THE WASHINGTON TWO-STEP

ONE STEP FORWARD, ONE STEP BACK

Federal Legislative and Regulatory Action on Reproductive Health in 2009

National
Family Planning
& Reproductive Health Association

The Washington Two-Step: One Step Forward, One Step Back

Federal Legislative and Regulatory Action on Reproductive Health in 2009

National
Family Planning
& Reproductive Health Association

This publication is made possible with the generous support of the Robert Sterling Clark Foundation.

Table of Contents

Introduction

As 2009 began, the nation's capitol buzzed with an equal sense of purpose and promise not often felt in a town as political and hard-charging as Washington. Between the economic collapse, two wars and the ever-present specter of terrorism, America was ready for change—change in the form of President Obama.

For reproductive health advocates and supporters, change could not come soon enough. Eight years of an anti-family planning, anti-choice Bush administration had proven to be a long, hard winter. The new Obama administration and a significant pro-family planning majority in Congress created an opportunity for something better. Gone were the days of constant, reactive defense to the next attack on reproductive health and women's rights. Gone were the days of never being able to engage in the proactive pursuit of improved and expanded reproductive rights for all. It was time for reproductive health, rights and justice to be part of the national conversation, to be welcomed as an important item on Congress' and the White House's agenda.

As usual in Washington, nothing is ever as simple as it seems, and a step forward is often followed by a step back. Despite hope and high expectations, 2009 brought both victory and defeat. Reproductive health advanced in a number of ways: the repeal of the "Global Gag rule" and a strong shift in the United States' commitment to international family planning, inclusion of important reproductive health provisions in health care reform and modest funding increases for Title X amidst an economic recession, to name a few. Along with those positives, however, came bruising battles and disappointing losses, including the biggest reproductive health story of 2009: the unprecedented restriction on access to abortion in health care reform.

And yet the year ended much as it began, with a sense of hope that can only come after a prolonged, painful battle. Despite the ups and downs, important reproductive health provisions were advanced, and Congress managed to pass sweeping health care reform legislation. Although much work remains to be done on health reform before it can be signed into law, reform is closer than it has been in a generation and it includes historic provisions that could greatly benefit low-income women and men in need of family planning care. Even as the Washington two-step continues, it moves the causes of reproductive health, rights and justice ever-forward.

The Economic Recession

The implosion of the U.S. economy in the fall of 2008 sent shockwaves across the country throughout 2009. What came to be called "The Great Recession" impacted every corner of America in an ever-expanding series of waves: from President Obama's first-year agenda to budget crises in the states to seemingly endless unemployment, dramatically affecting family planning programs and the patients they serve.

The Stimulus Package

One of the first orders of business for the newly elected Congress and Obama administration was an economic recovery package, or stimulus bill, designed to help stabilize the still-deteriorating economy and infuse capital into states and communities. Congress debated the package for nearly a month, searching for a middle ground that, in the end, left both progressives and conservatives unhappy.

The final bill, which was signed into law on February 17, totaled $787 billion, down from a high of $940 billion. As the bill wound its way from the House to the Senate, amendments from both sides impacted both the price tag and the content. As Democrats struggled to secure the 60 votes needed to avoid a filibuster on the bill, a bipartisan group of Senators led by Senators Susan Collins (R-ME) and Ben Nelson (D-NE) negotiated a compromise proposal to cut more than $100 billion from the bill, largely at the expense of health care and education spending including research, preventive care, Head Start, and stabilization funding for state education budgets.

For family planning advocates, the signing of the stimulus package marked the end of what had been a long and frustrating few weeks. A provision to give states the option of expanding their Medicaid coverage of family planning—an effective and money-saving way to prevent unintended pregnancy—sparked an unexpected, ferocious attack from conservative members of Congress. Fearing the fight could bring down the stimulus bill, the White House pulled its support for the provision, and Democratic leaders removed it from the bill a short time later.

As Goes the Economy, So Goes Health Care

Even as Congress debated the stimulus bill, the growing unemployment rate was having a profound impact on state budgets, as increasing numbers sought public assistance for wage loss, food subsidies and health care. Around the country, Medicaid rolls swelled due to round after round of employee layoffs. As the recession deepened, many states were forced to make hard choices about their budgets. Despite the increasing numbers of people in need of publicly subsidized health care, states began cutting their Medicaid programs, and governors and state legislators appealed to Washington for an infusion of federal resources which, by the end of 2009, had not come.

The Recession's Impact on Family Planning

In the fall of 2009, the Guttmacher Institute confirmed the tale NFPRHA's members had long been telling: the Great Recession was having a significant impact not only on the number of patients being seen by family planning providers, but also on the fundamental decisions women were making about their childbearing and reproductive health.

In its report, *A Real-Time Look at the Impact of the Recession on Women's Family Planning and Pregnancy Decisions*, the Guttmacher Institute found that almost half the women surveyed wanted to either delay childbearing or limit the number of children they have, due to the economy.[1] Fifty-two percent of women reported being financially worse off than they were a year before, and those women said they worried more about their ability to take care of their children.[2] The report went on to say that nearly one in four women had put off a gynecologic or birth control visit in the past year to save money, and the same proportion reported having a harder time paying for birth control than they did in previous years.[3]

1 *A Real-Time Look at the Impact of the Recession on Women's Family Planning and Pregnancy Decisions,* New York: The Guttmacher Institute, 2009.

2 Ibid.

3 Ibid.

Guttmacher produced a second report in November that studied the impact of the recession on family planning centers around the country. *A Real-Time Look at the Impact of the Recession on Publicly Funded Family Planning Centers* found that along with re-shaping women's childbearing desires, the recession had put an enormous strain on safety-net health care providers such as publicly funded family planning centers.[4] The report showed that two-thirds of publicly funded family planning centers that participated in the Guttmacher Institute's survey reported an increase in the number of clients served from the first quarter of 2008 to the first quarter of 2009.[5] Indeed, the most recent U.S. Office of Population Affairs' Family Planning Annual Report (FPAR), which provides annual data on Title X patients and services provided, showed an increase in patients served after three years of declines, to more than 5 million patients in 2008.[6]

While the economy had begun to show signs of recovery by the end of 2009, most analysts believe that the recovery will take well into 2010 or 2011. In the meantime, safety-net providers will continue to bear much of the burden of maintaining health care for the most vulnerable populations.

4 *A Real-Time Look at the Impact of the Recession on Publicly Funded Family Planning Centers*, New York: The Guttmacher Institute, 2009.

5 Ibid.

6 Fowler, CI, Gable, J, Wang, J, and Lyda-McDonald, B. *Family Planning Annual Report: 2008 National Summary,* Research Triangle Park, NC: RTI International, November, 2009.

Health Care Reform

Apart from the economy, no single issue dominated the nation's attention in 2009 like health care reform. From the halls of the White House and Congress to town halls across the nation, the debate over reforming America's broken health care system permeated the airwaves and the American consciousness.

The hope of comprehensive health care reform quickly devolved into the reality of politics, setting the stage for a protracted debate which revealed deep philosophical divides not only between political parties, but also within them. What might have once seemed like a relatively easy course to reform, driven by the momentum of a new presidency and an overwhelming majority in both the House and the Senate, became anything but easy, and by the summer it was clear that enacting comprehensive health reform would be an uphill battle. Still, by year's end—thanks to a historic Christmas Eve vote in the Senate—both chambers of Congress had passed their respective health care reform bills, and while deep differences remain to be addressed, America ended 2009 closer to health care reform than it has ever been. Among the numerous and deep ideological rifts threaded throughout the health reform debate—such as the battle over a public option, individual and employer mandates, and the high cost of reform—there was one of particular relevance to reproductive health supporters: the issue of abortion.

The Plan and Process for Health Care Reform

The White House began the year by asking Congress to have a bill on President Obama's desk by the time Congress adjourned for its traditional August recess. Rather than present a bill for congressional leadership to pass, the President offered Congress criteria for what health care reform should accomplish: the bill should cover the uninsured, make health care affordable and be paid for by raising revenue through health care savings and targeted tax increases on higher-income individuals.

With that charge, the House and Senate began their work on health care reform bills in early spring 2009. A total of five congressional committees held jurisdiction over health care reform: three in the House (the Ways and Means Committee, Energy and Commerce Committee, and Education and Labor Committee) and two in the Senate (the Finance Committee and the Health, Education, Labor and Pensions Committee). In the spring, these committees each began a process for soliciting input and feedback on the ideas that would shape their work, with many committees engaging in formal or informal discussions with stakeholder groups around the country. The overall reform process differed greatly between the House and Senate, with the two Senate committees working independently to produce their own bills while the three House committees chose to work together to produce what would be called the Tri-Committee bill.

The Senate HELP Committee Becomes the First Congressional Committee to Pass Health Care Reform

The Senate was the first out of the gate on health care reform, with the Finance and the Health, Education, Labor and Pensions (HELP) Committees both working to produce their own bills. The Senate Finance Committee put forward a series of options papers as its process moved forward in May and June, and the HELP Committee released an outline of its bill in early June. Many had expected the health care reform effort to be led by Senator Ted Kennedy (D-MA), the Chairman of the HELP Committee and a life-long champion on health care. However, Senator Kennedy's battle with cancer throughout much of 2009 resulted in the Finance Committee, chaired by Senator Max Baucus (D-MT), taking a greater role in the early health care reform process then some might have envisioned.

Still, the HELP Committee, under the leadership of Acting Chairman Christopher Dodd (D-CT), was the first committee to produce a bill—what would become the "Affordable Health Choices" Act (S. 1679). The HELP Committee's proposal laid out some of the principles (many of which were common to the Finance Committee's options papers) that would become fundamental to the discussion through much of 2009: the creation of an insurance exchange, substantial insurance market reforms, delivery system reforms aimed at improving efficiency and quality of care, improving prevention and chronic disease management, and reducing health disparities. The HELP bill also included a number of provisions that would cause many to judge the HELP bill to be the most progressive of the three bills eventually drafted: a publicly operated health insurance plan that would compete with private plans in the new exchange, expansion of Medicaid eligibility up to 150 percent of the federal poverty level, premium assistance for people with incomes between 150 and 500 percent of the federal poverty level, and measures around shared responsibility, including both an individual

mandate to have health insurance and a mandate that employers provide coverage or pay into the public system.

The HELP Committee began marking up its bill in June, and committee leaders had high hopes for a speedy and efficient mark-up. Those hopes, however, were quickly dashed, with Republicans filing hundreds of amendments on the early sections of the bill, which included what had been considered to be non-controversial portions of the bill: quality, prevention and workforce. After several weeks of debate and a brief recess for the July 4 holiday, the HELP Committee entered into the most difficult part of its mark-up, the coverage section.

Along with the debate over the public option, which by that point had turned into a major ideological battle, reproductive health advocates saw the first attacks on women's health in a scene which would be repeated over and over again in health care reform. The HELP Committee defeated four anti-choice amendments attempting to ban abortion in health care reform.[7] The mark-up also yielded passage of a positive "Women's Health Amendment," offered by Senator Barbara Mikulski (D-MD), to require that health plans contract with essential community providers, including family planning providers, who serve predominantly low-income and medically underserved individuals.

On July 15, after an epic mark-up of nearly 60 hours and votes on more than 200 amendments, the HELP Committee became the first congressional committee to pass a health care reform bill. The 13-10 vote was entirely along party lines, a harbinger of things to come.

Three Committees, One Bill in the House

On June 19, leaders of the three House committees of jurisdiction released a discussion draft of their health care reform bill. House leaders intended to begin mark-ups in the three committees immediately following the July 4 recess, but a revolt by a coalition of conservative Democrats called the "Blue Dogs" derailed that process. After a series of discussions with the Blue Dogs, the Tri-Committee introduced its official bill for mark-up, "America's Affordable Health Choices" Act (H.R. 3200).

The Tri-Committee bill included the creation of a health insurance exchange that would serve as a national health insurance marketplace where individuals and small businesses could purchase insurance, and a public option designed to help control insurance costs by injecting competition into the market. The Tri-Committee bill also included an expansion of Medicaid to 133 percent of the federal poverty level, federal subsidies for low-income individuals to help them purchase insurance coverage, and insurance market reforms and consumer protection provisions including a ban on preexisting condition exclusions and the elimination of lifetime caps on benefits. In a victory for reproductive health, the bill also contained language to give states the option of expanding coverage for family planning services under Medicaid (without the need to obtain a waiver from the Centers for Medicare and Medicaid Services (CMS)), and language requiring health plans in the exchange to contract with essential community providers.

Simultaneous mark-ups were scheduled across the three committees, and went relatively smoothly in two of them. The Ways and Means Committee conducted a one-day mark-up of provisions in the bill under the committee's jurisdiction, which concluded around 1 a.m. on July 17 with passage of the bill by a vote of 23-18. Prior to passage, the committee defeated two anti-choice amendments designed to ban abortion in health care reform. The Education and Labor Committee began its mark-up on July 15 and passed the bill by a vote of 26-22 late the morning of July 17. Prior to passage, the committee also defeated two amendments attempting to ban abortion in health care reform.

The Energy and Commerce Committee, which held the broadest jurisdiction over the bill and therefore was expected to have the most extensive mark-up of the three committees, began its consideration of the bill on July 16. After only a few days of mark-up, however, Energy and Commerce Committee Chairman Henry Waxman (D-CA) was forced to break from consideration of the bill after the Blue Dogs threatened to derail the bill over a list of issues including concerns over a government-run plan and abortion. After tense negotiations between Democratic leaders and the Blue Dogs, led by Representative Bart Stupak (D-MI), the committee resumed its work, but not without a cost to reproductive health.

An amendment by Representatives Stupak, Joe Pitts (R-PA) and Lee Terry (R-NE) effectively codifying the Weldon refusal law—which prohibits federal, state and local governments receiving funding under the annual Labor, Health and Human Services and Education Appropriations bill from discriminating against individuals, health care facilities, insurance plans and other entities because they refuse to provide, pay for, provide coverage of, or refer for abortion—passed by voice vote. The Stupak/Pitts/Terry amendment would further ensure this language applies to any federal agency or program and any state or local government that receives funds under the health care reform bill.

Another amendment (known as the Capps amendment) designed to address anti-choice concerns about public funding of abortion while maintaining access to abortion in health care reform also passed the committee.[8] Two other anti-choice amendments were both defeated. In the end, the committee passed the Tri-Committee bill by a vote of 31-28 on July 31, and House leaders began work to reconcile the three committee-passed versions of the bill.

7 For more on the fight over abortion in health care reform, see "Access to Abortion Care" beginning on page 24.

8 For more on the Capps amendment, see "Access to Abortion Care" beginning on page 24.

After Months of Delay, the Senate Finance Committee Produces the Final Committee Bill

Although it had been the first committee to issue substantive concepts for health care reform, the Senate Finance Committee was the last to finish work on its bill, passing its version of health care reform in October. The process had stalled in the early summer due to ideological disagreements between Democratic and Republican members of the committee. Chairman Baucus established what he termed a "coalition of the willing" to try and reach a compromise on some of the most contentious aspects of the bill, including a public option and financing of the overall package. One of the key sticking points was once again over abortion, as anti-choice members of the committee demanded limits on access to reproductive health care in the new health care system.

By mid-July, Finance Committee negotiations had broken down in the coalition of the willing over differences including a cap on the tax exclusion for employer-provided benefits that had been designed to help offset, or pay for, the committee's bill. By early August, Chairman Baucus had put all hope for the bill into the hands of a new group of committee members, the so-called Gang of Six consisting of Senator Baucus, Ranking Member Chuck Grassley (R-IA), and Senators Jeff Bingaman (D-NM), Kent Conrad (D-ND), Olympia Snowe (R-ME), and Mike Enzi (R-WY). Finally on September 22, the Finance Committee began to mark up its bill.

Much attention surrounded the Finance Committee's mark-up and bill, "America's Healthy Futures" Act. Given the more conservative nature of the Finance Committee, plus the committee's obligation to find a way to pay for its bill (as opposed to the HELP Committee, which had no such committee requirement), the consensus in Washington was that the Finance Committee's bill would trump the more progressive HELP bill and would form the basis of the final bill voted on in the Senate.

The Senate Finance bill included many of the provisions contained in both the Senate HELP Committee and House Tri-Committee bill. The bill expanded Medicaid coverage up to 133 percent of the federal poverty level, and provided premium assistance in the form of subsidies for low- and middle-income individuals between 133 and 400 percent of the federal poverty level who purchased health insurance through the exchange. While the bill as presented to the committee did not include the Medicaid family planning state option language, the provision was later included by amendment. The bill also included language similar to the House Energy and Commerce Committee's Capps amendment.

There were a number of provisions of the Finance bill that fell short of the more progressive policies included in other bills. The most notable omission from the Finance bill was a federally administered public health insurance option. Chairman Baucus had concluded that the full Senate lacked a sufficient number of votes to pass a bill with a public option, and therefore he, along with a handful of the more conservative Democratic members on the Finance Committee, voted with Republicans to defeat amendments to include a public option in the Finance bill.

As with all other committee mark-ups, opponents of choice offered numerous amendments to ban abortion in health care reform. Only two of these amendments were voted on and both were defeated 10-13. Two contradictory amendments related to sexuality education passed the committee: an amendment by Senator Orrin Hatch (R-UT) to restore the failed Title V abstinence-only program passed 12-11, as did an amendment from Chairman Baucus creating a new stream of funding for comprehensive sexuality education, which passed 14-9.[9] On October 13, the Finance Committee became the final committee of jurisdiction to pass health care reform, doing so by a vote of 14-9. Senator Snowe was the only Republican to vote for health care reform in any of the five committees that held mark-ups.

Health Care Reform Passes the House

Following passage of the Tri-Committee bill through the three House committees, Democratic leaders began working to merge the bills into one final bill to go to the House floor. In late October, the House produced the "Affordable Health Care for America" Act (H.R. 3962). In order to address the concerns of some of the conservative members of the Democratic Caucus, some changes were made to the bill during the merging process, including weakening the public option and reducing the cost of the bill to the federal government by increasing the Medicaid coverage eligibility level to 150 percent of the federal poverty level.

More importantly to reproductive health advocates, anti-choice Democrats and the United States Conference of Catholic Bishops ratcheted up their opposition to the bill because it failed to include stronger abortion restrictions. Representative Stupak, along with a handful of anti-choice members, threatened to stop the process if he was prevented from offering an amendment to the bill that would prevent women with coverage in the exchange from having abortion coverage. Fearing the bill might not pass, House leaders allowed Representative Stupak to offer his amendment. The Stupak amendment passed the House by a vote of 240-194 and was subsequently included in the health reform bill. On November 7, H.R. 3962 narrowly passed the House by a vote of 220-215.

9 For more on abstinence-only and comprehensive sexuality education, see "Abstinence-Only Programs and Comprehensive Sexuality Education" beginning on page 21.

Senate Overcomes Roadblocks to Pass Health Care Reform

A number of problems immediately arose in the merging of the Senate HELP and Finance Committee bills, the two most significant of which were whether to include a public option in the Senate bill and how to cover abortion in the newly created state exchanges. It also became quickly apparent that rather than obtaining a simple majority for passage, the health care reform bill would be filibustered. This meant that Senate Majority Leader Harry Reid (D-NV) would need to secure 60 votes to pass the bill, a tall order for any piece of legislation but especially difficult given the acrimony of the debate surrounding health care reform. Only one Republican, Senator Snowe, was considered remotely open to voting for passage in the Senate, meaning that Senator Reid would need to obtain support from every one of the Senate's 58 Democrats plus the two Democratic-leaning Independent Senators.

Two Senators in particular, Senator Joe Lieberman (I-CT) and conservative Democratic Senator Ben Nelson (D-NE), voiced serious concerns that would need to be addressed in order to pass the bill. Senator Lieberman opposed any form of a federally run public health insurance option and vowed to block passage if it was included in the bill. In an attempt to find a middle ground between Democrats who wanted a public option and a handful of Senators in his caucus, like Senators Lieberman and Nelson, who opposed the public option, Senator Reid crafted a compromise provision that would create a public plan but which would allow states to opt out.

While discussions over Senators' concerns over the bill continued, Senator Reid finally believed that he had enough support to overcome the first of many procedural hurdles to bring the bill to the Senate floor. On November 21, the Senate voted to move forward with its health care reform bill. The vote on a motion to proceed (a procedural step necessary to bring the bill to the floor for debate) passed 60-39 along party lines, clearing the way for debate on the substance of the bill to begin.

Unlike the strict rules in the House governing how amendments are handled on the floor, the rules of the Senate allow for a relatively unlimited number of amendments to be offered during floor debate. The Senate rules also allow for a filibuster at numerous stages of the debate process, meaning that while getting the 60 votes necessary to bring the bill to the floor was a victory for Senator Reid, he would have to face the 60-vote threshold several more times before a vote on final passage could take place.

On November 30, the Senate began debate on the merged Finance/HELP bill, the "Patient Protection and Affordable Care" Act (H.R. 3590). The very first amendment offered came from Senator Mikulski to guarantee women access to life-saving preventive services and screenings by lowering insurance co-pays and deductibles for such services. The Mikulski "Women's Health Amendment," which could allow for family planning services to be considered preventive services and therefore be exempt from co-pays, passed the Senate several days later.

Senator Reid faced another battle over an issue he had thought settled: the public option. Although the opt-out plan had garnered enough support to move forward on the bill in November, that support collapsed in December. Senator Reid charged ten Democrats—five moderates and five progressives—with hammering out a deal on the public option. Ideas floated by the group included scrapping the opt-out public plan in favor of a new government-administered national insurance plan similar to the Federal Employees Health Benefits (FEHB) program, and allowing those aged 55 and older to buy in to Medicare. Eventually the public option was withdrawn entirely in order to overcome the objections of those opposed to a public plan.

At this point, Senator Nelson's opposition to abortion emerged as a major hurdle to the health care reform bill. The Senate managed to defeat an amendment by Senator Nelson to impose Stupak amendment-like abortion restrictions in the Senate bill. However, Senator Nelson threatened to withhold his support for the final bill if he did not get language he supported, forcing Democratic leaders to negotiate a deal to include new language on abortion that would, among other things, require those who purchase a plan that covers abortion to write two separate checks each month, one for abortion coverage within the plan and another for the rest of the coverage offered by that plan.

Along with the abortion language, Senator Nelson also secured a pledge for the federal government to pick up Nebraska's share of the cost of increasing Medicaid eligibility under the health care reform bill, in what would become known as the "Cornhusker Kickback." With a final deal reached with Senator Nelson to secure his vote and after overcoming a series of procedural hurdles including three separate cloture motions, the Senate passed its health care reform bill in the early hours of Christmas Eve, by a vote of 60-39.

Passed, But Not Finished

The passage of health care reform bills in both chambers of Congress was a huge milestone, the most successful attempt to fix the broken health care system in a generation. Substantial challenges remain, however, before the President can sign a bill into law. The bills passed by the House and Senate need to become one, final bill—either through a merging of the two bills or one of the chambers passing the other's bill. It may sound like a simple process, but as of the end of 2009, a clear path forward was not in sight.[10]

10 For more on the future of health care reform, see "A Look Ahead" beginning on page 39.

Title X Family Planning

On January 20, the same day President Obama took office, the Bush administration's provider refusal regulations finally took effect, threatening patients' access to quality, comprehensive reproductive health care. This parting shot at family planning came as part of an onslaught of "midnight regulations" (referring to the practice of approving numerous, often controversial rules in the final months of a presidential administration) published by the outgoing Bush administration. Thus, even as advocates welcomed the new Obama administration, President Bush's war on contraception continued to do damage.

NFPRHA Files Lawsuit to Block Enforcement of HHS Refusal Regulations

In the summer of 2008, word leaked out that the Bush administration was working on regulations designed to provide a new, potentially unlimited right for institutions and individuals to refuse to provide contraceptive services. On August 26, 2008, the Department of Health and Human Services (HHS) officially proposed regulations permitting institutions and individuals employed at federally funded health care entities to refuse to provide a variety of basic health care services, including information, counseling and referrals, while completely ignoring the needs and rights of patients. Although the proposed rule differed from an earlier draft of the regulations, concerns about the implications of the proposed rule were significant.

Following a 30-day comment period and months of outraged opposition both on Capitol Hill and in the media, HHS issued a final rule in December 2008 with an effective date of January 20, 2009—Inauguration Day. On January 15, five days before the HHS refusal regulations were scheduled to go into effect, NFPRHA filed a lawsuit to block enforcement of the refusal rule. *National Family Planning & Reproductive Health Association, Inc. v. Leavitt* was filed in the U.S. District Court for the District of Connecticut by the American Civil Liberties Union (ACLU) on behalf of NFPRHA and its members. In addition to NFPRHA's suit, lawsuits challenging the regulations were simultaneously filed in the same court by Connecticut Attorney General Richard Blumenthal and the Planned Parenthood Federation of America. Attorney General Blumenthal's office was joined by the Attorneys General of California, Illinois, Massachusetts, New Jersey, New York, Oregon and Rhode Island.

Just over one month later, on February 27, the Obama White House issued a notice on reginfo.gov indicating its intention to rescind the refusal rule, which was in effect but had not been implemented. A new notice of proposed rulemaking proposing to rescind the Bush administration's rule was published in the Federal Register on March 10, with a 30-day comment period. Following the closing of the comment period, advocates and providers waited for a final rule to be issued. As health care reform took center stage, it appeared that no further action would be taken by the Obama administration on the refusal rule until after health care reform was signed into law. By the end of 2009, no new rule had been issued, and NFPRHA's lawsuit—which had been stayed pending further action by the administration—remained active but on hold.

Title X Gets Modest, But Important, Funding Increases for FY 2009 and FY 2010

One of Congress's early pieces of business was to finish its work on Fiscal Year (FY) 2009 Appropriations, including appropriations for HHS. Although the fiscal year had technically begun on October 1, 2008, Congress had passed a continuing resolution (CR) in late September to fund the government for the first half of FY 2009, effectively punting much of the annual appropriations fight to the next Congress. In late February, Congress passed the FY 2009 Omnibus Appropriations bill, which included the Labor, Health and Human Services and Education (Labor-HHS) Appropriations bill. President Obama signed the package into law in early March, which included a $7.5 million increase for the Title X family planning program, bringing total funding for Title X to $307.5 million.

President Obama's First Budget Request

President Obama outlined his priorities for his first budget to Congress in March. The President released a budget outline which included the Medicaid family planning expansion, despite a bruising fight over the provision in late January.[11] In May, the White House released the President's detailed FY 2010 budget request to Congress, which included a $10 million increase for the Title X program. As many programs saw their budgets cut or flat funded, the modest increase signaled the administration's support for family planning. However, the President's request fell far short of the significant investment requested for Title X and needed by its providers. In an important victory for evidence-based programs, the budget reflected the President's intention to defund ineffective abstinence-only programs and called for a new investment in comprehensive sexuality education.[12]

In the early summer House and Senate appropriators began to consider FY 2010 Labor-HHS Appropriations. On July 10, the Labor-HHS Subcommittee of the House Appropriations Committee marked up its FY 2010 Labor-HHS Appropriations bill (H.R.3293), which followed the President's lead on Title X funding and included $317.5 million for the program. One week later, the full House Appropriations Committee approved the FY 2010 Labor-HHS Appropriations bill, which then headed to the House floor.

During House consideration of the bill, long-time family planning opponent Representative Mike Pence (R-IN) introduced an amendment to prohibit Planned Parenthood health centers from receiving Title X funds. As with a similar amendment offered by Representative Pence in 2007, this blatant attack was overwhelmingly rejected by the House (247-183). Following the defeat of the Pence amendment, the House proceeded to a final vote approving the Labor-HHS Appropriations bill, by a vote of 264-153.

In the Senate, the appropriations process started smoothly but quickly stalled. On July 28, the Senate Appropriations Labor-HHS Subcommittee took up its FY 2010 bill which included the same $10 million Title X increase as the House bill. The full Appropriations Committee passed the bill on July 30, and the measure was expected to go to the Senate floor following the August recess. However, by the end of FY 2009 on September 30, the Senate had not taken up many of its FY 2010 spending bills, including Labor-HHS.

Consequently, Congress passed a continuing resolution to fund programs through the end of October at FY 2009 levels. A second CR passed on October 27, funding government operations through December 18, 2009 or until all FY2010 Appropriations bills were enacted. As the end of the year approached, the Senate began planning an appropriations package known as a mini-bus to move the remaining FY 2010 Appropriations bills, including Labor-HHS. On December 13, the Senate passed the Omnibus Appropriations bill (H.R. 3288), a catch-all bill containing the Labor-HHS Appropriations bill as well as all of the remaining FY 2010 spending bills, except for that for the Department of Defense.

Administration Names New HHS Secretary, But No DASPA

At the beginning of the year, it was widely known that the President's first choice for Secretary of HHS was former Senate Majority Leader Tom Daschle. However, concerns over his finances, including reports of his failure to pay over $100,000 in back taxes, led Mr. Daschle to remove himself from consideration on February 3.

One month later, President Obama announced Kansas Governor Kathleen Sebelius—a former state insurance commissioner—as his choice to head the agency. Her Senate confirmation hearings began on March 31, with then-Governor Sebelius testifying before both the Health, Education, Labor and Pensions (HELP) Committee and the Finance Committee. Although Sebelius faced harsh criticism from anti-choice advocates, a quick confirmation was widely expected. The process hit a snag in the Finance Committee, however, with some Republican Senators succeeding in delaying a confirmation vote, citing the need for more time to review her answers to their questions. On April 21, the Finance Committee approved Sebelius' nomination, clearing the way for the full Senate's approval. On April 28, the Senate voted to confirm Sebelius by a vote of 65-31, with eight Republicans breaking party lines to vote for the nomination.

Given the long vacancy at the head of HHS, it was no surprise that a new Deputy Assistant Secretary for Population Affairs (DASPA)—who oversees the Title X program—was not named in the first part of 2009. However, and although rumors swirled for months in the latter half of 2009 about possible candidates for the position, by the end of the year a DASPA had still not been named. The position has been open since May 21, 2008, when Bush appointee Dr. Susan Orr resigned after months of controversy.

11 For more on the fight over the Medicaid family planning expansion, see "The Economic Recession" beginning on page 7 and "Medicaid-Funded Family Planning" beginning on page 19.

12 For more on the de-funding of abstinence-only and the funding of comprehensive sexuality education, see "Abstinence-Only Programs and Comprehensive Sexuality Education" beginning on page 21.

Fiscal Year (FY) 2010 Funding for Selected Public Health Programs ($ in millions)

Program	FY 2010 Final	FY 2009 Final	Change from FY 2009 Final
Title X Family Planning	$317.5	$307.5	+$10
Social Services Block Grant	$1,700	$1,700	$0
MCH Block Grant	$662	$662	$0
Teen Pregnancy Prevention Initiative[i] (OAH)	$110	N/A	+$110
Abstinence-Only Programs (total)	$0	$162	-$162
1. Community-Based Abstinence Education (CBAE) Program	$0	$99[ii]	-$99
2. Title V State Abstinence Grant Program[iii]	$0	$50	-$50
3. Adolescent Family Life Act Abstinence Earmark	$0	$13	-$13
CDC HIV/AIDS, Viral Hepatitis, STD and TB Prevention (total)[iv]	$1,045	$1,006	+$39
HIV/AIDS	$728	$692	+$36
Viral Hepatitis	$19	$18	+$1
STD	$154	$152	+$2
TB	$144	$144	$0
Ryan White	$2,266	$2,227	+$39
Community Health Centers	$2,146	$2,146	$0

i These amounts do not include the approximate $4.5 million in evaluation funding.

ii Includes $4.5 million for evaluation.

iii Program expired on June 30, 2009.

iv 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.

Institute of Medicine Issues Positive Report on Title X

In 2007, the Office of Family Planning at the Office of Population Affairs (OPA), which oversees the Title X program, asked the Institute of Medicine (IOM) to provide a critical review of the program, focusing on assessing its administration and management. The review included whether the program was serving its intended populations and assessed to what extent the program needed to reexamine the scope of its services and objectives.

On May 26, the IOM released its report, *A Review of the HHS Family Planning Program: Mission, Management, and Measurement of Results*, which supported both the program and its mission, stating that "family planning is one of the most significant public health achievements of the twentieth century."[13] The report went on to say that "funding for the program has periodically grown in actual dollars, but has not kept pace with inflation, increased costs of contraceptives, supplies, and diagnostics; greater numbers of people seeking services; increased costs of salaries and benefits; growing infrastructure expenses; or rising insurance costs."[14]

Additionally, the report found that while "Title X is a valuable program that successfully serves its target audience... several aspects of the program's structure could be improved to increase the ability of Title X to meet the needs of its intended population."[15] To address these findings, the report recommended that the Department of Health and Human Services "reassert the Title X program's original goals of helping individuals plan for desired pregnancies as well as avoid unintended ones [and] develop a multiyear, evidence-based strategic plan for the program to help ensure that it is grounded in science," stating "the extent to which the program meets [the needs of the intended population] cannot be assessed without a greater capacity for long-term data collection."[16] Finally, the report recommended that "funding for Title X should be increased so the program can meet its statutory responsibility to provide family planning services to those who cannot obtain them through other sources."[17]

Many of the IOM report's recommendations echoed those made in NFPRHA's *Title X Action Plan: Reforming the U.S. Family Planning Program for Uninsured and Low-Income Americans*,[18] which was officially released in April at the 2009 NFPRHA National Conference. NFPRHA's *Title X Action Plan* was the result of more than two years of work by a 20-member Advisory Council of family planning providers who assessed the Title X program and made recommendations to ensure its continued and improved effectiveness.

OPA Issues New Program Instruction on Clinical Services

On May 5, OPA released a new program instruction[19] to provide guidance to Title X providers about the delivery of clinical services and consistency with nationally recognized standards of care. The instruction was designed to update the existing Title X Program Guidelines ("Program Guidelines for Project Grants for Family Planning Services"), which detail the range of services that must be provided to patients. The Guidelines had not been updated since they were originally issued in 2001, and in that time there had been a number of changes or updates to the recommended standards of practice for clinical services. In some cases, the current standards of practice were in conflict with the recommendations of the Title X Guidelines.

Specifically, the program instruction guided Title X providers to develop clinical protocols consistent with current nationally recognized standards of care, including the current practice recommendations put forth by organizations and agencies like the American College of Obstetricians and Gynecologists (ACOG); the Agency for Health Care Policy and Research, U.S. Preventive Services Task Force; and the Centers for Disease Control and Prevention.

13 IOM (Institute of Medicine). *A Review of the HHS Family Planning Program: Mission, Management, and Measurement of Results*. Washington, DC: The National Academies Press, 2009.

14 Ibid.

15 Ibid.

16 Ibid.

17 Ibid.

18 A copy of NFPRHA's *Title X Action Plan* can be found online at http://www.nfprha.org/images/pdf/TitleX_ActionPlan.pdf.

19 Department of Health and Human Services, Office of the Secretary. *OPA Program Instruction Series, OPA 09-01: Clinical Services in Title X Family Planning Clinics - Consistency with Current Practice Recommendations*, April 28, 2009, *available at* http://www.hhs.gov/opa/familyplanning/toolsdocs/opa09_01.html.html.

Preventing Unintended Pregnancy

In the early days of 2009, the Obama administration indicated a significant shift from the outgoing Bush administration toward evidence-based programs that emphasized preventive care and recognized the importance of family planning.

The "Prevention First" Act

On January 6, the first day of the 111th congressional session, Senate Majority Leader Harry Reid (D-NV) introduced the "Prevention First" Act (S.21), the omnibus legislation designed to reduce the rate of unintended pregnancy by expanding access to family planning services, education and counseling. Representatives Louise Slaughter (D-NY) and Diana DeGette (D-CO) introduced "Prevention First" in the House (H.R. 463) the following week.

The gold standard in legislation for family planning and reproductive health, "Prevention First" would authorize a substantial funding increase for the Title X family planning program and would require states to expand Medicaid coverage of family planning services and supplies to women who would be eligible for Medicaid-covered prenatal, labor, delivery, and postpartum care if they became pregnant. It would also end health insurance discrimination against women by ensuring equity in contraceptive coverage, requiring private health plans to provide the same level of coverage for prescription contraception as they do for other prescription drugs and services.

Additionally, "Prevention First" would improve awareness of and access to emergency contraception (EC) by ensuring that women receive factually accurate information about EC and are provided with EC upon request in hospital emergency rooms. The Secretary of Health and Human Services would be required to develop and disseminate information about emergency contraception to women and health care providers. "Prevention First" would also provide competitive grants to public and private entities to establish or expand teen pregnancy prevention programs that provide medically accurate information regarding contraceptive use.

The introduction of "Prevention First" on the first day of the 111th congressional session indicated the importance of family planning as well as preventive and evidence-based approaches to sexual and reproductive health to the Democratic majority. By the close of 2009, "Prevention First" had garnered 28 cosponsors in the Senate and 143 in the House.

Representatives Ryan and DeLauro Introduce the "Preventing Unintended Pregnancies, Reducing the Need for Abortion and Supporting Parents" Act

On July 23, Representatives Tim Ryan (D-OH) and Rosa DeLauro (D-CT) introduced the "Preventing Unintended Pregnancies, Reducing the Need for Abortion and Supporting Parents" Act, billing it as a common sense, common ground measure to prevent unintended pregnancy by increasing access to reproductive health care. Along with other legislation such as the "Prevention First" Act, the Ryan-DeLauro bill aimed to achieve shared goals of reducing unintended pregnancy, supporting parents, and improving public health.

Representative Ryan—a supporter of family planning but opponent of choice—has spent a number of years working on legislation that supports prevention but that could, in his view, attract support in Congress among both pro- and anti-choice members. In 2009, Representative Ryan, joined by pro-choice, pro-family planning Representative DeLauro, reached out to the reproductive health community to try to address some of its concerns. The bill that emerged from those efforts garnered NFPRHA's support as well as the support of organizations including Planned Parenthood Federation of America, NARAL Pro-Choice America, and the National Women's Law Center.

The Ryan/DeLauro bill would make investments in programs that share bipartisan agreement, including a significant funding increase for the Title X family planning program and a provision to expand Medicaid coverage of family planning services for low-income women. In addition, the bill would establish new avenues of support for pregnant and parenting women, and enact comprehensive sexuality education programs intended to provide youth with important information about contraception and the prevention of sexually transmitted infections and unintended pregnancy.

By the close of 2009, the "Preventing Unintended Pregnancies, Reducing the Need for Abortion and Supporting Parents" Act had 44 cosponsors in the House.

Senator Lautenberg and Representative Lee Re-Introduce the "REAL" Act

On March 17, Senator Frank Lautenberg (D-NJ) and Representative Barbara Lee (D-CA) re-introduced their comprehensive sexuality education legislation, the "Responsible Education About Life (REAL)" Act (H.R. 1551/S. 611). The bill would establish a grant program for funding age-appropriate, science-based, medically accurate sexuality education. On March 11, President Obama signed the FY 09 Omnibus Appropriations bill, which cut the Community Based Abstinence Education (CBAE) program by $14 million, without dedicating funding toward comprehensive sexuality education.[20]

20 The first funding for comprehensive sexuality education would be included in the FY 2010 Labor-HHS Appropriations bill. For more on the de-funding of abstinence-only and the funding of comprehensive sexuality education, see "Abstinence-Only Programs and Comprehensive Sexuality Education" beginning on page 21.

Medicaid-Funded Family Planning

Medicaid continues to be the major source of funding for family planning in the United States, accounting for 71 percent of all family planning dollars spent in the U.S. in 2006, up from 20 percent in 1980.[21] Medicaid-funded family planning services are essential to low-income women and men, and generate significant cost savings for the states and for the federal government. Despite the positive benefits, Medicaid-funded family planning kicked up an unexpected storm of controversy early in 2009 that left advocates reeling and helped set the tone on reproductive health for the year.

Waivers to Expand Eligibility for Family Planning Services Under Medicaid

Part of the significant growth in Medicaid spending on family planning in recent years has been from state-led initiatives to expand their traditional Medicaid programs to cover family planning services. Since the early 1990s, many states have been granted waivers by the Centers for Medicare and Medicaid Services (CMS) at the Department of Health and Human Services (HHS) to expand Medicaid coverage of family planning services. Recognizing the public health benefits and cost-effectiveness of helping women avoid unintended pregnancies, by the end of 2009 twenty-seven states had waivers to expand Medicaid eligibility. Of those, 21 states expanded Medicaid coverage based on income. Five other states were at some stage of working toward a waiver by year's end.

Medicaid family planning waivers have proven extremely effective in preventing unintended pregnancy, yet the waiver process itself is difficult and time consuming, lasting an average of 15 months and requiring a significant investment of governmental time and resources. Although the legal requirements for applying for and renewing a waiver are minimal, CMS has developed a complicated and sometimes inconsistent approach to overseeing family planning waivers, changing its requirements and instructions over time and, unfortunately, over different presidential administrations.

In an effort to ease the process and encourage more states to expand their Medicaid coverage of family planning, reproductive health advocates have pursued legislation that would give states the option to expand coverage for family planning services under Medicaid without the need to obtain a waiver from CMS. In recent years, the Medicaid family planning expansion provision was included in a number of bills, but the language would always be pulled—usually at the eleventh hour—when anti-family planning members of Congress would threaten to derail the underlying bill if the language was included.

The Fight Over the Stimulus Bill

Early in 2009, an opportunity to finally pass the Medicaid family planning state option presented itself in the form of an economic recovery, or stimulus, bill. Since the bill was designed to infuse much-needed capital into states and communities, it seemed logical to include the Medicaid family planning expansion which could, over time, help states help a growing number of patients. Recognizing the value of the expansion, the House Energy and Commerce Committee, which was helping to draft the stimulus bill, included the Medicaid family planning expansion in its text. The Congressional Budget Office, which determines how much legislation costs, determined that the Medicaid family planning state option would not cost a thing; in fact, the provision would save federal taxpayers $200 million over 5 years and $700 million over 10 years, in addition to producing much-needed cost savings to states.[22]

Almost immediately, congressional conservatives—led by House Minority Leader John Boehner (R-OH)—attacked the provision, charging that funding contraceptives could not possibly do anything to stimulate the economy. The attacks left the White House and Democratic leaders scrambling, concerned over whether the stimulus bill would garner any Republican support in the House of Representatives. Fearing the worst, the White House pulled its support for the Medicaid family planning provision, and the provision was pulled from the bill a few days later. Notably, when the final votes were cast in the House, not a single Republican member of Congress voted for the stimulus package.

21 Gold RB et al., *Next Steps for America's Family Planning Program*, New York: The Guttmacher Institute, 2009.

22 Congressional Budget Office, *Preliminary Estimate of the Effects on Direct Spending of Title V of the Energy and Commerce Stimulus Draft,* 2009.

Medicaid Expansion, Round Two

Still reeling from this loss, reproductive health advocates set their sights on the next best chance to pass the Medicaid family planning expansion: health care reform. The House Tri-Committee included the expansion in its bill, and the provision was included in the final bill passed by the House. The Senate Finance Committee also included the provision in its bill, though the process was slightly more complicated. Committee Chairman Max Baucus (D-MT) did not include the Medicaid family planning state option language, so Senator Debbie Stabenow (D-MI) planned to offer an amendment during the committee mark-up to add the language. Although it was widely expected that a committee fight would ensue, Senator Stabenow's amendment sparked little debate and was adopted by the committee as part of a group of non-controversial amendments, and the Senate-passed health reform bill included this language.

Abstinence-Only Programs and Comprehensive Sexuality Education

After more than a decade of harmful abstinence-only programs which received more than $1 billion in federal funds with no evidence of effectiveness, the Obama administration signaled a new day in Washington concerning these failed programs. The new Obama team promised to cut funding for programs that do not work, a promise that became reality with the President's first budget request to Congress. The Obama administration instead budgeted funds for a new Teen Pregnancy Prevention Initiative, signaling his intention for Congress to create something reproductive health advocates had long-championed: a dedicated stream of federal funding for comprehensive sexuality education.

President and Congress Work to End Abstinence-Only

The first victory of 2009 came in the form of passage of a $14 million cut to the Community-Based Abstinence Education (CBAE) program in the Fiscal Year (FY) 2009 Omnibus Appropriations bill, the first cut to abstinence-only funding in nearly a decade. This win was just the beginning of a turn in the legislative tide against abstinence-only programs and toward more comprehensive approaches.

Able to read the writing on the wall, abstinence-only supporters in Congress wasted no time in trying to ensure the survival of these programs. On March 27, both the House and Senate Budget Committees introduced their budget resolutions for FY 2010 which set the overall blueprint for the spending packages Congress would consider later in the year. Senator Jim Bunning (R-KY) offered an amendment in the Senate Budget Committee's markup to extend the Title V (Section 510) abstinence-only program through December 2010. The program, which allocated $50 million a year to states for abstinence-only programs, was set to expire on June 30, 2009, and support in Congress to allow the program to lapse was strong. The Bunning amendment failed in a 13-10 party line vote.

On May 7, the President released his detailed FY 2010 budget request to Congress. In a significant victory for evidence-based programs, the budget reflected the President's intention to defund the abstinence-only programs and invest in evidence-based approaches to address the serious public health challenges posed by increased rates of unintended and teen pregnancy and sexually transmitted infections (STIs). The President's budget request allotted $110 million for a new Teen Pregnancy Prevention Initiative, of which $75 million would be for "programs that replicate the elements of one or more teenage pregnancy prevention programs that have been proven through rigorous evaluation to delay sexual activity, increase contraceptive use (without increasing sexual activity), or reduce teenage pregnancy" and $25 million for research and demonstration grants, with an additional $4.5 million for evaluation.[23] The President's budget also maintained Adolescent Family Life Act (AFL) funding at the FY 2009 level of $13.1 million, with the same 75/25 percent split in funding priorities. Lastly, the budget included $50 million in mandatory funds for states, territories and tribes for teen pregnancy prevention and eliminated the Title V abstinence program. This brought the President's total request for comprehensive sexuality education funding to roughly $178 million while zeroing out dedicated abstinence-only funding, a huge victory.

Then, on July 10, the Labor, Health and Human Services and Education (Labor-HHS) Subcommittee of the House Appropriations Committee marked up its FY 2010 bill, which followed the President's lead concerning failed abstinence-only programs by zeroing out dedicated abstinence-only funding in favor of $114.5 million for a new teen pregnancy prevention program, following the 75/25 percent breakdown that the President's budget used. On July 17, the full House Appropriations Committee approved the bill. Among the numerous amendments offered to the bill during markup, Representatives Zach Wamp (R-TN) and Robert Aderholt (R-AL) sponsored one that would have continued funding of current CBAE grantees, with the money coming out of the new prevention initiative. The amendment was defeated 24-35.

23 U.S. Department of Health and Human Services, *Fiscal Year 2010: Budget in Brief*, May 7, 2009.

On July 28, the Senate Appropriations Labor-HHS Subcommittee took up its FY 2010 bill, which also took its cue from the President and zeroed out dedicated abstinence-only funding while providing $104 million for a new teenage pregnancy prevention program, with a similar funding breakdown to that of the President's budget and the House Appropriations bill. On July 30, the Senate Appropriations Committee approved the bill by a vote of 29 - 1, with Senator Sam Brownback (R-KS) voting no by proxy.

As health care reform continued to occupy the Senate schedule, the chamber was unable to complete its appropriations work prior to the September 30 end of FY 2009. Congress passed one continuing resolution after another to keep government spending flowing. These delays ultimately forced Congress to pass an omnibus spending bill in order to complete the FY 2010 Appropriations. The bill included the new evidence-based Teen Pregnancy Prevention Initiative, funded at $114.5 million ($110 million for the program, with an additional sum of approximately $4.5 million for evaluation), to be implemented and administered by the newly authorized Office of Adolescent Health (OAH) in the Office of the HHS Secretary.

Teen Pregnancy Rate Increases After Years of Decline

Lending support to the move toward funding comprehensive sexuality education, the Centers for Disease Control and Prevention (CDC) released a report the first week in January detailing a significant rise in the teen birth rate in 26 states.[24] The report reflected 2006 data, the most recent year for which data were available, and showed an increase in the teen birth rate of three percent, up to 41.9 births per 1,000 15-19 year-olds.[25] This increase ended the trend of declining birth rates among girls ages 15-19, which had dropped by 34 percent between 1991-2005.[26] The CDC report showed that states with the highest increases were in the south and southwest.[27]

In early September, a report released from *Child Trends* found that Texas led the nation in repeat teen births and births to girls under 15 years old.[28] The statistics re-energized the debate over abstinence-only programs versus comprehensive sexuality education in Texas, where 94 percent of schools feature abstinence-only programs. Some state legislators and newspaper editorial boards took the opportunity to call for comprehensive and medically accurate sexuality education in Texas public schools. State Senator Rodney Ellis and State Representative Ellen Cohen wrote in an op-ed for the *Houston Chronicle*, "Clearly this single-minded approach is failing our teens and taxpayers. We propose a solution that works and involves a tiered approach. Start with abstinence but also educate young people about the various options to avoid pregnancy."[29] The "Education Works" bill, which would have ensured that teens learn about contraception and protection against STIs, died in committee during the last legislative session, but state representatives intend to re-introduce the bill during the 2011 legislative session.

Studies Show the Need for Comprehensive Sexuality Education

In early January, an evaluation of the Cleveland Metropolitan School District's Responsible Sexual Behavior Initiative found overwhelmingly positive results for the comprehensive sexuality education program.[30] The study, conducted by Philliber Research Associates on behalf of the AIDS Funding Collaborative, examined both the impact of the program on student educational results and community support for a comprehensive approach toward sexuality education.[31] The Initiative, which was in its second year in 2009, teaches age-appropriate information to students in elementary, middle and high schools. The survey found that 1st through 3rd graders learned how to respond to attempted abuse and respecting others.[32] Older students were taught healthy attitudes about protecting themselves and their partners from sexually transmitted infections and unwanted pregnancy.[33] Additionally, the results showed parents and educators believed that these were important lessons for their children to learn.[34]

24 Brady Hamilton et. al., "Births: Preliminary Data for 2007," *National Vital Statistics Reports,* vol. 57, No. 12, Centers for Disease Control and Prevention, March 18, 2009.

25 Ibid.

26 Ibid.

27 Ibid.

28 Child Trends, *Facts at a Glance: A Fact Sheet Reporting National State and City Trends in Teen Childbearing*, Pub. 2009-25, September 2009,

29 The Houston Chronicle, "Focus on abstinence alone is failing Texas teenagers," September 8, 2009.

30 Philliber Research Associates, *Evaluation of Responsible Sexual Behavior In the Cleveland Metropolitan School District,* December 2008.

31 Ibid.

32 Ibid.

33 Ibid.

34 Ibid.

In mid-April, the Sexuality Information and Education Council of the United States (SIECUS) released *State Profiles: A Portrait of Sexuality Education and Abstinence-Only-Until-Marriage Programs in the States*.[35] The report analyzed the $176 million in federal funding for abstinence-only programs for Fiscal Year 2008. Abstinence-only funding supported over 350 programs, including crisis pregnancy centers in 20 states, which received $20 million.[36] Half of all abstinence-only funding went to support programs in 16 southern states.[37] However, the report showed a promising trend of states and communities rejecting abstinence-only program funds: seven states did not accept any federal funding for abstinence-only programs and 22 states did not accept Title V abstinence-only-until-marriage funds.[38]

Abstinence-Only Debate Emerges in Health Care Reform

While most of the contentious debate around reproductive health in health care reform was focused on abortion coverage, sexuality education was not immune to attack as Senator Orrin Hatch (R-UT) sought to revive abstinence-only programs during the Senate Finance Committee mark-up. On September 29, Senator Hatch offered an amendment to health care reform that would have restored the failed Title V abstinence-only program, which passed by a vote of 12-11. However, that same day the committee also approved an amendment by Chairman Max Baucus (D-MT) to create a comprehensive sexuality education state grant program. When the Senate passed its health care reform bill on December 24, the two contradictory amendments both remained in the legislation.

35 Sexuality Information and Education Council of the United States (SEICUS), *State Profiles: A Portrait of Sexuality Education and Abstinence-Only-Until-Marriage, Fiscal Year 2008 Edition*, 2009.

36 Ibid.

37 Ibid.

38 Ibid.

Access to Abortion Care

On January 22, 2009, just days into his presidency, President Obama issued the following statement for the anniversary of *Roe v. Wade*:

> *"On the 36th anniversary of Roe v. Wade, we are reminded that this decision not only protects women's health and reproductive freedom, but stands for a broader principle: that government should not intrude on our most private family matters. I remain committed to protecting a woman's right to choose.*
>
> *While this is a sensitive and often divisive issue, no matter what our views, we are united in our determination to prevent unintended pregnancies, reduce the need for abortion, and support women and families in the choices they make. To accomplish these goals, we must work to find common ground to expand access to affordable contraception, accurate health information, and preventative services.*
>
> *On this anniversary, we must also recommit ourselves more broadly to ensuring that our daughters have the same rights and opportunities as our sons: the chance to attain a world-class education; to have fulfilling careers in any industry; to be treated fairly and paid equally for their work; and to have no limits on their dreams. That is what I want for women everywhere."*[39]

Time would quickly show, however, that despite the best intentions, a woman's right to choose is often the first thing to fall to the wayside when other issues are at stake.

Abortion Becomes a Focal Point of the Debate Over Health Care Reform

While ordinarily there are only a small handful of votes on abortion in a given year, 2009 saw a huge number of votes as anti-choice lawmakers used health care reform as a vehicle to advance their agenda, and Congress spent significant time and energy arguing over what constitutes the "status quo."

The Senate HELP Committee

The fights on abortion began in earnest with the first committee to formally take up health care reform, the Senate Health, Education, Labor and Pensions (HELP) Committee. Four anti-choice amendments were defeated during the HELP mark-up, all by votes of 11-12 along party lines with anti-choice Democratic Senator Bob Casey (D-PA) voting with Republicans. The amendments included:

- An amendment by Senator Orrin Hatch (R-UT) which sought to ban abortion coverage in the health care exchange for any participants who receive government-subsidized coverage.
- An amendment by Senator Mike Enzi (R-WY) which sought to prohibit health care reform from covering abortion services.
- An amendment by Senator Tom Coburn (R-OK) which sought to undermine confidentiality protections for minors.
- A second amendment by Senator Coburn which sought to unnecessarily expand existing provider refusal protections in order to prevent individuals and institutional entities (including insurance companies and HMOs) from being discriminated against for refusing to "perform, provide, pay for, provide coverage of, refer for, make other arrangements for abortion or abortion training," without concern for patient protections.

The Three House Committees

Unlike in the Senate, the three House committees of jurisdiction chose to craft a single bill, the "Affordable Health Care for America" Act (H.R. 3962), with each committee holding a mark-up, giving anti-choice members of Congress numerous opportunities to attack abortion through amendments.

39 The White House, Office of the Press Secretary, "Statement of President Obama on the 36th Anniversary of Roe v. Wade," January 22, 2009.

In the Ways and Means Committee, two anti-choice amendments were defeated:

- An amendment by Representative Sam Johnson (R-TX) to explicitly exclude abortion from the essential benefits package failed by a vote of 18-23.
- An amendment by Representative Eric Cantor (R-VA) to prohibit funds from being used for abortion services failed by a vote of 19-22.

In the Education and Labor Committee, two more anti-choice amendments were defeated:

- Two amendments by Representative Mark Souder (R-IN) designed to prevent health care reform from covering abortion both failed by votes of 19-28.

The Energy and Commerce Committee dealt with several abortion-related amendments, one of which was defeated through a then little-known procedural maneuver, at its mark-up.

- An amendment by Representatives Bart Stupak (D-MI), Joe Pitts (R-PA) and Lee Terry (R-NE) codifying the Weldon refusal amendment passed by voice vote.
- An amendment by Representative Lois Capps (D-CA), designed to address anti-choice concerns about public funding for abortion and other issues, passed by a vote of 30-28. The Capps amendment maintained the status quo regarding public funding of abortion under existing law. The amendment stated that plans in the exchange could neither be mandated nor prohibited from providing abortion services, and established a system of separate accounts within health plans to ensure that abortion services would be reimbursed from the private account and not from federal funds.
- An amendment by Representative Stupak to ban coverage of abortion services in health care reform except in cases of rape, incest or when the life of the woman is endangered, initially passed by a vote of 31-27, with Chairman Waxman—a pro-choice champion—changing his vote at the last minute and voting in favor of the amendment. The move left many in the room shaking their heads, but just a short time later the Chairman made a motion to reconsider the amendment, something a member can do only if he or she voted in favor of the amendment. During the interim, the Chairman had worked the votes on his committee and the motion to reconsider passed by a vote of 35-24, after which the committee voted again on the amendment, this time defeating it 29-30.

The Senate Finance Committee

The Senate Finance Committee, which spent most of the spring and summer on a failed attempt at achieving a bipartisan bill, was the last committee to hold a mark-up. Two anti-choice amendments were defeated in the committee:

- An amendment by Senator Orrin Hatch (R-UT) to ban abortion coverage in the exchange and force those who wanted that coverage to purchase a separate rider was defeated 10-13, with Democratic Senator Kent Conrad (D-ND) voting for the amendment and pro-choice Republican Senator Olympia Snowe (R-ME) voting against.
- A second amendment by Senator Hatch which sought to codify the Weldon refusal amendment also failed 10-13.

The House Votes to Ban Abortion in Health Care Reform

While the defeat of the Stupak abortion ban amendment during the Energy and Commerce Committee mark-up had been a welcome relief, it also foreshadowed the trouble that was to come when the Tri-Committee bill reached the full House of Representatives. The drama over abortion began late the night of November 6, when House Democratic leaders agreed to allow a vote on an amendment by Representative Stupak to ban abortion in health care reform in order to secure enough votes to pass the rule (a procedural vote governing debate on the bill itself).

The Stupak amendment prohibits any coverage of abortion in the public option and prohibits anyone receiving a federal subsidy from purchasing a health insurance plan that includes abortion. It also prohibits private health insurance plans from offering abortion coverage to both subsidized and unsubsidized individuals in the exchange. To obtain abortion coverage, women would have to seek separate insurance riders which, in the five states where coverage is only permitted by rider, do not exist. The Stupak amendment passed the House by a vote of 240-194, and was subsequently included in the health reform bill that was approved by the House 220-215.

The Senate Passes Health Care Reform With Nelson "Two Check" Language

Like the House, the Senate had its own challenges in bringing a bill to the floor, but faced the additional hurdle of needing every single Democratic and Independent Senator's vote to pass health care reform. Several Senators from within the Democratic ranks made this exceedingly difficult, but it was Senator Ben Nelson (D-NE) who threatened to derail the entire health care reform bill over abortion.

Despite the Senate bill's inclusion of language similar to the Capps amendment, Senator Nelson wanted to impose Stupak amendment-like abortion restrictions in the Senate bill. On December 7, Senator Nelson, in conjunction with a cadre of anti-choice Senators including Orrin Hatch, Bob Casey, Sam Brownback (R-KS), John Thune (R-SD), Mike Enzi, Tom Coburn, Mike Johanns (R-NE), David Vitter (R-LA) and John Barrasso (R-WY) introduced an amendment which closely mirrored the Stupak language prohibiting any coverage of abortion in the public option and preventing anyone receiving a federal subsidy from purchasing a health insurance plan that includes abortion. The Nelson amendment also would have prohibited private health insurance plans from offering abortion coverage to both subsidized and unsubsidized individuals in the exchange, essentially denying women the ability to purchase with their own funds private health insurance that covers abortion and requiring them to seek an insurance rider for abortion care.

The Senate floor debate over the Nelson amendment was impassioned, with numerous pro-choice, women Senators coming to the floor to speak out against the amendment. Opponents of the Nelson amendment used a procedural maneuver called a motion to table (which only requires a simple majority vote) to effectively kill the amendment. The motion to table the Nelson amendment passed 54-45. Senator Nelson was not dissuaded, however, threatening to vote against cloture to prevent the bill from passing. Senate Majority Leader Harry Reid (D-NV) worked behind the scenes to negotiate an agreement on abortion and a host of other issues in order to garner the 60 votes needed to overcome a Republican filibuster and pass the bill. With time running out, Senator Reid eventually tapped anti-choice Senator Casey to work out a compromise with Senator Nelson on how to treat abortion in the exchange. After a series of negotiations and a middle-of-the-night deal with Senator Nelson, on December 19 Senator Reid introduced his manager's amendment which included language acceptable to Senator Nelson.

Commonly referred to as the Nelson language, the new provision would explicitly allow states to ban abortion coverage in state exchanges, in all likelihood leading to a patchwork system of abortion coverage where some states would ban coverage while others would not. For those with coverage, the Nelson language would create hurdles to obtaining abortion coverage in much the same way as an insurance rider would, including requiring those who purchase a plan that covers abortion to write two separate checks each month, one for abortion coverage within the plan, and another for the rest of the coverage offered by that plan.

NFPRHA, along with a number of its coalition partners, opposed the Senate health reform bill because of the Nelson language. Despite many of the provisions in the bill that would make important gains for low-income women and their families, NFPRHA could not support legislation that would undermine one of the core principles of NFPRHA's mission: to support reproductive freedom for all.

Despite opposition from pro-choice groups and members of Congress, the Senate passed its health care bill by a vote of 60-39 with the Nelson language included.

FY 2010 Budget and Appropriations

On May 7, the President released his detailed FY 2010 budget request to Congress. In it, he removed two abortion-related riders that have been included in recent years: a rider that banned coverage of abortion in the Federal Employees Health Benefits (FEHB) program, and a rider that banned the District of Columbia (DC) from using its own locally-raised funds for abortion services for low-income women.

Following the President's lead, both the Senate and House Appropriations Committees took steps to eliminate the DC ban on funding abortion services, which had been attached to the Financial Services Appropriations bill each year since 1995. While Congress generally prohibits the use of federal funds for abortion services, states are allowed to use their local funds, such as those raised from local taxes. For many years, however, Congress has prohibited the District of Columbia from using its local funds for abortion services. Thanks to the leadership of the Financial Services Appropriations Subcommittee Chairmen, Representative José Serrano (D-NY) and Senator Richard Durbin (D-IL), the ban was not included in either the House or Senate versions of the FY 2010 Financial Services Appropriations bills.

Keeping the DC ban from being enacted in FY 2010 was met with resistance. On July 7, the House Appropriations Committee defeated an amendment by longtime reproductive health foe Representative Todd Tiahrt (R-KS) and Representative Lincoln Davis (D-TN) seeking to restore the ban. The amendment failed by a vote of 26-33. The Committee later approved the Financial Services bill, setting the stage for a floor vote. Two days after the House committee vote, the Senate Appropriations Committee defeated a similar amendment by Senator Brownback by a vote of 13-15.

On July 16, the House began floor debate on the Financial Services Appropriations bill. First there was the narrow passage of a rule (by a vote of 216-213) preventing two amendments intended to reinsert the DC ban into the bill from being offered. Next, Representative Tiahrt offered a motion to recommit, which would have effectively killed the bill, but his motion was ruled out of order. Chairman Serrano then made a motion to table Representative Tiahrt's appeal of the Chair's ruling on the point of order that was approved 225-195. The bill was then approved by a vote of 219-208.

Meanwhile in the Senate, floor debates on several appropriations bills continued to be delayed, ultimately forcing the Senate to pass an omnibus spending bill (H.R. 3288). The spending bill included the Senate's Financial Services Appropriations bill which, along with removing the DC ban moved to eliminate the restrictions on coverage of abortion in the FEHB program. Because the House had already had floor votes on all 12 appropriations bills, when crafting its

appropriations package the Senate tended to adopt the House language, since the Senate language had only been subject to committee-level votes at that point. Therefore, while the DC ban was removed from the final Senate bill (and thus was not included in the FY 2010 Omnibus sent to the President's desk), the abortion coverage restriction in the FEHB program was unfortunately reinserted into the final Omnibus.

The removal of the DC ban was a great victory for low-income women in the District of Columbia. While it was disappointing to not also see the removal of the abortion coverage ban in the FEHB program, the FY 2010 Omnibus moved Congress one step closer to respecting the rights of some groups of low-income women to access the same services as those who do not depend on the federal government for their health care.

President Obama's Common Ground Initiative

Despite the President's stated support for a woman's right to choose, President Obama also sought to bridge the gap on abortion in his first year in office. The President used his May 17 commencement address at Notre Dame to highlight his desire to forge a new path, inviting his audience to find common ground on issues that they may advocate staunchly for or against, such as abortion.

The President pursued this idea of finding common ground on abortion by choosing to meet with both pro- and anti-choice activists in the late spring and early summer to build a strategy to reduce unintended pregnancy and the need for abortion, support families and improve maternal and child health. While many on both sides agree that there is some common ground to be found, there are also plenty of differences. One notable difference is the anti-choice and anti-family planning call for more support of crisis pregnancy centers, despite the practice for these centers to offer misinformation and biased counseling. Pro-choice groups, on the other hand, support increased access to contraception and a comprehensive approach to sexuality education.

While it had seemed to many that the President intended to release language concerning this initiative by the end of the summer, possibly in the form of legislation, as of the end of 2009 no such language had been made public, probably due in part to the acrimonious debate over abortion in health care reform.

Abortion Battle Intensifies in the States

In 2009, 18 states enacted 34 laws related to abortion, and many more were introduced. These measures included in-person counseling and mandatory waiting periods, parental notification and other restrictions on minors seeking abortion services, expansion of refusal clause language, mandatory ultrasounds, state funding for crisis pregnancy centers (often by earmarking profits from "Choose Life" license plates), fetal personhood initiatives, bans on late-term abortions, abortion bans that would replace *Roe v. Wade* should it ever be overturned and bans designed to work their way through the courts and challenge *Roe v. Wade.*

In one of the most prolonged battles over a state abortion law, on August 4 the Illinois "Parental Notice of Abortion" Act was finally scheduled to go into effect, nearly fifteen years after it was enacted. The law would require abortion providers in Illinois to notify an adult family member of a minor's abortion 48 hours prior to the procedure. The Illinois "Parental Notice of Abortion" Act, which was upheld by the Seventh Circuit Court of Appeals in July, requires notification for any female under the age of 18 who has not been married and has not been legally emancipated, and the notification requirement is only excusable by a judge.

After passage in August, the state Medical Disciplinary Board voted to put in place a 90-day grace period. While some health centers began complying with the law even during the grace period, others did not. Then, on November 4, after the state board voted to allow enforcement of the law, Cook County Judge Daniel Riley issued a temporary restraining order putting the law on hold while he heard arguments from the American Civil Liberties Union (ACLU). At the end of the year the law had still not been enforced.

In an example of the battles over laws designed to undermine or overturn *Roe v. Wade*, a North Dakota measure that would define personhood as beginning at conception passed the state house 51-41 on February 17. The bill ascribes personhood to "any organism with the genome of homo sapiens." If signed into law, reproductive rights advocates feared it would be used to end a woman's right to choose in North Dakota. Doctors feared passage of the bill would complicate in vitro fertilization procedures, possibly making them illegal. The bill's sponsor, Representative Dan Ruby (R-Minot) defended his bill to the *Associated Press*, saying "This is very simply defining when life begins, and giving that life some protections under our Constitution—the right to life, liberty and the pursuit of happiness."[40] However, the North Dakota State Senate voted down the bill (HB 1572, 29-16) on April 3, following a similar Reproductive rights advocates saw the bill as an assault on a woman's right to choose. So-called fetal personhood bills are one front in the ongoing war against reproductive rights, and they have been introduced in other states including Maryland, Montana, South Carolina, Alabama and Georgia.

40 Associated Press, "North Dakota House Gives Fertilized Egg Full Rights," February 18, 2009.

Judicial Nominations

On April 30, Supreme Court Justice David Souter announced that he would resign his seat on the Court at the end of the 2008-09 term. Justice Souter had been a relatively solid vote on the Court's liberal wing and it was not considered likely that his replacement would shift the Court's ideological balanced. Early on, it was reported that President Obama would likely name a woman to fill the seat, as Justice Ruth Bader Ginsburg had been the Court's only female voice since Justice Sandra Day O'Connor stepped down.

On May 26, President Obama nominated Judge Sonia Sotomayor to replace Justice Souter on the Supreme Court. Once confirmed, Sotomayor became only the third woman and the first Latina to sit on the High Court. She had been appointed to the U.S. District Court for the Southern District of New York by President George H. W. Bush in 1992, and was elevated to the Court of Appeals for the Second Circuit by President Clinton in 1997.

Sotomayor proved to be a relatively non-controversial nominee, receiving praise for her background and extensive legal and judicial experience. Unlike the two most recent Supreme Court nomination fights over Chief Justice John Roberts and Associate Justice Samuel Alito, the issue of abortion did not play a large part in Sotomayor's confirmation hearing. Senator Herb Kohl (D-WI) asked Judge Sotomayor if she believed the Constitution included a right to privacy. She answered, "There is a right of privacy. The Court has found it in various places in the Constitution, has recognized rights under those various provisions of the Constitution." And in response to being asked if *Roe v. Wade* should be upheld, Judge Sotomayor replied, "The Court's decision in *Planned Parenthood [v. Casey]* reaffirmed the core holding of *Roe*. That is the precedence of the Court and settled in terms of the holding of the Court."

On July 28, the Senate Judiciary Committee voted 13-6 to confirm Judge Sonia Sotomayor's nomination to the Supreme Court. Senator Lindsey Graham (R-SC) was the lone Republican on the committee to vote in favor of the nominee. On August 6, the Senate voted to confirm Judge Sotomayor by a comfortable margin, 68-31. Nine Republicans joined Democrats in supporting her nomination.

While the nomination of Justice Sotomayor may have been a victory for President Obama, not all his nominations went as smoothly in his first year in office, and the issue of abortion did hold up at least one well-known nomination. President Obama nominated Dawn Johnsen to the position of Assistant Attorney General for the Office of Legal Counsel (OLC), Department of Justice. A legal scholar and, most recently, a professor at Indiana University School of Law, Johnsen's academic career has focused on protection against abuses of power by the executive branch. She served in the OLC during the Clinton administration, including a period where she was acting director. Johnsen also previously served as Legal Director for NARAL Pro-Choice America (formerly the National Abortion & Reproductive Rights Action League).

Despite her qualifications, the conservative right waged an all-out campaign to block Johnsen's nomination, describing her as "truly from the radical fringe" and claiming that "her appointment is a slap in the face to fair-minded Americans." Publicly, conservatives decried her appointment because of her stated support for values such as a right to privacy and access to health care for all Americans, but it was widely believed that the real concern for the far right was Johnsen's outspoken criticism of the Bush torture memos. As Congress prepared to adjourn for the Memorial Day recess on May 25, Senate Republicans opposed to her nomination threatened to filibuster, thereby stalling the process. President Obama decided not to sidestep Senate approval and appoint nominees while Congress was in recess, as President Bush had done before him and which Obama had strongly opposed as a U.S. Senator.

At the end of 2009, Dawn Johnsen had still not had a confirmation hearing or the opportunity for an up-or-down vote on her nomination. NFPRHA firmly supports Johnsen's nomination to head the Office of Legal Counsel (OLC) at the Department of Justice, and has urged the Senate to confirm her quickly and without delay.

The Murder of Dr. George Tiller

On May 31, the country was stunned by the brutal murder of Dr. George Tiller, a Wichita, Kansas doctor who provided abortion care to thousands of women. Dr. Tiller was gunned down while attending Sunday services at Reformation Lutheran Church, where he served as an usher. Dr. Tiller was most widely known for the late-term abortions he provided, though his health center offered a full range of family planning and reproductive health services.

The alleged gunman was known to be an active follower of Operation Rescue, a far-right fringe group that has at times advocated violence to end legal access to abortion services in the United States. The attack on Dr. Tiller was not the first. In 1993, he was shot in both arms and his health center sustained a pipe bomb attack in the mid-80s. Dr. Tiller will be remembered most for his stalwart commitment to reproductive health care for women and for his courage to stand up to his most violent critics. In the aftermath of this murder, Attorney General Eric Holder ordered additional security at reproductive health centers around the country.

Breast and Cervical Cancer Prevention

After years of controversy over the prevention of human papillomavirus (HPV), most notably due to ideological attacks on condoms (which served as a proxy for the battle over comprehensive prevention efforts versus abstinence-only), 2009 was a relatively uncontroversial year for HPV and cervical cancer. Instead, it was breast cancer prevention which sparked controversy late in the year, after the U.S. Preventive Services Task Force (USPSTF) issued new breast cancer screening recommendations that drew wide condemnation in the media and in the halls of Congress, resulting in a national conversation about the costs and benefits of preventive care coverage in health insurance.

New Breast Cancer and Cervical Cancer Screening Guidelines Spark Controversy

Just as the Senate began its floor debate on health care reform, the USPSTF—a panel of private sector experts in primary care convened by the Federal government—issued new recommendations for breast cancer screening. The USPSTF raised the age at which women should begin routine mammograms, recommending that instead of beginning at age 40, routine screening should occur at age 50.[41] The USPSTF recommendation was the result of research that produced insufficient evidence that routine screening in women between ages 40-49 produced benefits that sufficiently outweighed the negative consequences, including over-treatment, false positives and increased anxiety resulting from a positive (and often inaccurate) breast cancer test.[42]

On the heels of the USPSTF breast cancer recommendations, the American Congress of Obstetricians and Gynecologists (ACOG; formerly the American College of Obstetricians and Gynecologists) published updated cervical cancer screening recommendations.[43] ACOG recommended that women should begin routine cervical cancer screening at age 21, and that screening should occur every 2 years for women between the ages of 21 and 29 years, instead of the previously recommended annual screenings.[44] ACOG further recommended that women over 30 who had three consecutive negative cervical cancer screens should seek screening every 3 years.[45]

ACOG Recommendations Draw Support, While USPSTF Recommendations Draw (Mostly) Fire

While the ACOG cervical cancer screening recommendations were widely supported, the USPSTF's breast cancer screening recommendations drew mixed—and often heated—reactions. Breast cancer awareness and treatment advocates like the Susan G. Komen Foundation, angry that a federal public health research body would advise against routine cancer screening for women in their forties, released a press statement opposing the recommendations.[46] Conversely, the National Breast Cancer Coalition (NBCC) rallied behind the USPSTF recommendations,[47] using the USPSTF recommendations to validate the organization's long-held opinion that mammography screening had been overemphasized as a breast cancer prevention tool.[48]

41 U.S. Preventive Services Task Force, *Screening for Breast Cancer: Recommendation Statement*, December 2009.

42 Ibid.

43 American College of Obstetricians and Gynecologists, *Obstetrics and Gynecology*, "Cervical Cytology Screening," December 2009.

44 Ibid.

45 Ibid.

46 Susan G. Komen Foundation, "Susan G. Komen for the Cure® Founder, Nancy G. Brinker, Calls New Mammography Guidelines a "Set Back," Nov. 23, 2009.

47 National Breast Cancer Coalition, "Analysis of USPSTF 2009 Revised Breast Cancer Screening Recommendations," Nov. 16, 2009.

48 Ibid.

The response on Capitol Hill to the USPSTF recommendations was much less mixed. Most notably, Representative Debbie Wasserman Schultz (D-FL)—a breast cancer survivor—expressed skepticism of the Task Force's recommendations, highlighting the conflicting recommendations between the USPSTF and other cancer organizations like the American Cancer Society and the American Medical Association.[49] Representative Wasserman Schultz, an outspoken advocate on the issue of educating young women and women of color about breast cancer prevention, was the sponsor of the "Breast Cancer Education and Awareness Requires Early Learning (EARLY)" Act, designed to increase resources to help educate young women about the risk factors and benefits of early detection of breast cancer. Teresa Heinz Kerry, the wife of Senator John Kerry (D-MA) and also a breast cancer survivor, called the change misguided and encouraged women to ignore the updated recommendations.[50]

Mammograms Take Center Stage in Health Care Reform

The firestorm over the updated screening recommendations was complicated by the politics of the health care reform debate in Congress. A provision in one of the health reform proposals would have linked health insurance coverage requirements with the USPSTF's preventive screening recommendations. Many opposed to the recommendations and others generally opposed to health reform argued that efforts to reform the nation's health system would result in health care rationing—as evidenced by the reduced access to annual mammography screenings. These assertions forced the White House to enter into the debate, with Health and Human Services Secretary Kathleen Sebelius releasing a statement telling women to continue accessing routine screenings in line with their previous health practices.[51]

As the Senate began its debate on health care reform, Senator Barbara Mikulski (D-MD) offered the first amendment, which would guarantee women access to life-saving preventive services and screenings by lowering insurance co-pays and deductibles for such services. Senator Mikulski noted the controversy over the mammogram recommendations, pointing out that the Senate bill did not cover the key preventive services that women need, such as breast and cervical cancer screenings. The Mikulski amendment passed 61-39 and was incorporated into the Senate-passed health care reform bill.

Cervarix Approved by FDA, Gardasil Wins Approval for Expanded Use

Cervarix, GlaxoSmithKline's (GSK's) HPV vaccine, won approval from the FDA in 2009 and joined Merck's vaccine, Gardasil, on the U.S. market. In October, the FDA approved Cervarix for use in girls and young women ages 10 to 25 to prevent infection with HPV types 16 and 18, which are the leading causes of cervical cancer. Cervarix does not protect against the types of HPV that cause genital warts, but according to data from GSK, it provides cross-protection against other strains which together account for about 86 percent of cervical cancers.

The FDA also approved Gardasil to prevent genital warts in boys and young men age 9 through 26. Gardasil has been on the market since 2006 for use by females 9 to 26 years old, but manufacturer Merck had applied for expanded use of the vaccine in males of the same age group. Following the FDA's approval, the Centers for Disease Control and Prevention's (CDC's) Advisory Committee on Immunization Practices (ACIP)—which provides guidance on the routine administration of vaccines to pediatric and adult populations—met and recommended against the routine vaccination of boys and men with Gardasil, due in part to a cost-benefit analysis in the *British Medical Journal*. The committee did vote in favor of allowing doctors to recommend the vaccine be given to males to reduce the risk of genital warts, and that public funding be made available through the Vaccines for Children (VFC) program for boys 9 to 18 who are uninsured, on Medicaid, or who meet other criteria.

At the same meeting, the ACIP recommended the use of Cervarix in women ages 13-25 who have not been previously vaccinated, and the routine administration of Cervarix for girls ages 11 and 12. The committee also recommended that public funding for Cervarix be made available through the VFC program.

49 U.S. Representative Debbie Wasserman Schultz, "Statement Regarding New Breast Cancer Screening Guidelines," Nov. 18, 2009.

50 Theresa Heinz Kerry, "Get That Mammogram," *Women's Voices for Change*, Dec. 23, 2009.

51 Department of Health and Human Services, Office of the Secretary, "Secretary Sebelius Statement on New Breast Cancer Screening Recommendations," Nov. 18, 2009.

CDC Lifts Requirement That Immigrant Women and Girls Get HPV Vaccine

Reproductive justice advocates celebrated a significant victory near the end of 2009, when the Obama administration ended a requirement that immigrant women and girls seeking to become legal permanent residents of the United States be vaccinated with Gardasil. Since 1996, all people seeking legal permanent residence in the U.S. must be immunized against vaccine-preventable diseases recommended by the ACIP. In July 2008, following the ACIP's recommendation of Gardasil for girls and women, Gardasil was included on a list of mandatory vaccinations for green card applicants and immigrants applying for citizenship. Immigrant girls and women ages 11 to 26 were required to get at least the first dose of the HPV vaccine. Effective December 14, 2009, the CDC changed its policy to require immunizations for immigrants only when there is a public health need at the time a person immigrates or changes their status to green card holder.

Reproductive justice advocates were outraged by the policy, which they argued placed a significant financial burden on women seeking legal immigration status. Disproportionately uninsured or underinsured, advocates argued that immigrant women were unlikely to be able to afford the $360 cost for the three-dose Gardasil regimen, especially in addition to the significant amount of money immigrant applicants already had to spend on application fees and other requirements. Advocates also argued that because HPV did not pose an immediate risk to public health (unlike the diseases targeted by other required vaccinations for immigrants, such as measles), immigrants should not be required to be vaccinated. In making the change, the CDC acknowledged that Gardasil did not fit into the "public health spirit of outbreak prevention," since HPV is not easily transmissible.[52]

52 National Prevention Information Network, "Immigrant Seekers Won't Have to Get HPV Vaccine," November 16, 2009, available at http://www.cdcnpin.org/scripts/display/NewsDisplay.asp?NewsNbr=54277.

Contraceptive Use and Access

The economic recession had a significant impact on family planning and reproductive health. Beyond the economy, however, 2009 was an important year for contraceptive use and access.

Congress Finally Fixes Nominal Drug Pricing

In recent years, the cost of birth control skyrocketed across the country, having a particularly devastating impact on low-income women and college students. The increased price of contraceptives was due in part to the Deficit Reduction Act (DRA) of 2005, under which only certain sales of covered outpatient drugs at nominal prices could be excluded from the Medicaid best price calculation. The DRA had an unintended impact on non-340B eligible family planning providers, who could no longer obtain nominally priced drugs from manufacturers. Since 2005, NFPRHA, in coordination with other reproductive health organizations, sought to correct the error through legislation and restore the eligibility of health centers who serve low-income populations to obtain nominally priced drugs. In March, Congress finally included the no-cost fix in their FY 2009 Omnibus Appropriations bill, which President Obama signed into law.

EC in the Military Bill Introduced

The "Compassionate Care for Servicewomen" Act (H.R. 2064) was introduced in December with renewed vigor from Senators Al Franken (D-MN) and Olympia Snowe (R-ME) in the Senate and Representative Michael Michaud (D-ME) in the House. This legislation aimed to add "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. The decision to stock EC is not mandatory, instead left to individual military base commanders in an ad-hoc system that leaves many servicewomen at greater risk for unintended pregnancy.

FDA Ordered to Make Plan B More Accessible

In April, a federal court ruled that the Food and Drug Administration (FDA) must make Plan B available over-the-counter (OTC) to women aged 17 within 30 days, and that the agency must reconsider whether or not Plan B should be available for over-the-counter sale to all ages.[53] Although the court did not require a timeframe under which the FDA must conclude its reconsideration on Plan B, the order was a welcome move. After a protracted battle between the Bush administration and reproductive health advocates, the FDA finally approved Plan B for OTC sales in 2006. However, excitement over that move was dampened by an arbitrary decision by the agency to limit OTC sales to women age 18 and older.

U.S. District Judge Edward R. Korman wrote in his decision, "no useful purpose would be served by continuing to deprive 17 year olds access to Plan B without a prescription. The FDA's justification for this age restriction, that pharmacists would be unable to enforce the prescription requirement if the cutoff were age 17, rather than 18, lacks all credibility."[54] Judge Korman went on to write that the FDA significantly veered from its regular process of approving drugs for OTC use, and it seemed that the agency's motivation for delaying the process was strictly political.[55]

FDA Approves New Contraceptive Methods

The FDA approved several new contraceptive methods in 2009, including the first generic version of an emergency contraceptive. The generic Plan B, called "Next Choice" and made by Watson Pharmaceuticals Inc., was approved by the FDA in June. Watson later received FDA approval to make its generic available OTC to women ages 17 and older. Teva Pharmaceuticals' new single dose of emergency contraception, Plan B One-Step, was approved by the FDA in July. "Plan B One-Step" is also available OTC for women 17 and older, and replaces the previous two-pill dose of Plan B.

53 CNN, "FDA to allow morning-after pill over the counter for 17-year-olds," April 22, 2009.

54 Ibid.

55 Ibid.

Additionally, the FDA approved the Adiana permanent contraceptive system, an alternative to tubal ligation. The Adiana procedure is minimally invasive and requires no incisions. Similar to Essure, a small insert is placed in the fallopian tubes using a catheter and the body heals around it, forming a permanent block between the ovaries and the uterus. It is 98.4 percent effective three months after insertion.

The FDA also approved FC2, an updated version of the female condom produced by the Female Health Company. FC2 is made with nitrile, which is softer than polyurethane, meaning FC2 makes less noise than its predecessor. The new material is also much less expensive and will cut the cost of the female condom from nearly four dollars each to less than one dollar, a significant improvement over the first generation of female condoms. The female condom has been one of the least popular contraceptive methods despite its many benefits. It is the only contraceptive method controlled by women that protects against sexually transmitted infections, and it provides more coverage than a male condom. Because FC2 is made from nitrile and not latex, it does not deteriorate due to temperature or humidity and it can serve as an alternative for those who have latex allergies.

Safety of Yaz and Yasmin Questioned

In September, two widely used oral contraceptives—Yasmin and its lower-estrogen equivalent, Yaz—drew much attention from the FDA due to mounting public concern regarding the drugs' safety. Citing major health complications such as blood clotting and strokes, Bayer—the drugs' manufacturer—faced numerous lawsuits in 2009. The progestin in the drugs has been shown to increase the body's potassium levels which could prove unsafe for women predisposed to blood clots or stroke.

As part of a deal with the FDA and 27 state attorneys general, Bayer will launch an unprecedented $20 million ad campaign for its birth control pill Yaz. Bayer has been charged with marketing Yaz for off-label uses, such as pre-menstrual syndrome management and acne reduction, and the new ad campaign will clarify Yaz's approved uses, such as pregnancy prevention.

STI and HIV/AIDS Prevention

Increases in the rates of sexually transmitted infections offered compelling arguments for evidence-based prevention programs and funding to support those efforts. Still, funding fell far short of what was needed in 2009 to address existing problems and new challenges, including health disparities and a decreased rate of condom use among teens.

"Ryan White" Reauthorized

On October 30, President Obama signed into law the "Ryan White HIV/AIDS Treatment Extension" Act (S. 1793), which reauthorized the "Ryan White Comprehensive AIDS Resources Emergency (CARE)" Act (commonly known as "Ryan White") through 2013. Congress passed the extension earlier in the month, overwhelmingly approving the measure in the House by a vote of 408-9, and by voice vote (meaning support was deemed strong enough that a roll call vote was not necessary) in the Senate.

Enacted in 1990, Ryan White provides primary health care, medication, and support services for more than 500,000 low-income people living with HIV/AIDS. The law was reauthorized in 1996 and 2000, and was on track to be reauthorized in 2005 before efforts stalled in the Senate. Congress continued funding the program past its September 2005 expiration while negotiations in the Senate continued, and in December of 2006, Congress passed the "Ryan White HIV/AIDS Treatment Modernization" Act reauthorizing the program until 2009.

The 2006 Ryan White reauthorization included a sunset provision, meaning that the program would lapse unless expressly reauthorized by Congress by October 30, 2009. The October extension authorizes $2.35 billion for Fiscal Year (FY) 2010, with increases of 5 percent each year, taking the program to $2.7 billion by FY 2013. Additionally, the bill mandates that states adopt name-based reporting for patients by 2012, challenging some states' practice of assigning HIV/AIDS patients a numeric code for privacy protection, and sets a goal of 5 million HIV tests annually. The law also includes compromise provisions from the 2006 reauthorization that allow for funding to go to new regions with small-but-growing epidemics while still ensuring that significant money is not shifted away from states and cities with large numbers of people living with HIV/AIDS.

STI Rates on the Rise

In January, the Centers for Disease Control and Prevention (CDC) released updated surveillance data on American sexually transmitted infection (STI) rates in 2007 which showed the greatest number of Chlamydia cases (1.1 million) ever recorded by the CDC.[56] Although the increase in Chlamydia case reports in 2007—a continuation of a trend that began in the late 1980s—most likely represented continued improvements in screening tests and frequency, the CDC also acknowledged the numbers could reflect a true increase in morbidity.[57] The report also showed continued health disparities based on race, ethnicity, gender, sexual orientation and economic status. The rate of Chlamydial infections among women was three times higher than among men.[58] Sixty-five percent of syphilis cases occurred among men who had sex with men, and blacks were 19 times more likely to be infected with gonorrhea than whites.[59]

A study released in June from the Mailman School of Public Health at Columbia University showed that the rate of condom use among teenagers had dropped while their sexual activity had largely remained the same. The study, "Changing Behavioral Risk for Pregnancy Among High School Students in the United States, 1991-2007," surveyed young women in grades 9-12 between 2003-2007.[60] The findings were a reversal from the patterns in the 1990s and early 2000s in which the nation saw an increase in contraception use and a decrease in the teen pregnancy rate.

56 Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance, 2007*. Atlanta, GA: U.S. Department of Health and Human Services, December 2008.

57 Ibid.

58 Ibid.

59 Ibid.

60 John Santelli, et. al., "Changing Behavioral Risk for Pregnancy Among High School Students in the United States, 1991-2007, *Journal of Adolescent Health*, July 2009.

Despite the increase in STI rates and declines in condom use among teens, federal funding for prevention has been on the decline for years. 2009 saw the first increase in funding for CDC's Division of Sexually Transmitted Diseases (STD) Prevention since 2003. The Division of STD Prevention was funded at $154 million in FY 2010, up from $152 million in FY 2009, with the small yet significant increase designated by the Senate for the joint CDC/Office of Population Affairs' Infertility Prevention Program (IPP) that funds Chlamydia screening and treatment services for low-income, sexually active women attending family planning, STI, and other women's health care clinics.

"GYT: Get Yourself Tested"

In April, recognizing "National STD Awareness Month," MTV, the Kaiser Family Foundation and Planned Parenthood Federation of America, in conjunction with other partners nationwide, officially unveiled "GYT: Get Yourself Tested," a campaign to increase testing for STIs among those under 25 years of age. The campaign was designed to dispel misconceptions and some of the stigma about STI testing and encourage young people to get tested.

According to the CDC, one in four teen girls in the U.S. has at least one common STI. Other estimates find that as many as one in two sexually-active young people will contract an STI by age 25—and most will not know it. GYT utilized online resources and social networking to reach the younger demographic. The campaign centered around a central online hub, www.gyt09.org, where young people could go to learn more about being tested, find tips on how to broach the subject of STD testing with a partner, and enter a zip code to find local testing facilities. A complimentary texting service allowed users to get information directly to their mobile phones. Widgets and other special applications allowed information sharing though popular social networking sites like Facebook and MySpace. Many reproductive health providers around the country participated in the campaign, offering free STI testing during certain days or hours to encourage more people to get tested.

CDC Urges HIV Testing for Teens

Addressing the trends in teen risk behavior, the CDC used "National HIV Testing Day" to focus on the importance of HIV testing for sexually active teens. The June 26 issue of the CDC's *Morbidity and Mortality Weekly Report (MMWR)* highlighted data from the 2007 Youth Risk Behavior Survey of high school students, showing that only 12.9 percent of high school students nationwide had been tested for HIV.[61] Testing was most common among female students and students who had at any time been taught in school about AIDS or HIV infection.[62]

The low rate of testing among teens was of particular concern because teens and young adults between the ages of 13 and 24 represented 4.4 percent of the total number of people living with HIV infection in 2006, but made up an estimated 9.9 percent of undiagnosed cases.[63] The report went on to say, "HIV testing among sexually active adolescents is an important strategy to reduce the incidence of HIV infection … Because adolescents might be sexually active but unwilling to discuss this information, health-care providers should provide HIV testing routinely to all patients aged ≥13 years in accordance with CDC recommendations."[64]

The CDC continued its focus on teens in the July 17 *MMWR* with a report on alarming rates of STIs in young people. "Sexual and Reproductive Health of Persons Aged 10-24 Years—United States, 2002-2007," showed a rise in the number of syphilis and Chlamydia infections for both young men and women.[65] The report also showed an increase in HIV and AIDS in young men ages 15-24, and that one-third of youth had not received instruction on contraceptive methods by age 18.[66] The report also identified significant health disparities, such as high rates of pregnancy among Hispanic teens aged 15-19 and high rates of HIV, AIDS and other STIs in non-Hispanic black youth.[67] Geographically, youth in the south had higher rates of pregnancy, gonorrhea, Chlamydia and syphilis, though much of the variation in STI rates was due to the racial composition of that region.[68]

61 Centers for Disease Control and Prevention, "HIV Testing Among High School Students—United States, 2007," *Morbidity and Mortality Weekly Report*, June 26, 2009.

62 Ibid.

63 Ibid.

64 Ibid.

65 Centers for Disease Control and Prevention, "Sexual and Reproductive Health of Persons Aged 10-24 Years—United States, 2002-2007," *Morbidity and Mortality Weekly Report*, July 17, 2009.

66 Ibid.

67 Ibid.

68 Ibid.

Needle Exchange Ban Rider Defeated

As with the fight over the ban on the District of Columbia (DC) being able to use its own locally-raised funds for abortion services for low-income women, the FY 2010 Financial Services Appropriations bill was the focal point of another fight over the ability of the DC government to act in its own best interest, this time over needle exchange programs. In July, Representative Jack Kingston (R-GA) offered an amendment to the FY 2010 Financial Services bill to reinstate a ban on DC's ability to combat HIV/AIDS among injection-drug users by using local tax dollars for a needle exchange program. The amendment, which was attached to the House bill, would have reinstated the nearly decade-old ban, which had been attached as a rider to the Financial Services Appropriations bill until it was removed in the FY 2009 Appropriations bill passed in 2008.

The move was particularly egregious given the District's high rate of HIV/AIDS infections. According to DC's *2008 Epidemiology Report*, at least 3 percent of District residents had HIV or AIDS, a number which far surpassed the 1 percent threshold constituting a "generalized and severe" epidemic.[69] The report found at least 15,120 DC residents were infected with HIV or had full-blown AIDS in 2007, a 22 percent increase from 2006. African-American men, with an infection rate of nearly 7 percent, were disproportionately impacted. Although a variety of factors likely contributed to the high HIV/AIDS rate, critics pointed to congressional control over the District as a significant barrier to addressing the epidemic.

Thankfully, Representative Kingston's needle exchange ban rider was removed when the House and Senate crafted the Omnibus Appropriations bill for FY 2010 that was eventually passed and signed into law. The District ended 2009 free to use its own funds for needle exchange programs, which could help to combat the alarming rate of HIV/AIDS among its residents.

69 Government of the District of Columbia, Department of Health, *District of Columbia HIV/AIDS Epidemiology Update 2008*, February 2009.

International Family Planning

As the Obama administration began, there was a clear shift in the commitment of the United States to international family planning. One of his first acts as President was to issue an executive order repealing the harmful "Mexico City Policy"—also known as the "Global Gag rule"—calling it "excessively broad." Rescinding the policy removed the funding restrictions that were put in place to prevent non-governmental organizations from counseling women about all of their reproductive health options, including abortion.

The Global Gag rule has been imposed and removed as Republican and Democratic presidential administrations took office since first imposed by President Ronald Reagan in 1984. The rule was rescinded by President Clinton in 1993 but reinstated by President George W. Bush in 2001. In an effort to end the continual back-and-forth between repeal and reinstatement with each successive administration, in July Senator Frank Lautenberg (D-NJ) proposed an amendment to the Fiscal Year (FY) 2010 State and Foreign Operations funding measure to permanently repeal the Global Gag rule. The provision was eventually stripped from the FY 2010 Omnibus Appropriations bill during House negotiations after anti-abortion lawmakers threatened to block the bill's passage.

Appropriations

The FY 2009 Omnibus Appropriations bill that President Obama signed in March included $545 million for international family programs. This represented an increase of more than $80 million from the FY 2008 level. Included in that total was the U.S.'s $50 million contribution to the United Nations Population Fund (UNFPA), which had been blocked annually by the Bush administration.

The Bush administration's refusal to allow the U.S.'s UNFPA contribution stemmed from its misinterpretation of the "Kemp-Kasten" law, which precludes funding to organizations participating in coercive abortion or involuntary sterilization, despite the fact that U.S. fact-finding missions have disproved allegations that UNFPA supports China's coercive population control programs. When the House passed the FY 2009 Omnibus on February 25, the bill included language that would allow for the UNFPA funding to be released notwithstanding Kemp-Kasten restrictions for six designated activities including: ensuring safe childbirth and emergency obstetric care; increasing availability of contraceptive supplies; prevention and treatment of obstetric fistula; re-establishing maternal health services in conflict and disaster zones; combating harmful traditional practices, including female genital mutilation and child marriage; and promoting access to water and sanitation, food, and health care for poor women and girls. This meant that even if there was a negative Kemp-Kasten determination, UNFPA could still receive U.S. funds for those core activities.

During Senate consideration of the bill, Senator Roger Wicker (R-MS) offered an amendment that would have removed that language and reinforced Kemp-Kasten, but the amendment failed 39-55. When the President signed the bill, it allowed much-needed funds to maintain global reproductive health efforts. In response to the renewed funding, UNFPA Executive Director Thoraya Ahmed Obaid stated, "We believe that access to safe and effective voluntary family planning is one of the most effective ways to prevent unintended pregnancies and empower women and men to plan their families."[70]

In FY 2010, international family planning received $648.5 million, continuing the trend towards reinvesting in international reproductive health and family planning services. These increases, after years of dwindling support for international family planning programs, were yet another sign that the Obama administration recognized the vital role that family planning plays in improving the lives of women worldwide.

70 State News Service, "US's $50 Million Contribution Will Help Empower Women, Says Top UN Official," March 26, 2009.

New Study Highlights the Need for Investment in International Family Planning

A joint Guttmacher Institute/UNFPA report released in 2009 detailed the benefits of investing in family planning abroad not only for maternal and child health, but for a country's economic prosperity as whole. *Adding it Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health* found that investing in family planning would not only lower the rate of unintended pregnancy, but would also lower rates of HIV and other STIs.[71] Furthermore, the report found that increasing access to contraceptive services, family planning and pregnancy-related care could significantly reduce the number of maternal and newborn deaths in developing countries.[72]

Obama Administration Affirms its Support for PEPFAR

In 2008, the "President's Emergency Plan for Aids Relief" (PEPFAR) was reauthorized for five years (through 2013), providing $48 million for prevention and treatment of HIV/AIDS, tuberculosis, and malaria in poor countries. There was much speculation as to the program's viability in light of President Obama's emphasis on prevention and family planning instead of emergency treatment and abstinence-only programming. However, on World AIDS Day in December, President Obama and Secretary of State Hillary Clinton affirmed their commitment to PEPFAR.

Women's Reproductive Health and U.S. Foreign Policy

With the Obama administration came a new focus on women's issues at the State Department. In 1995, in a speech delivered at the United Nations Conference on Women in Beijing, Clinton affirmed "women's rights are human rights, once and for all."[73] Once at the State Department, Secretary of State Clinton set her sights on making that declaration a reality in U.S. foreign policy. A new office of Global Women's Issues was established in March. The State Department also began factoring reproductive health into the criteria by which it evaluates human rights conditions in other countries.

During her March 27 remarks at the Planned Parenthood Federation Awards Gala, Secretary Clinton reaffirmed these beliefs stating, "It's about making sure that every woman and girl everywhere has the opportunities that she deserves to fulfill her potential, a potential as a mother, as a worker, as a human being… I believe that women's rights and empowerment is an indispensible ingredient of smart power and therefore is integrated into our renewed emphasis on diplomacy and development…"[74]

President Obama Moves to Lift HIV Travel Ban

In October, President Obama issued an executive order to the Department of Health and Human Services to lift a travel ban in place for over twenty years which prohibited immigration into the United States by HIV-positive individuals. The U.S. had been among a dozen countries that barred entry to travelers with visas or anyone seeking a green card based on their HIV status.

71 Singh S et al., *Adding It Up: The Costs and Benefi ts of Investing in Family Planning and Maternal and Newborn Health*, New York: Guttmacher Institute and United Nations Population Fund, 2009.

72 Ibid.

73 The New York Times, "Hillary Clinton, in China, Details Abuse of Women," September 6, 1995.

74 U.S. Department of State, "Remarks at Planned Parenthood Federation of America Awards Gala," March 27, 2009.

A Look Ahead March 12, 2010

The Second Session of the 111th Congress holds the potential for significant advancement on a number of NFPRHA's policy priorities and the priorities of its members. The Fiscal Year (FY) 2011 appropriations season began with an announcement from President Obama that he intended to "freeze" spending on all nondiscretionary programs in his budget in an effort to reduce the deficit. Despite the announcement, President Obama included a $9.9 million increase in funding for the Title X program in his FY 2011 budget request. Although the $9.9 million falls short of NFPRHA's requested $76.5 million, the increase signals the President's continued support for comprehensive family planning care.

The election of Republican Scott Brown to the seat of the late Massachusetts Senator Edward Kennedy temporarily stalled the health care reform process early in 2010, as congressional leaders grappled with how to move ahead without the Democrats' filibuster-proof majority. After weeks of questions about reconciling the very different health care bills passed in the House and Senate and finding the votes needed to send a bill to the President's desk, President Obama seized the initiative and began to move the process forward. Urging lawmakers to finish the work they had started, the President offered a policy proposal that built on the Senate's "Patient Protection and Affordable Care" Act but incorporated many of the policies in the House bill that would improve health care access to low-income families.

This proposal became the basis of a bill designed to address the concerns of the House but also gain the support of the Senate through a process known as "budget reconciliation," which would require a simple majority (51 votes) to pass a bill. Under this scenario, the House would pass both the Senate bill and a corrections bill, followed by the Senate passing the corrections bill under reconciliation. This would mean that most of NFPRHA's priorities—the Medicaid family planning state option, the expansion of Medicaid eligibility up to 133 percent of the federal poverty level, and the requirement that health plans contract with essential community providers—would be part of a final bill ultimately signed into law. Unfortunately, the harmful language included by Senator Ben Nelson (D-NE) severely restricting access to abortion coverage in health insurance would also remain.

Even as congressional leaders and the White House push to secure the votes needed for passage, the road remains littered with policy and political challenges. Representative Bart Stupak (D-MI) continues to attempt to derail health reform unless it includes a complete prohibition on women with coverage in the state-based exchange from having abortion coverage. It will take substantial political will on the part of Democratic members of Congress to get a final bill to the President's desk, but as of this writing, there appears to be momentum on the side of passing comprehensive reform.

After health care reform, there will be limited opportunities for advancing family planning policy or health policy in general through Congress. Achieving health reform was harder than many anticipated, and the deep recession, public discontent with the federal government's priorities and concerns about the fall's elections will push Congress' attention towards legislation designed to reduce unemployment and stabilize financial markets.

The country's record-high deficits coupled with high unemployment rates will encourage lawmakers to tighten discretionary spending, putting a further strain on underfunded public health programs like Title X. Although the need for the services provided by Title X continues to grow, the program is unlikely to see more than the $9.9 million increase included in the President's budget. Still, the expansion of Medicaid eligibility up to 133 percent of the federal poverty level and the Medicaid family planning state option—if health care reform is signed into law—could help family planning providers better serve their patients.

While many financial observers believe the nation's economy is slowly moving in a positive direction, millions of low-income women and men have yet to see the effects of such movement. Across the country, governors are facing tremendous budget shortfalls and will be forced to make cuts anywhere they can, with at-risk populations and those dependent on government support certain to be affected.

In 2010, NFPRHA will continue its work to protect and improve low-income access to reproductive health care, fighting on behalf of its members to overcome challenges and secure the resources necessary to provide quality, comprehensive family planning services.

About NFPRHA

The National Family Planning & Reproductive Health Association (NFPRHA) is a vital membership organization representing the nation's dedicated family planning providers—nurses, nurse practitioners, administrators and other key health care professionals.

We serve our members by providing advocacy, education and training for those in the family planning and reproductive health care field.

For more than 35 years, NFPRHA members have provided comprehensive preventive health care services in thousands of health centers to millions of women and men annually. Everyday our members help people act responsibly, stay healthy and plan for strong families.

NFPRHA's 2009 federal legislative report was made possible with the generous support of the Robert Sterling Clark Foundation. It was written by Jackie Chimelewski, Rachel Fey, Robin Summers and Dana Thomas, under the direction of Clare Coleman, President & CEO.

National
Family Planning
& Reproductive Health Association