the Senator's initiative to reduce the number of unintended pregnancies, the Prevention First Act (S. 21/H.R. 819).

As mentioned in the appropriations section, the Senate rejected the Vitter amendment (S. Amdt. 3330) to the FY08 Labor, Health and Human Services, and Education appropriations bill (H.R. 3043) that would have prevented an entity from receiving federal health funding if it or any of its sub-grantees performs abortion services. The defeat of the Vitter amendment was a great victory for family planning supporters.

COMPROMISE AMENDMENT ON "PERSONHOOD"

Representative Louise Slaughter (D-NY) introduced the Genetic Information Nondiscrimination Act (GINA, H.R. 493), which would prohibit health insurers or employers from accessing the genetic information of patients or employees and using it in hiring, firing or other business decisions. Rep. Slaughter first introduced similar legislation more than a decade ago.

In February 2007, anti-choice Representative Tim Walberg (R-MI) introduced an amendment to the bill to "clarify" that coverage extended to the "unborn." The amendment failed by a 20-27 vote during the markup of the bill by the House Education and Labor Committee. Opponents of the amendment argued that the issue was a red herring and merely designed to establish "personhood" at the earliest possible stage. Subsequently, the Energy and Commerce Committee approved a version of the bill that would include fetuses and embryos in the bill's protections against discrimination but would not provide fetuses or embryos with any new rights.

In April, by a nearly unanimous vote (420-3), the House approved the version of GINA which stipulated that the bill protected fetuses and embryos against discrimination but would not provide fetuses or embryos with any new rights.

The Senate Health, Education, Labor and Pensions (HELP)

Committee approved similar legislation (S. 358) sponsored by Senator Olympia Snowe (R-ME), on January 31, but the bill was not expected to reach the Senate floor by the end of the year as a result of a hold by Senator Tom Coburn (R-OK).

MENTAL HEALTH RELATING TO PREGNANCY AND ABORTION

In May, the House Energy and Commerce Subcommittee on Health held a hearing on a bill (H.R. 20) designed to identify causes and treatments for postpartum depression. The bill, sponsored by Representative Bobby Rush (D-IL), would expand research at the National Institute of Mental Health and other agencies on postpartum depression and postpartum psychosis. Subcommittee Ranking Member Nathan Deal (R-GA), cosponsor of the bill, said in his opening statement that more should be known about all aspects of depression, including depression that might occur after undergoing an abortion. The statement led to a sharp response from Representative Diana DeGette (D-CO), who called the statement "offensive." Deal responded that although he would not attempt to modify the bill to include research on the condition, Republicans in the House might be so inclined.

In July, the House Energy and Commerce Committee approved the Rush bill on postpartum depression. The bill included compromise language authorizing the National Institutes of Health to conduct studies of the relative mental health consequences for women resolving an unintended pregnancy in various ways, including carrying the pregnancy to term, placing the child up for adoption, having a miscarriage, or having an abortion.

POSITIVE MEASURES ON HEALTH

Family planning advocates continue to raise the alarm on the proliferation of clinics which pose as abortion-providers, but then provide misleading and inaccurate health information to patients. Since 2001, such facilities have received over $30 million in federal funding, mostly through funding streams for abstinence-only education programs. In May, Representative Carolyn Maloney (D-NY) re-introduced her bill designed to address the growing number of Crisis Pregnancy Centers that falsely present themselves as legitimate abortion providers in order to lure in women and talk them out of getting an abortion. The Stop Deceptive Advertising for Women's Services Act (H.R. 2478) would prohibit any person who does not provide abortion services from advertising with the intent of deceptively creating the impression that they in fact are an abortion services provider.

Federal Abortion Ban Upheld by the Supreme Court

On April 18, the Supreme Court upheld the Federal Abortion Ban, effectively overturning 30 years of precedent that women's health must be protected from dangerous laws that restrict abortion. In *Gonzalez v. Carhart,* the Court, by a 5-4 decision, held that the Federal Abortion Ban was constitutional, even though the law does not contain an exception to protect a woman's health and despite the Court's 2000 decision in *Stenberg v. Carhart* striking down a similar Nebraska ban. Justice Kennedy, who was considered by many to be the potential new swing vote following Justice Sandra Day O'Connor's departure, wrote the decision for the majority, which was joined by Justices Alito, Roberts, Scalia and Thomas. Justices Stevens, Souter, and Breyer joined Justice Ginsberg in her strong dissent, in which she called the decision "alarming" and a "decision so at odds with [the Court's] jurisprudence" that it "should not have staying power." Ginsberg wrote, "Though today's opinion does not go so far as to discard *Roe or Casey,* the Court, differently composed than it was when we last considered a restrictive abortion regulation, is hardly faithful to our earlier invocations of 'the rule of law' and the 'principles of *stare decisis.*'"

In response to the ruling, Senator Barbara Boxer (D-CA) and Representative Jerrold Nadler (D-NY) re-introduced the Freedom of Choice Act (S. 1173/H.R. 1964), which would codify the rights guaranteed under the Constitution by *Roe v. Wade*. It would bar government at any level from interfering with a woman's right to choose to bear a child or to terminate her pregnancy.

According to the Guttmacher Institute, as of year's end, 14 states had abortion bans in place similar to the one upheld

by the Supreme Court, with only one state, Louisiana, enacting a ban after the court's decision was announced.

States Fall Short of Dramatic Change on Abortion

Over the course of the year, states moved to restrict abortion rights in several ways. Of major concern, legislators in 12 states introduced measures to ban abortion. Despite the significant media attention surrounding this activity, only two states, Mississippi and North Dakota, actually enacted new laws in 2007. These so-called trigger laws would go into effect in the event *Roe v. Wade* is overturned. According to the Guttmacher Institute, four states now have such provisions.

TRIGGER LAWS

Even in light of its conservative decision to uphold the federal abortion ban, a majority of the Supreme Court of the United States remains likely to uphold the rights guaranteed by the Constitution as set forth in *Roe v. Wade*. But if the Court should shift further to the right and reverse Roe, several states have taken steps to enact legislation, called trigger laws, which would make abortion illegal immediately upon such a reversal.

In March, Mississippi Governor Haley Barbour (R) signed a law which would make abortion illegal in the state in the event the Supreme Court of the United States overturns *Roe v. Wade*. The law would ban nearly all abortions in Mississippi, creating criminal penalties of up to 10 years in prison for anyone performing an illegal abortion. The law only includes exceptions in cases of rape or if the pregnancy threatened the woman's life, not in cases of incest or when the woman's health is threatened. The measure also tightens parental consent laws for minors seeking an abortion, and requires abortion providers to perform a sonogram and give the pregnant woman an opportunity to listen to a fetal heartbeat.

In April 2007, North Dakota Governor John Hoeven (R) signed the bill to ban nearly all abortions in the state should *Roe v. Wade* be overturned. This ban would take effect when the North Dakota Attorney General and Legislative Counsel determine that it would be upheld as constitutional.

South Dakota lawmakers went back to the drawing board after a law banning abortion was defeated by a ballot initiative, 56 percent to 44 percent. In January 2007, lawmakers introduced a slightly altered, but still broad, abortion ban. The legislation would have banned abortion in the state except to save a woman's life, and in cases of rape, incest, and when there was a threat of severe injury to a woman's health. Each exception carried its own unique restrictions, including a concurring opinion from an uninvolved doctor that the woman's health was in jeopardy, or that blood samples from the aborted fetus be given to the police for DNA testing in cases of rape and incest. Abortions could only be performed until the 17th week of pregnancy. The bill also authorized 10 years in prison as a maximum penalty for illegal abortions. The bill had passed the South Dakota House on a 45-25 vote, but failed in a state Senate committee. Note that South Dakota enacted a trigger law in 2005.

STATE FAMILY PLANNING FUNDS

Restrictions on state family planning funds were re-enacted in Colorado and Michigan and expanded in Texas. Colorado legislators overrode Governor Bill Ritter's (D) veto and continued the prohibition on state funds going to organizations that provide abortion services with their own funds, while the budget adopted in Michigan continues the prohibition on the use of state family planning funds for abortion counseling and referral. Texas, meanwhile, added a requirement that agencies receiving state family planning funds be completely separate from abortion providers; two other states have a similar provision.

OTHER STATES

As in prior years, conservative members of the Virginia General Assembly introduced a host of anti-choice bills at the beginning of the legislative session, including bills to require parental consent prior to prescribing contraceptives to minors, require women seeking an abortion to be shown an ultrasound of the fetus, and require women seeking an abortion to be informed by a physician who is not performing the abortion as to the viability of the pregnancy. None became law.

In May, Kansas Governor Kathleen Sebelius (D) signed a law that will change the state's definition of a "person" to include an "unborn child" from the time of conception and allow prosecutors to charge anyone who attacks a pregnant woman with a separate crime against the fetus. Under previous Kansas law, it was a felony to injure a pregnant woman, but the fetus was not also treated as a victim. Kansas was the only state to enact a fetal homicide statute in 2007.

Reproductive Health: Breast and Cervical Cancer

NFPRHA strongly supports preventative health measures, such as screenings for breast cancer, cervical cancer and sexually transmitted diseases, which save lives and lower social costs. From 1980-2000, Title X providers conducted 54.4 million breast screenings, as well as an estimated 57.3 million Pap tests, which resulted in the early detection of as many as 55,000 cases of invasive cervical cancer.

After federal approval of the human papillomavirus (HPV) vaccine in 2006, federal and state legislators scrambled to address the health and political implications of vaccine mandates. Only one state ultimately approved a mandate for school-age girls. A handful of states made the HPV vaccine available at no cost and four states required health insurance companies to cover the cost of the vaccine.

Spreading the word about the HPV vaccine is necessary to avert a health crisis, given the high rates of infection among young women. More than one-third of women are infected with the at least one strain of the HPV by the age of 24, according to a study published in the Journal of the American Medical Association in February. The study found that 7.5 million females ages 14-24 are infected with some type of HPV at a given point, nearly two-thirds more than previously thought. The highest prevalence of any type of HPV infection is among women ages 20-24, 45 percent of whom are infected. The study found that only 2.3 percent of women were carrying one of the two HPV strains (HPV-16, HPV-18) most likely to lead to cervical cancer, which is approximately half the rate found by previous studies. The findings stem from the National Health and Nutrition Examination Survey (NHANES).

In January 2007, the Centers for Disease Control and Prevention (CDC) recommended that girls ages 11 and 12 receive Merck's HPV vaccine, Gardasil. The recommendation was included in changes CDC made to its 2007 immunization schedule, published in CDC's Morbidity and Mortality Weekly Report. CDC approved Gardasil for sale in the United States in July 2006, and CDC's Advisory Committee on Immunization Practices unanimously recommended that the vaccine be given to girls ages 11 and 12. The 2007 immunization schedule also states that the vaccine "can be started in females as young as age nine years; and a catch-up vaccination is recommended for females 13 to 26 who have not been vaccinated previously or who have not completed the full vaccine series."

Also in January, the American Cancer Society (ACS) issued its guideline for HPV vaccination, recommending routine HPV vaccination for girls aged 11-12. The guideline notes that girls as young as 9 may be vaccinated, and recommends catch-up vaccinations for girls aged 13-18. However, the ACS guideline stopped short of the federal Advisory Committee on Immunization Practices recommendation of catch-up vaccinations for adolescents and women ages 13 to 26. The ACS guideline states that there is not enough information to recommend for or against vaccinating women 19-26 years old, and recommends that these women discuss vaccination with their doctor. The guideline, however, does reinforce the importance of continued cervical cancer screening.

NFPRHA continues to respond to the high rate of interest among our members regarding availability of the vaccine in family planning clinics. More than 100 members joined the first Service Delivery call of the year in April regarding the HPV vaccine. Speakers and callers alike shared their insights on a range of issues, including state laws and federal requirements concerning parental consent, accessing the Merck Vaccine Patient Assistance Program, incorporating the vaccine into patient flow, and encouraging communication between children and parents.

Congressional Action on Cancer Screenings

On April 20, President Bush signed into law a bill reauthorizing the National Breast and Cervical Cancer Early

Detection Program (P.L. 110-18), which subsidizes mammograms, pap tests and other screening methods for low-income, uninsured, and underserved women. The reauthorization was sponsored by Representative Tammy Baldwin (D-WI) and Senator Barbara Mikulski (D-MD). First enacted in 1990, the program expired in 2003. However, Congress continued to support it, providing $202 million in FY 2007. The 2007 reauthorization increased funding from $225 million in FY 2008 to $275 million by FY 2012 and would allow states to apply for federal waivers to spend a greater portion of their grants on hard-to-reach women.

In a move to protect low-income women, Representative Rosa DeLauro (D-CT) introduced the Medicare Cervical Cancer Screening and Detection Coverage Act of 2007 (H.R. 4055) at the beginning of November, to ensure Medicare coverage of screening tests for HPV. The bill would amend current law, which already includes coverage of pap tests and pelvic exams under Medicare, to add HPV screening tests starting January 1, 2008.

In a statement, the congresswoman said, "Cervical cancer is a preventable disease. Over the past five decades, the Pap test has been the lynchpin in our ability to dramatically reduce the rate of cervical cancer. By incorporating new technology – the HPV test – with current routine screening practices, we can lower those rates even further."

Funding for tests for low-income women in particular are extremely important, given that women often put off needed medical care because of cost. An April report from the National Women's Law Center and the Commonwealth Fund found that high medical costs cause many women to avoid needed health care. The report, "Women and Health Coverage: The Affordability Gap," finds that women have higher medical costs than men as a share of their income, and that women are more likely than men to have difficulty getting health care, regardless of whether or not they are insured. Further difficulties stem from the fact that women are more likely to have medical bill and debt problems. In conjunction with the report, NWLC also released a companion issue brief that examines health care reform proposals and how they could address the particular challenges women face.

HIGH COST OF RECOMMENDED CANCER SCREENINGS

The American Cancer Society (ACS) called for increased use of magnetic resonance imaging (M.R.I.) scans in women who have breast cancer or who are at high risk for developing it. ACS issued a new set of guidelines recommending M.R.I. scans and mammograms once a year starting at age 30 for high-risk women, defined as a 20-25 percent or higher lifetime chance of developing breast cancer. The recommendations do not apply to most healthy women, who have only an average risk of developing the disease. (March/April 2007 issue of CA: *A Cancer Journal for Clinicians)* A study in the March 29 issue of *The New England Journal of Medicine* shows that M.R.I. scans can find tumors mammograms miss, specifically in the "healthy" breast of women who have newly diagnosed cancer in the other breast. Breast M.R.I. scans can cost upwards of $2,000, and are only covered by insurance and Medicare in some cases.

Access to the HPV Vaccine

NO-COST HPV VACCINES

In 2007, the New Hampshire Department of Health and Human Services recommended to all health care providers that the HPV vaccine be routinely administered to 9-26 year-old females and that the state's Immunization Program (NHIP) supply the vaccine to medical providers for young women ages 11-18, as funding and supply allow. The state indicated that it would have access to funding and supplies over a 12-month period to cover 25 percent of 11-18-year-old females. New Hampshire health insurers are expected to cover a substantial portion of the cost of the HPV vaccine purchased through NHIP, with remaining vaccine costs covered by Vaccine for Children funds.

In January 2007, South Dakota Governor Mike Rounds (R) announced that the state would provide the HPV vaccine to girls ages 11-18 at no cost. About 44,000 females will be eligible for the voluntary vaccination program in the first year, and in future years the program was expected to focus on girls ages 11-12. In February, the state House of

Representatives voted 61-9 to authorize $9.2 million ($1.7 million in state funds and $7.5 million in federal funds) for the program. In March, the Senate gave its approval, by a vote of 33-2. Governor Rounds then signed the bill into law authorizing the program, effective immediately.

In March, Governor Deval Patrick (D) announced that his FY 2008 budget included a $24.8 million increase in public health spending to provide universal state coverage for three new immunizations for children, including the HPV vaccine. Patrick planned to provide the vaccine on a voluntary basis for 72,126 girls and women ages 9 to 18. However, the legislature did not approve the funding, opting instead for a study. Most Massachusetts children in low-income households are eligible for a free shot through federal programs and other insurance coverage expansion initiatives.

Illinois Governor Rod R. Blagojevich (D) made Illinois the first and only state in the country to offer free breast and cervical cancer screenings and treatment to all uninsured women. In September, Governor Blagojevich announced the program, which allows women ages 35 to 64 to receive free pelvic exams, pap tests, and breast exams. Women between the ages of 40 and 64 are also eligible for free mammograms. Anyone diagnosed with breast or cervical cancer will then qualify for health coverage for the duration of her treatment. Illinois previously had a free screening program, but the program was limited to women whose household incomes are $52,000 or less for a family of four. Beginning October 1, 2007, about 260,000 additional women will be eligible for the expanded program.

STATES REQUIRE INSURANCE COVERAGE OF HPV VACCINE

According to the Guttmacher Institute, four states (Colorado, Illinois, Nevada and New Mexico) approved legislation to require coverage of the HPV vaccine in private health insurance plans, although the mandates apply to different age-groups. In Colorado and Nevada, insured females aged 9–26 are covered; in Illinois the mandate covers girls younger than 18 and in New Mexico it applies to girls aged 9–14.

Illinois Governor Rod Blagojevich (D) signed into law a measure that requires insurance companies to cover the HPV vaccine for girls under eighteen who meet requirements to be established by the Illinois Department of Public Health. Additionally, the law requires the Department of Health to establish and administer a program under which any female under eighteen can receive a free series of HPV vaccinations as medically indicated upon request. The program must begin operation no later than July 1, 2011.

The California Assembly passed legislation requiring that every individual or group health insurance plan that includes coverage for treatment of cervical cancer also cover the HPV vaccine. This requirement would apply to health insurance plans issued, amended or renewed after January 1, 2008. California Governor Arnold Schwarzenegger (R) vetoed this bill.

VACCINE MANDATES REJECTED IN MOST STATES

Proposals to mandate vaccination for school entry were introduced in 25 states and the District of Columbia early in 2007. However, much of the momentum for school mandates dissipated when groups as disparate as religious conservatives, communities of color, and others expressed opposition to a mandate. By year's end, only Virginia had adopted a mandate, while Texas and Arizona passed measures expressly prohibiting a mandate. A mandate adopted by the New Mexico legislature was vetoed by Governor Bill Richardson (D).

In February, the Virginia General Assembly became the first state legislature to approve legislation (SB 1230) making the HPV vaccine mandatory for school-age girls. Governor Tim Kaine (D) signed the bill into law in March. Kaine had expressed "some qualms" over signing the measure because of concerns that the parental opt-out provision in the bill was not broad enough, later deciding that the provision, which allows parents to opt out as long as they have reviewed required materials describing the link between HPV and cervical cancer and complete the requisite form, is adequate. The requirement will go into effect beginning with the 2009 school year.

Early in the year, Texas Governor Rick Perry (R) signed an executive order mandating HPV vaccination for girls entering the sixth grade beginning in September 2008. Parents would be able to opt out by applying for an exemption. In February, the Public Health Committee of the Texas House of Representatives voted 6-3 to overturn the executive order. The House committee also voted 9-0 to pass a bill that would require the Texas Department of State Health Services to develop a program to educate the public about HPV. In March, the full House voted 118-23 to overturn the order. The State Senate then overwhelmingly approved the bill, which prohibits state officials from requiring the HPV vaccine for school attendance. The ban expires in four years, creating an opportunity for the issue of mandating the vaccine to be revisited in the future. Governor Perry declined to veto the bill.

At the federal level, Representative Phil Gingrey (R-GA) introduced the Parental Right to Decide Protection Act (H.R. 1153), to prohibit federal funds from being used by states to make the HPV vaccine mandatory. This bill was successfully attached to the Labor, Health and Human Services, and Education appropriations bill (as mentioned in the Appropriations section). This provision has the potential to limit access to the HPV vaccine for low-income families who rely on Medicaid, SCHIP, or the Vaccines for Children program in order to obtain the vaccine.

In February, Merck, the maker of the HPV vaccine, Gardasil, announced it will stop its lobbying efforts urging states to mandate that young girls be immunized against HPV. The decision came following the repeal of Governor Perry's executive order and an alleged connection to Merck's lobbying efforts in Texas.

Regulatory Action on HPV Vaccines

In March, Roche announced that the Food and Drug Administration (FDA) will review applications for the company's two HPV diagnostic tests. Roche's Amplicor HPV test is designed to detect thirteen of the more common high-risk HPV strains, while the other test, Linear Array HPV Genotyping test, is designed to identify which of the thirteen strains are in a sample. At the time, Digene's HPV DNA test was the only HPV test approved by the FDA for primary screening in conjunction with a Pap test in women ages 30 and older.

In April, Merck applied to the FDA for expanded approval for its HPV vaccine, Gardasil. The vaccine protects against four types (8, 11, 16, and 18) of HPV, two of which (16, 18) are responsible for about 70 percent of cervical cancer cases, with the other two types (8, 11) responsible for 90 percent of genital wart cases. The four types combined, however, also account for 35 to 50 percent of all low-grade cervical, vulvar, and vaginal lesions. The expansion would allow Gardasil to be marketed for use in helping to prevent vaginal and vulvar cancers.

A study published in the May 10 issue of the *New England Journal of Medicine* found that the HPV vaccine, Gardasil, is less effective among women previously infected with HPV. Gardasil has been shown to be 100 percent effective in preventing infection with HPV strains 16 and 18, and about 99 percent effective in preventing strains 6 and 11. The study, funded by Merck, found that the vaccine was 98 percent effective in preventing precancerous lesions of the cervix related to strains 16 and 18 among women who had not previously been infected with the two strains, but the vaccine's efficacy dropped to 44 percent among women previously infected by strains 16 or 18.

In December, the FDA decided to delay approval of GlaxoSmithKline's HPV vaccine, Cervarix. According to the company, the FDA notified GSK that it completed its review of the vaccine but still had remaining questions. Unlike Merck's Gardasil, which focuses on four strains of HPV, Cervarix targets two, HPV types 16 and 18, that currently cause 70% of all cervical cancers. The drug has been approved in 45 countries, including the European Union, Mexico, Singapore and the Phillipines.

Link Between HPV and Oral Cancer

For the first time, researchers have established a definitive link between HPV and oral cancer. A study published in the May 10 issue of the *New England Journal of Medicine* found

that people infected with the HPV through oral sex are 32 times as likely to develop oropharyngeal cancer as people who do not have HPV. The study could help explain why rates of oral cancer among younger people and non-smokers have increased in recent years. Although the HPV vaccine has not been specifically tested in relation to reducing the risk for oral cancer, the vaccine does protect against the type of HPV (HPV 16) associated with the increased oral cancer risk.

Food & Drug Administration (FDA) Actions

The Food and Drug Administration (FDA) took several steps in 2007 regarding oral and other contraceptives. The FDA also announced cuts to its Office of Women's Health, but then backed down after several members of Congress insisted on full funding.

Regulatory Activity Relating to Contraception

FDA APPROVAL OF NEW CONTRACEPTION PILL

In July, Wyeth Pharmaceuticals launched its new birth control pill Lybrel in the United States. Lybrel, approved by the FDA in May, is the first low-dose combination pill that will prevent women from getting their period for up to a year. The pill is taken 365 days a year, instead of the usual regimen of 21 active pills followed by seven placebo pills. Wyeth said that most women in clinical studies experienced some breakthrough bleeding and spotting during the first three to six months of taking the pill. Data from a clinical trial showed that 59 percent of women taking Lybrel stopped bleeding after six months, but 18 percent of women dropped out because of bleeding or spotting. A European trial found that Lybrel prevented pregnancy in all 323 women who took the drug.

PATENT RENEWAL FOR SEASONALE

The FDA approved Seasonale, which allows users to have only four menstrual periods per year, in September 2003. Barr's original three-year product exclusivity expired on September 5. Competitor Watson Pharmaceuticals has been seeking approval for a generic version of the drug since 2004, claiming that Barr's patent was invalid and unenforceable. Watson launched its generic version in September. However, also in September, the United States Patent and Trademark Office reissued Barr Pharmaceuticals' patent for the birth control pill Seasonale, giving the company exclusive rights to market the drug until June 23, 2017.

COMMITTEE HEARING ON BIRTH CONTROL

In January 2007, the FDA's Reproductive Health Drugs Advisory Committee met to discuss the efficacy of hormonal birth control. The committee recommended modifying clinical trials to include women who are more representative of the general population, such as women who are overweight, as well as requiring drug makers to test new approaches on smokers, teenagers, women older than 35, and others to get better data on effectiveness of, and risks associated with, birth control. The committee recommended against setting a specific level of effectiveness for hormonal contraceptives, saying that the effectiveness of birth control pills (specifically, the newer low-dose pills) should be weighed against other benefits that some women may experience with lower-dose pills. The panel did recommend, however, that the FDA ask drug companies to conduct follow-up studies on some new methods after they go on the market to identify any safety or reliability problems missed during initial testing.

NEW LABELING REQUIREMENT

In December, the FDA released a final rule requiring all over-the-counter products containing the spermicidal product nonoxynol-9 to carry labels stating that nonoxynol-9 does not protect against HIV or other sexually transmitted infections. The label will state that nonoxynol-9 can irritate the vagina and rectum, adding that products containing the spermicide may increase the risk of HIV. The rule, which will go into effect June 19, 2008, was first proposed in 2003 when a study conducted in Africa and Thailand found women using a contraceptive gel with nonoxynol-9 were at an increased risk of HIV.

Full Funding for the Office of Women's Health

In February, several news agencies reported that the Food and Drug Administration (FDA) was set to cut the FY 2007 budget of the Office of Women's Health (OWH) by nearly one-third, reducing its budget from $4 million to $2.8

million, leaving OWH with only enough money to cover staff salaries and projects already in progress.

Some lawmakers and advocacy groups were concerned that proposed cuts amounted to retaliation over the Plan B controversy. Dr. Susan Wood, the former head of the OWH, resigned over the delays in approving Barr Pharmaceuticals' application for over-the-counter access for Plan B. In a letter to FDA Commissioner Andrew C. von Eschenbach, Senators Hillary Rodham Clinton (D-NY), Patty Murray (D-WA), Barbara Mikulski (D-MD), and Olympia Snowe (R-ME) said the OWH should be fully funded in order to continue improving the well-being of women nationwide, and pledged to "pursue every course" to ensure the office receives its full funding.

By mid-March, however, following a public awareness campaign by NPFHRA, our community partners, and Members of Congress, the FDA released its 2007 operating plan, which funded the OWH at the same $4 million level it has had for several years.

Representative Rosa DeLauro (D-CT), chairman of the House appropriations subcommittee that funds the FDA, said, "It is disappointing that on the important issue of women's health, FDA had to be persuaded to simply maintain the funding level that was requested by the administration and provided by Congress," said. However, she said, "It is very gratifying that the FDA reversed course."

Centers for Disease Control & Prevention (CDC) Guidelines Related to HIV Testing and Sexually Transmitted Diseases

States have proposed a variety of bills in response to Centers for Disease Control and Prevention (CDC) recommendations regarding testing for HIV and sexually transmitted diseases. In 2006, the CDC recommended that all patients ages 13-64 be tested routinely for HIV unless they opt-out. Several states this year moved forward with mandatory testing for pregnant women. In 2007, the CDC also recommended that girls of 11 and 12 years old be given the human papillomavirus vaccine (HPV). As discussed in the previous section, most states failed to enact a mandate for the HPV vaccine for girls. However, the CDC issued a clear warning that STDs pose a "substantial threat to the health of Americans."

NFPRHA joins family planning advocates in supporting a range of preventative health measures recommended by the CDC, such as screenings for cervical cancer, HIV, and sexually transmitted diseases.

Scaling Back HIV Reduction Goal

In May, the CDC released a revision to its HIV Prevention Strategic Plan, calling for a 10 percent reduction in HIV infections by 2010, a significant retreat from the previous goal of reducing HIV infections by 50 percent. The "Addendum to the CDC HIV Prevention Strategic Plan Through 2005," released at the CDC/HRSA Advisory Council Meeting in May, says the CDC strives to "[r]educe the number of new HIV infections in the US by 10%, focusing particularly on eliminating racial and ethnic disparities in new HIV infections."

CDC's Recommendation on Routine HIV Testing

An October study found that the majority of state laws in place do not allow for HIV testing as recommended by the CDC. The CDC's revised recommendations call for HIV screening for all patients ages 13-64, regardless of risk; voluntary, opt-out screening; and simplified procedures for screening, including removing prevention counseling as a requirement prior to testing and no longer requiring written consent for screening. The study, however, published in the online journal *PLoS One* (Public Library of Science), finds that more than 30 states have laws which would bar the kind of testing proposed by CDC. For example, 33 states require informed consent for an HIV test, and 24 states require some type of disclosure about HIV testing, either through pre-test counseling or a consent process. Still, many health care providers, including family planning clinics, have begun implementing the CDC's recommendations, despite the lack of significant additional funds necessary for full implementation.

The U.S. Preventive Services Task Force (USPSTF), an independent organization sponsored by the Department of Health and Human Services' Agency for Healthcare Research and Quality, issued a report in May detailing its views on the CDC's September 2006 HIV testing recommendations. The report gave the testing recommendations a grade of "C," making no recommendation either for or against the guidelines. Instead, USPSTF said that while there is fair evidence that increased screening can detect additional individuals with HIV, the yield of screening persons without risk factors would be low, and the balance of benefits and harms is too close to justify a general recommendation.

HIV Testing of Pregnant Women at the State Level

Laws enacted in nine states - California, Georgia, Illinois, Iowa, Nevada, New Jersey, New Mexico, Rhode Island and Tennessee - established new provisions on HIV testing of pregnant women, according to the Guttmacher Institute. In all these states except Louisiana, Nevada and New Jersey, a

pregnant woman is required to be informed about the HIV test and then tested for HIV unless she declines. In addition to similar information and testing requirements for a pregnant woman, the measures adopted in Louisiana, Nevada and New Jersey also mandate that a provider perform an HIV test on an infant born to a mother who has not been tested. In Nevada and New Jersey a parent may refuse the test on the basis of religious beliefs. A law adopted in Maryland requires a physician to report the birth of any infant whose mother is HIV positive within 48 hours.

The California law goes beyond testing of pregnant women to apply to all patients. The bill (AB 682) passed by the legislature would create an opt-out policy for HIV screening, where doctors and hospitals would routinely test patients for HIV unless the patient declines to be tested. The bill was designed to increase the number of people tested for HIV in California by removing what some see as a barrier to testing: informed, written consent. The bill became law in October.

STDs Pose a Substantial Health Threat

In November, the CDC released its 2006 Sexually Transmitted Disease Surveillance Report. It found that Chlamydia is at its highest rate of infection ever, with 1,030,911 cases reported in 2006. Though reported rates of gonorrhea infection have been stable for years, they are also increasing; between 2005 and 2006, there was a 5.5% increase to a level of 120.9 cases per 100,000 people. The CDC also examined how racial disparities persist in the infection, noting the rate of gonorrhea was 18 times higher for African Americans than for whites in 2006.

John Douglas, Director of the CDC's Division of Sexually Transmitted Disease Prevention, stressed that the data does not present a complete picture. "Many cases of notifiable STDs are either never diagnosed or go unreported. In addition, some common STDs, such as HPV - human papillomavirus - and genital herpes, are not nationally notifiable. Nevertheless, looking at the new data on nationally reported STDs alone, it is clear that they represent a substantial threat to the health of Americans," he said.

International Family Planning & Global Women's Health

NFPRHA continues to support international family planning and initiatives for women's health in developing nations.

Global Gag Rule Still in Effect

Family planning advocates won a victory with the Senate passage of the repeal of the global gag rule, also known as the Mexico City policy, which currently prohibits family planning groups that promote or perform abortions from receiving funds from the U.S. Agency for International Development (USAID). However, the provision was dropped from the final appropriations bill prior to becoming law.

In June, the House State and Foreign Operations Appropriations Subcommittee approved its version of the FY 2008 State-Foreign Operations appropriations bill (H.R. 2764). The bill created a "commodities" exception to the gag rule, allowing the government to give contraceptives - but no financial assistance – to groups prohibited from receiving funds under the policy. The bill also increased the contribution to the United Nations Population Fund (UNFPA) to $40 million, and modified how the executive branch makes a Kemp-Kasten determination, which has been used by the Bush Administration to withhold the U.S. contribution to UNFPA since 2002. The bill also revised, but did not repeal, the earmark requiring one-third of all HIV/AIDS prevention funding to be spent on abstinence-only-until-marriage programs. The bill would allow President Bush (and future presidents) to waive the earmark requirement.

The House Appropriations Committee then approved the appropriations bill without any challenges to the subcommittee provisions. Subcommittee Chairwoman Nita Lowey (D-NY) accepted an amendment relating to the U.S. contribution to the UNFPA offered by vocal family planning opponent Representative Dave Weldon (R-FL). Weldon's amendment reiterates that the bill preserved the president's authority under the Kemp-Kasten restriction to determine whether or not an organization qualifies for U.S. support and removed two time deadlines related to the Kemp-Kasten determination that were included in the subcommittee bill.

The Senate Appropriations Committee then approved the bill, which provided $461 million for family planning and reproductive health programs, a $20 million increase above the level passed by the House. The Senate measure also included House-passed language providing a limited exemption to the Global Gag Rule, allowing the government to give contraceptives to groups otherwise prohibited from receiving funds.

In September, the full Senate voted in favor of the bill by a vote of 81-12. Senators Barbara Boxer (D-CA) and Olympia Snowe (R-ME) offered an amendment to fully repeal the Global Gag Rule. The Senate passed the repeal by a vote of 53-41 (Roll Call Vote 319). As expected, Senator Sam Brownback (R-KS) offered an amendment to restore the Global Gag Rule, but it was defeated, 40-54 (Roll Call Vote 320).

In a surprise move, Senator Brownback then offered an amendment to restore the Kemp-Kasten restrictions eliminated by the House, thereby blocking the release of the U.S. contribution to the UNFPA. Although Appropriations Subcommittee Chair Patrick Leahy (D-VT) defended the common sense language in the bill that would have permitted the release of funding to UNFPA, Senator Brownback framed the amendment as a vote against forced and coerced abortions, leaving many confused about the true nature of the vote. The amendment narrowly passed, 48-45 (Roll Call Vote 318).

The State-Foreign Operations appropriations bill was then included in the FY 2008 omnibus appropriations bill, which left the global gag rule intact. President Bush signed the omnibus bill in December after approval by both the House and Senate (P.L. 110-161).

Global Women's Health Legislation

Advocates for women's health introduced two bills to advance family planning and women's reproductive health on an international level. Both await committee action.

Representative Joe Crowley (D-NY) introduced the Women's Health and Dignity Act (H.R. 2604), a bill that would provide financial and other support to the United Nations Population Fund (UNFPA) to carry out activities to save women's lives, limit the incidence of abortion and maternal mortality associated with unsafe abortion, promote universal access to safe and reliable family planning, and assist women, children, and men in developing countries to live better lives.

Representative Carolyn Maloney (D-NY) re-introduced the Repairing Young Women's Lives Around the World Act (H.R. 2114), which would require that $34 million be provided to the UNFPA for the prevention and treatment of obstetric fistula. Since 2002, the foreign operations appropriations bill has included the United States' voluntary contribution to UNFPA, but the Bush Administration has withheld the funds, wrongly claiming that UNFPA supports forced abortions and sterilization. The bill seeks to restore UNFPA funding.

Court Upholds Restrictive Bush Policy on HIV/AIDs Funding

In February, a federal court upheld the prohibition on HIV/AIDS assistance to any agency that does not have an official policy explicitly opposing prostitution and sex trafficking. The U.S. Court of Appeals for the D.C. Circuit ruled that the Bush Administration can deny funding to HIV/AIDS groups that do not publicly disavow prostitution and sex trafficking. The unanimous ruling overturned an earlier decision by the D.C. District Court in *DKT International v. USAID,* which had ruled that the pledge requirement for HIV/AIDS grantees was an unconstitutional infringement of the First Amendment.

DKT, which helps distribute condoms to prostitutes and other sex workers in Vietnam, refused to sign a pledge in accordance with the 2003 law that requires foreign groups seeking funding as part of the United States' $15 billion international AIDS program to explicitly oppose prostitution and sex trafficking. (The law was expanded to U.S. based groups in 2005.) In 2005, DKT sued the U.S. Agency for International Development, asserting that its free speech rights were violated. The Circuit Court held that Congress has given the Bush Administration the authority to provide funding on the administration's terms, saying, "The act does not compel DKT to advocate the government's position on prostitution and sex trafficking; it requires only that if DKT wishes to receive funds it must communicate the message the government chooses to fund."

Legislative Outlook for 2008 and Beyond

In context of the 2008 presidential race and the public's growing impatience for change, NFPRHA has the opportunity to advance our message of family planning and reproductive health care in support of strong and healthy families to an increasingly engaged public.

We are reaching across the ideological divide to work with legislators who share our commitment to reducing the need for abortion by expanding funding for family planning. By building a consensus approach, we will strengthen our coalition and come closer to achieving our legislative goals.

We intend to build upon our success in securing increased federal funding for family planning services. For FY 2009, NFPRHA requested $400 million to maintain the high-quality services provided in Title X health centers and to support providing the new technologies available to women in cancer detection, contraceptive options, and sexually transmitted disease detection and treatment. However, the slim Democratic majority and the uphill battle to distinguish family planning from abortion continue to slow our progress.

Additional priorities include educating and working with members of Congress for broad legislative solutions regarding pregnancy prevention, ensuring Medicaid coverage of family planning services, sound legislation to reduce unintended pregnancies, a renewed focus on comprehensive sex education, and concrete measures to improve women's reproductive health.

NFPRHA continues to engage our members in creative ways to advance the family planning agenda at the federal and state level, and to build stronger relationships with ally organizations that represent the largest populations at risk for unintended pregnancies – specifically young people and people of color.

National
Family Planning
& Reproductive Health Association

Helping people act responsibly, stay healthy and plan for strong families

1627 k Street, NW, 12th Floor, Washington, D.C. 20006-1702 Phone • 202.293.3114 • www.nfprha.org