BREAKTHROUGH

BREAKDOWN

A HISTORIC YEAR IN FEDERAL POLICY

Federal Legislative and Regulatory Action
on Reproductive Health in 2010

National
Family Planning
& Reproductive Health Association

Breakthrough/Breakdown: A Historic Year in Federal Policy

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Introduction

Despite the ideological division and heated rhetoric which dominated public policy debate in Washington, DC and the nation throughout 2009, 2010 began on the verge of an historic breakthrough: enactment of sweeping federal health care reform. After weeks of negotiations on how to finalize a bill and garner the votes needed to send the bill to President Barack Obama's desk, Congress broke through the political log jam and passed the "Affordable Care Act" (ACA), which was signed into law on March 23, 2010.

The ACA represents a historic opportunity to expand access to health care for all Americans, perhaps most urgently for the millions of low-income and poor women and men who all-too-often have slipped through the cracks in the nation's health care delivery system. By 2014, the ACA will expand Medicaid to all Americans with incomes up to 133 percent of the federal poverty level ($14,400 in 2010), broaden insurance coverage for those with incomes above 133 percent of the federal poverty level and put into place a number of consumer protections designed to ensure that those in need of health coverage are able to get it and keep it.

The ACA also contains a number of important provisions designed to improve access to family planning services and supplies, such as the option for states to expand their Medicaid coverage of family planning by amending their Medicaid programs and the requirement that insurance plans contract with "essential community providers," which include publicly funded family planning providers.[i] It also, however, contains notable setbacks to decades-long efforts to achieve true reproductive rights and justice, in the form of restrictions on individuals' ability and opportunity to access abortion care with coverage that draws on federal subsidy or through private insurance coverage.

Following the ACA's passage, the Obama Administration turned quickly to implementation of the new law, beginning what will be a years-long process to fully realize all of the protections and requirements of the ACA. Yet even as the true work of health care reform got underway, the political tide was shifting.

A number of factors, including growing frustration over a terrible, deepening recession and lingering anger over the debate about the ACA, provoked the voting public to seek change on a scale similar to the change voters endorsed in 2008. However, in 2010, the political beneficiaries were the Republicans, who won majority control of the U.S. House of Representatives in a victory over Democrats that President Obama called a "shellacking."[ii] Republicans also made gains in the U.S. Senate, although Democrats maintain control of that chamber. A significant number of the new members of Congress are anti-choice, anti-family planning and/or anti-ACA, and are expected to seek to roll back reproductive rights, access to family planning care and even the ACA itself.[iii]

As important, however, for both reproductive health advocates and for the ACA are the gains made by conservatives in the state governorships and legislatures. While any legislative actions taken by the U.S. House will likely be at least partially negated by the Senate and, if necessary, a presidential veto, state governors and legislatures will play a significant role in the success or failure of the ACA and the expansion or further restriction of reproductive rights.

Although the results of the 2010 midterm elections signal a difficult two years ahead and a breakdown in the progress made in the last two years, it is important to remember that 2010 was also a breakthrough year for health care and reproductive health, and overall represents an historic year in federal policy.

i For more on the provisions of the ACA, see "Health Care Reform" beginning on page 8.

ii Spetalnick, M., & Holland, S. (2010, November 3). Subdued Obama says suffered a voter "shellacking." Reuters.

iii For more on the outlook of the new Congress, see "A Look Ahead" beginning on page 28.

The Recession

The recession that began in 2008 continued to affect all areas of American life—from federal and state government to the private sector and beyond—during 2010. From a collapsed housing market and high levels of unemployment to unprecedented state and local budget crises, Americans continued to struggle with the new economic landscape. As families and businesses cut back in an attempt to weather the economic storm, so too did federal, state and local governments. In his State of the Union address, President Obama proposed a 3 percent spending freeze for most domestic programs starting in Fiscal Year (FY) 2011 in an attempt to address criticism that government spending was out of control. Similarly, states faced massive budget shortfalls, causing many states to make difficult cuts to essential safety-net programs. While there were signs of recovery on the horizon, the recession continued to play a significant role in the lives of all Americans in 2010, especially the poor and low-income.

State Budgets in Crisis

Most states, unlike the federal government, are required by their own state laws to balance their annual budgets, making them particularly vulnerable to national economic downturns. The non-profit Center on Budget and Policy Priorities anticipates that the states' cumulative budget shortfall will reach $140 billion in FY 2011.[1] Despite the enactment of the federal stimulus bill in 2009 known as the "American Recovery and Reinvestment Act" (ARRA), which was intended to prevent a greater economic catastrophe, states struggled to find the money to pay for public assistance programs such as unemployment insurance, food subsidies, and subsidized health care. Cuts to these safety-net programs, combined with significantly lower tax revenues, led to reductions in services and benefits for the nation's most vulnerable citizens.

Although the ARRA helped stave off a depression of a magnitude not seen since the 1930s, Congress' failure to pass a full extension of the enhanced Medicaid match rate (Federal Medicaid Assistance Percentage, or FMAP) left many states in even deeper waters. The ARRA included $87 billion to increase the federal share of Medicaid payments to states by 8-11 percent, a significant infusion of funds for states with increased Medicaid enrollment due to the recession. The ARRA provision expired in December 2010, but many states bet that Congress would extend the enhanced match rate into 2011. Thus, as states developed their FY 2011 budgets, as many as 30 states assumed the extra funds into their calculations in an effort to avoid making difficult budget cuts. Ultimately, after a lengthy debate in Congress, a 6-month extension was enacted. However, the extension was less than many states had planned—for January-March 2011, the FMAP rate is increased by 3.2 percentage points; for April-June 2011, the regular matching rate will be increased by 1.2 percentage points.

Facing no easy choices to achieve a balanced budget, states tried a number of options, including slashing Medicaid provider payment rates, raiding "rainy day" funds, suspending contributions to state retirement systems and enacting across-the-board spending cuts.[2] Though state tax revenue increased slightly toward the end of 2010, long-term budget predictions remain a cause for concern. A report issued by the National Conference of State Legislators estimates that states will have a collective budget deficit of $72 billion in FY 2012.[3]

1 Williams, E., Oliff, P., Singham, A., & Johnson, N. (2010, June 29). *New Fiscal Year Brings More Grief for State Budgets, Putting Economic Recovery at Risk*. Washington, DC: Center on Budget and Policy Priorities.

2 Niolet, B. (2010, July 1). State's Budget Offers Ammo for All. *News Observer.*

3 National Conference of State Legislators. (2010, July). *State Budget Updates: July 2010 Preliminary Report.*

The Recession's Impact on Family Planning

The recession's impact on the number of uninsured brought more Americans into the safety-net system. In November, the U.S. Centers for Disease Control and Prevention (CDC) announced that 59.1 million Americans were without health insurance at some point in the 12 months before their CDC interview, up from 56.4 million in 2008.[4] Twenty-six percent of adults aged 18 to 64 were uninsured.[5] According to data collected in the first quarter of 2010, more adults spent more than 12 months before their CDC interview without health insurance than in the previous year, with 30.4 million "chronically uninsured" adults.[6]

The recession increased the demand on the nation's public health care system, and impacted the decisions that women make about when to become pregnant and how many children to have. According to the National Center for Health Statistics, the U.S. birth rate declined for the second year in a row, from 14.3 births for every 1,000 people in 2007 to 13.5 births for every 1,000 people in 2009.[7] Though data for 2010 is not yet available, it is reasonable to assume that the trend continued in 2010. Data published by the Guttmacher Institute in 2009 showed that two-thirds of the public family planning centers surveyed reported an increase in clients from the first quarter of 2008 to the first quarter of 2009.[8]

Family planning providers continued to see an increase in clients in 2010, as many women sought to delay childbearing until economic conditions improved. Even as family planning providers and systems struggled to meet the increased demand for services, some states were cutting family planning funding. In New Jersey, Governor Chris Christie (R) eliminated all family planning funding, even going so far as to withdraw the state's application to the federal Centers for Medicare & Medicaid Services to expand the state's Medicaid coverage of family planning services. In Washington state, Governor Christine Gregoire (D) announced late in 2010 that the state would eliminate all optional Medicaid programs, which included the state's successful Medicaid family planning waiver program.[9]

The Health Care Workforce Shortage

While the ACA promises to insure approximately 94 percent of American citizens by 2020, the reality is that coverage without access means little for patients seeking care. The recession has delayed the retirement of many older health care professionals who might retire in advance of ACA implementation, and has slowed down the creation of the new jobs needed to handle the forthcoming influx of new patients. A shortage of nursing school faculty is restricting enrollment in nursing programs, leading to waiting lists at many nursing schools and making it difficult to adequately train new nurses at the rate at which they are needed—those who do graduate are having difficulty finding work in the fields and locations in which they are trained to work. The shortage of providers is already felt by the medically underserved, especially in rural and low-income areas, and is only projected to become worse as millions more Americans gain health insurance coverage.

In response to the growing shortage of preventive and primary care providers throughout the United States, the U.S. Department of Health and Human Services (HHS) announced in June 2010 an allocation of $250 million to strengthen the primary care workforce. The funds came from the Prevention and Public Health Fund (PPHF), a funding stream created in the ACA for public health and prevention programs.[10]

4 United States, Department of Health and Human Services, Centers for Disease Control and Prevention. (2010, November 9). Vital Signs: Health Insurance Coverage and Health Care Utilization – United States, 2006-2009 and January-March 2010. *Morbidity and Mortality Weekly Report,* Vol. 59.

5 *Ibid.*

6 *Ibid.*

7 Marchione, M. (2010, August 28). Family Planning Forced by Recession. *Athens Banner-Herald.*

8 The Guttmacher Institute. (2009, September). *A Real Time Look at the Impact of the Recession on Publicly Funded Family Planning Center.* New York: The Guttmacher Institute.

9 As of this writing, Washington's waiver program was still in operation. For more on Medicaid family planning waivers, see "Medicaid-Funded Family Planning" beginning on page 16.

10 For more on the PPHF, see "Title X Family Planning" beginning on page 12.

Health Care Reform

On March 23, 2010, after one of the lengthiest and most contentious debates in recent American politics, President Obama signed the ACA into law. By the end of 2010, implementation was well underway, as the federal government issued regulations to help guide application of the landmark law, and states were beginning to take steps toward implementing the law. However, a number of legal challenges, as well as the results of the 2010 midterm elections, cast a shadow over the ACA that will extend well into 2011 and beyond.

The Final Days to Passage

The passage of health care reform bills in both chambers of Congress at the end of 2009 was a huge milestone; however, substantial challenges remained before the President could sign a bill into law. The election of Republican Scott Brown to the seat of the late Massachusetts Senator Edward Kennedy temporarily stalled the 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 by the House and Senate and finding the votes needed to send a bill to the President's desk, President Obama offered a policy proposal that was 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.

The final steps towards enacting health care reform began on March 21, 2010, when the House passed two bills. The first bill passed was the health care reform bill (the ACA) passed by the Senate at the end of 2009, which contained arbitrary restrictions on abortion services that complicated the already difficult process of obtaining and paying for appropriate health insurance.[11] Following the House's passage of the ACA, it passed a "corrections" bill which modified some of the provisions of the Senate-passed bill to which members of the House objected. In order to secure the 218 votes needed to pass health care reform, House leaders worked with a small number of anti-choice members led by Representative Bart Stupak (D-MI) seeking stronger restrictions on abortion access. The White House agreed to issue a Presidential executive order[12] reaffirming the application of the federal Hyde Amendment to the ACA, and reaffirming existing federal refusal laws[13] and the refusal provisions contained in the ACA. Although both progressive and conservative Democratic members opposed many provisions in the bill, the House passed the ACA by a vote of 219-212, and the corrections bill by a vote of 220-211.

As President Obama signed the ACA into law on March 23, the Senate began its consideration of the House-passed corrections bill. Because the corrections bill was being considered under Senate budget reconciliation rules, Senate Democrats only needed a 51-vote majority to pass the bill (rather than the 60 votes needed to avoid a Senate filibuster). Senate Republicans offered a number of amendments to the legislation, but none were approved. The Senate passed the corrections bill on March 25 by a vote of 56-43, but because Senate Republicans were successful in raising a procedural problem with unrelated student lending legislation that had been attached to the ACA, the House had to approve the corrections bill one last time, which it did on March 26 by a vote of 220-207.

The ACA's Impact on Family Planning

Throughout the course of the debate, advocates, health providers and policymakers committed to reform faced obstacles that at times seemed insurmountable. A recurring tide of misconceptions and falsehoods, the loss of the Democrats' filibuster-proof majority in the Senate with the election of Scott Brown (R-MA) to the fill the Senate seat of the late Ted Kennedy, and serious fractures within the Democratic party all threatened to derail reform

11 For more on the Nelson language, see "Access to Abortion Care" beginning on page 21.

12 The March 24, 2010, Executive Order (EO 13535) states, in part: "The Act maintains current Hyde Amendment restrictions governing abortion policy and extends those restrictions to the newly created health insurance exchanges. Under the Act, longstanding Federal laws to protect conscience (such as the Church Amendment, 42 U.S.C. 300a-7, and the Weldon Amendment, section 508(d)(1) of Public Law 111-8) remain intact and new protections prohibit discrimination against health care facilities and health care providers because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions."

13 Existing federal refusal laws give individuals and institutions the ability to refuse to provide or refer for abortion or sterilization services.

NFPRHA opposed the Nelson language contained in the Senate bill, but supported the ultimate passage of the ACA. Throughout the health care reform debate, NFPRHA's focus consistently remained on ensuring access to quality, affordable family planning and reproductive health services through the nation's network of publicly funded family planning providers.

By the end of 2010, a number of important ACA provisions were already in effect, including: allowing states to amend their Medicaid programs to expand coverage of family planning services, up to the income level the state uses to determine pregnancy-related care; prohibiting insurance companies from dropping an individual's coverage if he/she gets sick; eliminating putting lifetime or annual limits on an individual's coverage and allowing young adults to stay on their parents' insurance until age 26. By 2014, the ACA will:

- Expand Medicaid income eligibility to 133 percent of the federal poverty level (FPL). States will receive 100 percent federal support starting in 2014 and going through 2017 for newly eligible individuals. In 2018 and 2019, states will receive 95 percent support, and in 2020 and subsequent years, 90 percent;
- Provide premium subsidies for private plans sold in state-based insurance marketplaces called exchanges, for individuals with incomes between 133 and 400 percent of the FPL;
- Require that qualified health plans include within their health plan networks those essential community providers that serve predominately low-income, medically-underserved individuals. Essential community providers include, but are not limited to, providers defined in section 340B(a)(4) of the Public Health Service Act (which includes Title X providers); and
- Require health plans to provide coverage, with no co-pays or deductibles, of preventive care and screenings for women beyond the preventive services recommended by the United States Preventive Services Task Force (USPSTF).

The Women's Health Amendment

The ACA requires that all new, private health plans beginning on or after September 23, 2010, cover preventive services recommended by the USPSTF with no co-pays or deductibles (also known as "cost-sharing"). However, the full range of family planning services, including contraception and the treatment of sexually transmitted diseases (STDs), is not currently included in the list of USPSTF-recommended services.

During the Senate debate of the ACA, Senator Barbara Mikulski offered an amendment establishing a women's health preventive services benefit, which requires additional coverage of women's health services without cost-sharing.

NFPRHA supported the Mikulski amendment, which will reduce barriers to access for millions of women. Studies show that even nominal cost-sharing negatively influences access to health care services, and the provision was intended to ensure that services like mammograms, pelvic exams and other annual women's health services would be widely accessible.

While passage of the amendment was a clear step forward in the fight to ensure that women have access to essential health services, the question of precisely what services would be covered remained. The federal Health Resources and Services Administration (HRSA) within HHS was made responsible for determining what would be considered a "preventive service" for the purposes of this amendment. In July 2010, HHS, along with the U.S. Department of Labor, issued interim final rules regarding the USPSTF preventive services requirement; those rules stated that HHS was working on defining what would be included in the women's health preventive services benefit.

In September 2010, NFPRHA submitted formal comments to interim final rules on preventive services, urging, among other things, that HHS encourage a thorough yet expedited review process for determining what services would be included in the women's health preventive services benefit, and that the benefit include the full range of family planning services, including all contraceptive methods approved by the U.S. Food and Drug Administration (FDA).

NFPRHA also submitted formal comments to a solicitation from HHS' Agency for Healthcare Research and Quality (AHRQ) for topics pertaining to clinical preventive services for review by the USPSTF. NFPRHA asked the USPSTF to review "interventions related to preventing unintended pregnancy." A favorable review of the topic would ensure that women and men purchasing new commercial insurance plans in the health insurance exchanges created by the ACA would be able to access family planning services with no cost-sharing.

Although HRSA is responsible for developing the women's health preventive services benefit, the agency chose not to define what will be included. Instead, HRSA contracted with the non-governmental Institute of Medicine (IOM) to review potential preventive screenings and services to be considered for the women's health preventive services benefit.

On November 16, 2010, the IOM's Committee on Preventive Services for Women held its first meeting to review potential preventive screenings and services to be included in the women's health preventive services benefit. Following the formal presentations, attendees were given an opportunity to offer comments to the committee. While several anti-choice groups testified against including contraception or sterilization, the majority of speakers recommended that family planning be included as an essential preventive service for women. HHS hopes to announce the findings of the committee by summer 2011, and plans to ask HRSA to issue guidelines no later than August 1, 2011.

NFPRHA offered comments at a November 2010 IOM meeting, which addressed the impact that co-pays and cost have on individuals' ability to access family planning services. NFPRHA asked the committee to evaluate the full range of family planning services, including the visit, the contraceptive method and the counseling associated with the visit.

The 2014 Medicaid Expansion

One of the most significant pieces of the ACA is the requirement that states expand their Medicaid eligibility for individuals with incomes up to 133 percent of the FPL—$14,400 for an individual in 2010. This expansion will make an estimated 16 million uninsured individuals eligible for Medicaid in 2014. While current Medicaid eligibility generally prohibits childless adults from coverage, the 2014 expansion applies to all individuals, including those without children. It is this population that will make up the majority of new Medicaid beneficiaries starting in 2014—as of the end of 2010, only a handful of states had made inroads into covering childless adults through Medicaid, either through Section 1115 waivers from the Centers for Medicare & Medicaid Services (CMS) granting permission to expand their full-benefit Medicaid programs to that population, or through state programs that use non-federal funds to provide coverage.[14]

Health Information Technology

Health care providers, policymakers and advocates have long recognized the potential for health information technology (HIT) to improve quality of care and patient safety. HIT, primarily the use of Electronic Health Records (EHR), allows providers to electronically document and share patients' health history, including chronic health conditions, family health history and medication regimens to better assess the overall care needed by a patient. HIT is particularly promising for improving care for low-income individuals who tend to move on and off health insurance plans and in and out of providers in the safety-net system. Access to EHR would allow providers to better coordinate a patient's care, which can result in better health outcomes and ultimately cost savings to the health system. The ACA includes a number of provisions relating to HIT that address many of the challenges facing health care providers, including: creating new programs to encourage the use of HIT, increasing payment for entities that are already using HIT, developing new standards to ensure the appropriate use of HIT, and programs to increase training and development for providers using HIT.

14 For more on the 2014 Medicaid expansion, see "Medicaid-Funded Family Planning" on page 16.

The promise of HIT are not without concerns, however, particularly for publicly funded family planning providers. Many publicly funded family planning providers and systems have not been able to take advantage of this technology, in large part due to funding constraints. The slow adoption of HIT in safety-net clinics could put them at a disadvantage when it comes to reporting health outcome data for their patients and benefiting from federal incentive programs designed to reward providers for improving the care of their patients.

National Prevention Strategy

On June 10, 2010, President Obama signed an executive order creating the National Prevention, Health Promotion, and Public Health Council (National Prevention Council). The council, chaired by Surgeon General Regina Benjamin, is charged with providing coordination and leadership at the federal level, and among all executive departments and agencies, with respect to prevention, wellness, and health promotion practices.

On September 15, Surgeon General Benjamin convened the National Prevention Council to draft a framework to guide development of the National Prevention Strategy. The framework sought to promote community environments that make healthy choices easy and affordable and to implement effective preventive practices in specific strategic directions. These directions are to promote active lifestyles; address specific populations' needs to eliminate health disparities; counter alcohol/substance misuse; increase healthy eating; create healthy physical and social environment; ensure high impact, quality clinical preventive services; promote injury-free living; improve mental and emotional wellbeing; provide for strong public health infrastructure; and increase tobacco-free living.[15]

The National Prevention Council held an initial public comment period on the National Prevention Strategy late in 2010. Additional opportunities for input will be available in 2011 as the National Prevention Strategy further develops.

NFPRHA submitted comments on the National Prevention Strategy's draft framework in December 2010, urging that family planning services and supplies, and the prevention of unintended pregnancy, be incorporated into the National Prevention Strategy.

Post-enactment Legal Challenges to the ACA

On March 23, 2010, the same day that the ACA was signed into law, the Attorney General of Florida filed a lawsuit, along with 13 other states, in the U.S. District Court in the Northern District of Florida challenging the ACA. The plaintiffs argued that the law was unconstitutional because Congress overstepped its authority by requiring individuals to purchase health insurance. The lawsuit also contends that the required 2014 Medicaid expansion is a case of the federal government manipulating and pressuring the states.[16] By the end of 2010, 20 states were parties in the Florida lawsuit: Alabama, Alaska, Arizona, Colorado, Florida, Georgia, Idaho, Indiana, Louisiana, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Pennsylvania, South Carolina, South Dakota, Texas, Utah, and Washington. Following the election of numerous new anti-ACA governors in the 2010 midterm elections, several other states are considered likely to join the lawsuit as plaintiffs in 2011.

Although the Obama administration asked that the case be thrown out, on October 14, a federal judge reviewed the lawsuit and ruled that it could move forward. Oral arguments for the case were heard on December 16. The Florida lawsuit is widely believed to be headed to the U.S. Supreme Court, which may be the final arbiter of the ACA's constitutionality.

The Florida case was not the only lawsuit challenging the ACA in 2010. By year's end, the Obama administration had won two lawsuits on the merits—one filed by Thomas More Law Center in Michigan and the other filed by Liberty University in Virginia.[17] Numerous other legal challenges to the ACA were dismissed across the country. The administration also lost one lawsuit, filed by Virginia Attorney General Ken Cuccinelli. In December, the federal judge in that case struck down the ACA's individual mandate, but upheld the rest of the law.[18]

15 United States, Department of Health and Human Services. (2010, October 1). *The National Prevention and Health Promotion Strategy.* [Draft Framework].

16 Haberkorn, J. (2010, December 12). New day in court for health reform. *Politico.*

17 *Ibid.*

18 Millman, J. (2010, December 13). Federal judge rules against new healthcare law in Virginia lawsuit. *The Hill.*

Title X Family Planning

The Title X program celebrated its 40 anniversary in 2010, during a period of enormous change for the public health infrastructure. The ACA will have a tremendous impact on the publicly funded family planning providers and systems that help make up the health care safety net. The magnitude of change in family planning service delivery is greater than any since the creation of the Title X program in 1970. As the federal government dramatically increases the role of Medicaid and commercial insurance exchanges as sources of coverage for patient care, the Title X network will need to adapt and change in order to meet new realities.

The Title X 40th Anniversary Resolution

In recognition of the vital role that the Title X program plays, on June 24, 2010, Representative Judy Chu (D-CA) and Senator Jeff Merkley (D-OR) introduced a resolution recognizing the achievements of the Title X family planning program (H. Res. 1476 and S. Res. 565, respectively). The resolution praised the Title X program and Title X providers for their contributions to low-income access to family planning. This resolution provided an opportunity for members of Congress to demonstrate their support for the Title X program and its importance to the public health safety net during the program's 40th anniversary year.

NFPRHA staff worked with Representative Chu and Senator Merkley to draft and introduce the resolution. After sustained efforts and contact with congressional offices, S. Res. 565 had 14 cosponsors and H. Res. 1476 had 108 cosponsors at the end of the 111th Congress. Although the resolution was not signed into law, the support that it received in the House and Senate demonstrates Congress' recognition of the program's continued relevance.

The House and Senate resolution was referred to each chamber's appropriate committee of jurisdiction: the House Committee on Energy and Commerce and the Senate Committee on Health, Education, Labor and Pensions. Of the House co-sponsors, 20 were members of the Committee on Energy and Commerce (including Committee Chairman Henry Waxman (D-CA)), which technically allowed the resolution to bypass committee mark-up.

NFPRHA staff explored the likelihood of scheduling a floor vote in the last days of the 111th Congress with Representative Chu and House Energy and Commerce Committee staff, but Republican committee staff objected to including the Title X Resolution on the "suspension calendar"—a schedule of floor votes on generally non-controversial items—during the lame duck congressional session following the November elections. Republicans opposed the resolution on the principal of their anti-family planning stance and because there were no Republican co-sponsors of the resolution. Given the limited time for floor action at the end of any Congress, and the shift in power toward the Republicans that was already affecting the House by year's end, a floor vote was not scheduled.

FY 2011 Funding

The President's budget request for FY 2011 was released on February 1, 2010. As he announced during the State of the Union, President Obama called for an overall domestic spending freeze. While many programs faced flat-funding or even cuts, for the second year in a row the President requested an increase for the Title X program. President Obama also requested some modest investments in other public health programs of interest to reproductive health providers.

The President's budget requested $327.4 million for the Title X program for FY 2011 – an increase of approximately $9.9 million over the final FY 2010 funding level. This request reflected the proven effectiveness of Title X and the program's importance to the patients Title X providers serve. Although this request was a step in the right direction, it fell far short of the resources needed to adequately meet the needs of the Title X program or of the public health safety net it supports.

NFPRHA requested an increase of $76.5 million for Title X in FY 2011, for a total of $394 million.

On July 15, the House Labor, Health and Human Services and Education (Labor-HHS) Appropriations Subcommittee met to mark up its FY 2011 Labor-HHS Appropriations bill. The subcommittee draft of the bill included $327.4 million for the Title X program, equaling the President's FY 2011 budget request. The mark-up also included an attack on reproductive health, in the form of an amendment offered by Ranking Member Todd Tiahrt (R-KS) that was essentially the same as the Stupak-Pitts Amendment offered during the health care reform debate, which would have prohibited any coverage of abortion in the exchange and prohibited anyone receiving a federal subsidy from purchasing a health insurance plan that includes abortion. The Tiahrt amendment was defeated 5 - 11 along party lines.

On July 27, the Senate Labor-HHS Appropriations Subcommittee met to mark up its FY 2011 Labor-HHS Appropriations bill. The Senate subcommittee included $327.4 million for the Title X program, equaling the President's FY 2011 budget request and the House Labor-HHS Subcommittee mark.

Despite the early positive outlook for Title X appropriations, the continuing recession combined with the 2010 midterm elections resulted in neither the House nor Senate completing work on their individual appropriations bills by year's end, including the Labor-HHS bills. After passing short-term continuing resolutions (CRs) to keep the government funded at FY 2010 levels while congressional leaders attempted to negotiate longer-term funding, the Senate released an omnibus spending bill in December that would have included the $9.9 million increase for Title X. However, Senate Republicans blocked the omnibus spending bill, forcing congressional leaders to pass another short-term CR. The final CR of the 111th Congress funds government operations through March 4, 2011, at FY 2010 funding levels for most programs, including Title X.

Fiscal Year 2011 Funding for Selected Public Health Programs ($ in millions)

Program	FY 2011 Continuing Resolution[I]	FY 2010 Final	Change from FY 2010 Final
Title X Family Planning	$317.5	$317.5	$0
Social Services Block Grant	$1,700	$1,700	$0
MCH Block Grant	$662	$662	$0
Teen Pregnancy Prevention Initiative[II]	$114.5	$114.5	$0
Title V State Abstinence Grant Program[III]	$50	$50	$0
Personal Responsibility Education Program (PREP)[IV]	$55	$55	$0
CDC HIV/AIDS, Viral Hepatitis, STD and TB Prevention (total)[V]	$1,045	$1,045	$0
HIV/AIDS	$728	$728	$0
Viral Hepatitis	$19	$19	$0
STD	$154	$154	$0
TB	$144	$144	$0
Ryan White	$2,266	$2,266	$0
Community Health Centers	$2,146	$2,146	$0

I FY 2011 funding levels were set by a CR, which expires March 4, 2011.

II Includes $4.5 million for evaluation.

III This program expired on June 30, 2009, but was reauthorized by the ACA at $50 million per year for 5 years.

IV The Personal Responsibility Education Program (PREP) was created through the ACA. PREP provides states with $55 million per year for five years for evidence-based teen pregnancy, STD and HIV prevention programs.

V 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.

Initial Prevention and Public Health Funds Allocated

In addition to lobbying for increased appropriations for the Title X program, NFPRHA also advocated for funds from the PPHF created as part of the ACA to be allocated for Title X. The PPHF is a new mandatory source of funding for preventive health care, authorizing $500 million for FY 2010 to provide for expanded and sustained investment in prevention and public health programs authorized by the Public Health Service Act, like Title X. The PPHF also includes $750 million for FY 2011 and is slated to increase authorizations until funding reaches $2 billion per year beginning in FY 2014. The allocation of FY 2010 funds was at the sole discretion of HHS Secretary Kathleen Sebelius, but in future years the House and Senate Appropriations Committees will play a significant role in determining how the funds are spent.

In June 2010, Secretary Sebelius announced that the $500 million in PPHF funds for FY 2010 would be divided into two pools. The first pool of $250 million was to strengthen the primary health care workforce, and unfortunately did not include funding beneficial to Title X providers. The remaining $250 million in PPHF funds went toward promoting public health and wellness, focusing on chronic diseases and improving behaviors that negatively impact an individual's health. This money also did not include any direct benefit for Title X providers.

Marilyn Keefe Named DASPA

In May 2010, former NFPRHA Vice President for Public Policy Marilyn Keefe was selected as the Deputy Assistant Secretary for Population Affairs (DASPA). The DASPA leads the Office of Population Affairs (OPA), which oversees the Title X program at HHS, and is responsible for organizing and implementing federal domestic family planning policy priorities. In the December issue of NFPRHA's *Family Planning Matters*, Keefe said the following about her goals as DASPA:

> "My overarching goal is to ensure that federally funded family planning programs continue to deliver the quality services that have been a hallmark of the system for 40 years. I'm proud that OPA has a well-deserved reputation as an excellent steward of public funds and hope to continue and build on that reputation. On a programmatic level, OPA is in the midst of updating our program guidelines to ensure that they are both flexible and evidence-based. We also hope to expand our outreach to relevant communities through Webinars and an upgraded website."[19]

OPA Guidelines Revision Process

In 2010, OPA began an effort to review, revise and update the Title X program guidelines. OPA convened a core "expert workgroup" tasked with informing OPA's formal guidelines revision process.

NFPRHA, along with federal staff and NFPRHA's coalition partners, was invited to be a member of OPA's expert workgroup. NFPRHA's President & CEO, Clare Coleman, represents NFPRHA in the expert workgroup. In order to strengthen NFPRHA's preparation and participation in these meetings, NFPRHA convened a Title X Advisory Council made up of 29 NFPRHA members consisting of administrators and clinicians representing every HHS region and provider setting in the NFPRHA membership.

The first meeting of OPA's expert workgroup was held in April, and was intended to provide OPA with perspective and advice as it drafts a process for reviewing, revising and updating the Title X guidelines. The second meeting of OPA's expert workgroup was held in August. The meeting focused on the importance of providing a clear rationale for guidance that is dictated by statute or regulation, well-established in evidence, and consistent with quality standards. OPA's process for revising the Title X guidelines is expected to include comment and review from stakeholders from both inside and outside the Title X program and to take approximately two years to complete.

Judge Asks HHS to Provide Timeline for Issuing Final Refusal Rule

In December 2010, a federal judge in Connecticut asked HHS to report on the progress of its rulemaking regarding the 2008 Bush Refusal Rule, which permits 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.

19 National Family Planning & Reproductive Health Association. (2010, December). Q&A with Deputy Assistant Secretary for Population Affairs, Marilyn Keefe. *Family Planning Matters*.

The Bush administration issued the Refusal Rule in its final month in office 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, along with PPFA and Planned Parenthood of Connecticut as well as 8 state attorneys general, brought a lawsuit in federal district court in Connecticut. *National Family Planning & Reproductive Health Association, Inc. v. Leavitt* argued that the Rule had numerous legal flaws and should be invalidated.

In March 2009, the Obama administration published a proposal to rescind the Rule and asked for comments about that proposal. NFPRHA, along with many of its coalition partners, submitted comments in strong support of the proposal to rescind the Rule. Because rescission had been proposed, the federal lawsuit was put on hold. However, in December 2010, the judge in the case asked HHS to report to her about the progress of its rulemaking.

In a filing with the court, HHS indicated that it "expects" that it will have a final rule published within 60 to 90 days (i.e., between January 31, 2011 and March 1, 2011). Although HHS said that it "is working hard to finalize the rule in this time frame and should be able to do so," it also said that it was possible it would not and would need to revise what it told the court. NFPRHA's lawyers at the ACLU, along with Planned Parenthood, filed a response to HHS' filing with the court. In it, NFPRHA and Planned Parenthood said that they did not object to continuing to keep the lawsuit on hold for another 60 to 90 days. However, the plaintiffs have asked the court to schedule a meeting on the case with all parties in early March 2011, to determine how to proceed with the lawsuit in the event that HHS has not issued its final rule.

As has been the case since January 2009, the Rule remains in effect unless and until it is rescinded. It is not known what will be contained in the final rule—whether it will in fact simply be a total rescission or whether it will be a revised Rule.

Medicaid-Funded Family Planning

Medicaid is the largest source of funding for family planning in the United States, and will play an even more significant role in publicly funded family planning in the coming years. The ACA includes two important provisions that will positively impact the ability of low-income Americans to access the family planning care they need: the expansion of Medicaid eligibility to 133 percent of the FPL in 2014, and the option for states to expand their Medicaid coverage of family planning services by amending their state's Medicaid plan.

The 2014 Medicaid Expansion

The expansion of Medicaid eligibility to 133 percent of the FPL on January 1, 2014, is the main event for low-income Americans, the path approximately half of the estimated 32 million newly insured patients will take to coverage under the ACA. Today, an estimated 17 million adults do not have insurance and are at or below 133 percent of the FPL.[20] These individuals account for 37 percent of the total number of uninsured in the U.S.[21] In 2010, forty states had eligibility levels under 133 percent of the FPL for full-benefit Medicaid. For the majority of these states, the 2014 Medicaid expansion will bring a significant increase in eligibility simply in terms of percentage levels. For example, for the ten states with the lowest Medicaid eligibility (ranging from 17% to 33% of the FPL), the income eligibility cap will increase a minimum of $22,050 for a family of four, from $7,277 (33% of the FPL) to $29,327 (133% of the FPL).

Current Medicaid eligibility is generally limited to "working parents"—non-disabled, childless adults who have not been categorically eligible for Medicaid. The 2014 expansion, however, applies to *all* individuals, including those without children, and it is these individuals who will comprise the majority of new Medicaid patients starting in 2014. A handful of states have made inroads into covering childless adults, either through Section 1115 waivers granting permission to expand their full Medicaid programs to that population or through state programs that use non-federal funds to provide coverage. Massachusetts and Vermont, which already cover childless adults above 133 percent of the FPL, will have no new individuals eligible for Medicaid in 2014.[22] Arizona, Delaware, Hawaii, Maine and New York also have waivers to expand eligibility to childless adults, but their eligibility is under 133 percent of the FPL and so they will still have new eligibles in 2014.[23] In June, Connecticut became the first state to expand eligibility to childless adults under the ACA, implementing an incremental approach to the required 2014 expansion.[24] The District of Columbia (DC) followed suit in July.

Preparing family planning clinicians and administrators for the 2014 Medicaid expansion, and working with CMS and state Medicaid administrators, will be an important part of NFPRHA's work over the next few years.

A major challenge to expanding health care coverage through Medicaid will be identifying and enrolling newly eligible individuals. Despite how health care reform dominated the news in 2009 and early 2010, many low-income childless adults are not aware that they will be eligible for Medicaid in 2014. Lack of awareness of their new eligibility status, along with historic lack of eligibility and fluctuating income levels that can move individuals in and out of eligibility, will pose serious challenges

20 Kaiser Commission on Medicaid and the Uninsured. (2010, July). *Expanding Medicaid to Low-Income Childless Adults under Health Reform: Key Lessons from State Experiences*. Washington, DC: Kaiser Family Foundation.

21 *Ibid*.

22 Kaiser Commission on Medicaid and the Uninsured. (2010, May). *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL*. Washington, DC: Kaiser Family Foundation.

23 *Ibid*.

24 United States, Department of Health and Human Services. (2010, June 23). *Connecticut First in Nation to Expand Medicaid Coverage to New Groups Under the Affordable Care Act*. [Press Release].

to outreach and enrollment in 2014.[25] However, the 2014 expansion will be significantly easier for the states which have already expanded full Medicaid coverage to childless adults, as well as for those that have a Medicaid family planning waiver or which amend their state Medicaid plans to expand coverage of family planning prior to January 1, 2014.

Millions of women and men—with and without children—currently receiving family planning services through Medicaid waivers have incomes that are below 133 percent of the FPL. Thus, many of the individuals currently enrolled in family planning waiver programs will be eligible for full Medicaid in 2014, and because of their current waiver enrollment already have Medicaid records – meaning the state will not have to expend significant resources trying to identify them as potential enrollees in 2014.

Medicaid State Plan Amendments

Since the early 1990s, many states have been granted Section 1115 demonstration waivers by CMS to expand Medicaid coverage of family planning services. It is widely acknowledged that expanding Medicaid coverage of family planning has proven to reduce unintended pregnancy and improve public health, all while saving millions of public dollars. Recognizing the public health benefits and cost-effectiveness of helping women avoid unintended pregnancies, by the end of 2010 twenty-eight states had waivers approved by CMS to expand Medicaid coverage of family planning.

For several years, the family planning community has been working to pass a legislative provision that would give states the option to expand their Medicaid family planning coverage by amending their state Medicaid plans, rather than through obtaining a waiver from CMS. After a long history of mostly behind-the-scenes but sometimes very public fights to pass it, such as the controversy over the provision's inclusion in the stimulus bill in early 2009, the state family planning option became law as part of the ACA in 2010.

Passage of the state family planning option was a top priority for NFPRHA. NFPRHA's work on family planning SPAs and waivers continues through its Medicaid Peer-to-Peer Learning Network which, since 2008, has brought together NFPRHA members and state Medicaid program professionals to discuss key issues related to Medicaid-funded family planning, identify mutual areas of concern and share best practices for operating Medicaid family planning expansion programs.

States now can submit a state plan amendment (SPA) to their Medicaid program to expand family planning coverage to low-income women and men up to the same income eligibility level allowed for pregnancy-related care. The state family planning option was largely designed to smooth the burdensome administrative process states had been navigating in order to expand Medicaid coverage of family planning, and to encourage more states to expand their coverage as well. On average, it takes 15 months to apply for and obtain waiver approval from CMS, with significant investment of staff time and resources needed to draft, negotiate and renegotiate terms and conditions. The waiver process also requires states to go through a similarly onerous procedure for renewal. With the passage of the ACA, states can now apply for a SPA or a waiver to expand family planning eligibility under Medicaid, depending on the state's needs.

Unlike the waiver process, securing a SPA is much more streamlined: a SPA has no research and evaluation requirement, has a federally mandated timeline for approval, does not need to be renewed since it is a permanent change to the state's Medicaid program, and states do not need to prove that the SPA would cost the federal government less money than it would have spent without the SPA (i.e. the SPA does not need to be "budget neutral").

On July 2, 2010, CMS sent out guidance to the states on the newly authorized SPAs detailing eligibility, benefits, and the application process.[26] In August, CMS held a conference call with states to further clarify details related to family planning SPAs. The ACA creates a new, optional categorically needy group that is eligible for family planning and family planning-related

25 Kaiser Commission on Medicaid and the Uninsured. (2010, July). *Expanding Medicaid to Low-Income Childless Adults under Health Reform: Key Lessons from State Experiences*. Washington, DC: Kaiser Family Foundation.

26 United States, Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2010, July 2). *RE: Family Planning Services Option and New Benefit Rules for Benchmark Plans*.

services. Eligibility is based solely on income and pregnancy status: in order to qualify, a person cannot be pregnant and cannot have an income that exceeds the income eligibility level established by the state. The SPA income level set by the state cannot exceed the highest income level the state provides for pregnancy-related care under the state's Medicaid or Children's Health Insurance Plan (CHIP). The state cannot restrict eligibility based on age or gender—in other words, teens and men must be included.

States can also decide to consider individuals presumptively eligible, meaning that a person can be served under the SPA based only on preliminary information that the individual is eligible—regular documentation requirements, including citizenship documentation, do not apply to a presumptive eligibility determination. Thus, a provider can see a patient before he/she is enrolled in the program, the provider will be reimbursed and the state will receive federal matching funds for the services. The patient will still need to submit an application within a prescribed period of time, but presumptive eligibility enables providers to avoid harmful delays in patient care during the application process.

There are two kinds of benefits available under the SPA: "family planning services and supplies" and "family planning-related services." Family planning services and supplies are defined as being "furnished … to individuals of child-bearing age … who are eligible under the state plan and who desire such services and supplies."[27] In more specific terms, these are the same services and supplies (such as contraceptives, annual family planning visits and sterilization) which receive an enhanced 90 percent federal match rate for other Medicaid state plan beneficiaries. Family planning-related services are "medical diagnosis and treatment services" provided "pursuant to a family planning service in a family planning setting."[28] These services receive the state's regular FMAP rate.

To assist states in navigating the SPA application process, in October, NFPRHA, in conjunction with Rachel Gold from the Guttmacher Institute and Rian Frachele from the Oregon Department of Human Services, released a memo summarizing all guidance that CMS had provided—in writing and verbally—to date on family planning SPAs.

By the end of 2010, several states—including Wisconsin, South Carolina, and California—had applied to convert their state's family planning waiver into a SPA. In December, Wisconsin became the first state in the nation to have its family planning SPA approved by CMS. South Carolina's SPA application was also approved in December.

27 1905(a)(4)(C) of the Social Security Act.

28 United States, Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2010, July 2). *RE: Family Planning Services Option and New Benefit Rules for Benchmark Plans.*

Abstinence-Only Programs and Comprehensive Sexuality Education

The last two years have brought significant victories in the fight to end funding for ineffective, harmful abstinence-only programs. NFPRHA and its coalition partners not only successfully advocated for the elimination of funding for the Community-Based Abstinence Education program and the abstinence-only-until-marriage portion of the Adolescent Family Life Act, but also worked with Congress and the Obama administration to create two new dedicated funding streams for evidence-based initiatives to address the serious public health challenges posed by increased rates of teen pregnancy and STDs. Much work remains to ensure that the President fulfills his promise to end funding for programs that do not work and that Congress continues to put science before politics when it comes to the health of our nation's young people.

Federal Government Awards Multiple Grants Under New Teen Pregnancy and STD Prevention Initiatives

On April 10, 2010, HHS' Office of Adolescent Health (OAH) announced the first round of grants available under the new Teen Pregnancy Prevention Initiative (TPPI). TPPI, which was created as part of the Consolidated Appropriations Act of 2010 and funded at $110 million, provides competitive grants to public and private entities for evidence-based programs that reduce teen pregnancy. Under this initiative, $75 million was made available 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 was allocated for "research and demonstration grants to develop, replicate, refine, and test additional models and innovative strategies for preventing teenage pregnancy."

On September 30, HHS announced that $155 million in evidence-based teen pregnancy prevention grants was awarded to states, non-profit organizations, school districts, universities, and others. TPPI grants were awarded in two tiers: (1) replication of evidence-based programs and community-wide programs or (2) innovative approaches. Fifty-five million dollars of the awarded amount went to grants available through the Personal Responsibility Education Program (PREP), which was created through the ACA. PREP provides states with $55 million per year for five years for evidence-based teen pregnancy, STD and HIV prevention programs.

President and Congress Continue To Support Comprehensive Sexuality Education Programs

While HHS was preparing grant applications for the first round of pregnancy and STD prevention grants under the TPPI and PREP, the President and Congress began work on the FY 2011 budget and appropriations process. President Obama's FY 2011 budget request was a clear reflection of his administration's continued commitment to funding comprehensive, medically accurate sexuality education programs. The President's budget requested $129 million for TPPI, an increase of $19.2 million over FY 2010 levels. The funding structure for the FY 2011 TPPI mirrored that of FY 2010, with $85,000,000 designated for "replicating programs that have been proven effective through rigorous evaluation," and $28,000,000 reserved for research and demonstration grants. An additional $16 million was provided for program support, training, technical assistance and evaluation. In addition to the TPPI, the FY 2011 budget request included $50,000,000 for PREP in mandatory funds for states, territories and tribes to use for teen pregnancy prevention.

Both the House and Senate Appropriations Committees began their work drafting the annual appropriations bills using the President's budget as a guide. On July 15, the House Labor-HHS Appropriations Subcommittee met to mark up its FY 2011 Labor-HHS Appropriations bill. The Subcommittee draft of the bill, included $129.2 million for TPPI, an increase of $19 million over FY 2010 levels and equal to the President's budget request. On July 27, the Senate Labor-HHS Appropriations Subcommittee approved the FY 2011 Labor-HHS Appropriations bill with $118 million in funding for the

TPPI, an increase of $8 million over FY 2010 levels, and $11 million below the President's budget request. However, because the 111th Congress ended without passing its annual appropriations bills and only passing a CR to fund the government through March 4, 2011, the TPPI ended the year with funding at FY 2010 levels.

The Return of Abstinence-Only Programs

While the ACA created the PREP program, it also restored the Title V State Abstinence Grant Program, which had expired on June 30, 2009. The program, which will provide $50 million per year for five years to states, requires grantees to focus on abstinence promotion to the exclusion of other topics and embraces an abstinence-only-until-marriage definition, meaning that states cannot use these funds to implement comprehensive sex education. The renewal of these grants, which have been repeatedly proven ineffective and in some cases harmful to students, was deeply disappointing and contradicts the evidence-based interventions that are the focus of both TPPI and PREP. NFPRHA and its coalition partners will continue the fight to eliminate this program just as it did with the Community-Based Abstinence Education (CBAE) program.

Pregnant and Parenting Teen Bills and Teen Pregnancy Rates

On May 28, 2010, CDC Director Thomas Frieden met with a group of congressional staffers to discuss the nation's most pressing public health concerns, and listed teen pregnancy prevention as one of six "winnable" public health battles of our time. According to data released early in 2010 by the CDC, the overall teen birth rate among 15-to-19 year-olds rose 3 percent between 2005 and 2006. While there is considerable debate among public health officials on the causes for the increase, it is widely acknowledged that the higher rates of teenage pregnancy is not just a public health crisis, but that it has significant social economic impacts as well, including increased high school drop-out rates and higher levels of poverty.

Several bills were introduced in the 111th Congress intended to prevent teen pregnancy or provide various support mechanisms to teen parents. The "Pregnant and Parenting Students' Access to Education Act," introduced by Representative Jared Polis (D-CO), would provide grants to states and local school districts to address the academic and social needs of pregnant and parenting teens to improve graduation rates among this population. The "Teen Parent Graduation and College Achievement Act," introduced by Representative Judy Chu (D-CA), would provide grants to help pregnant and parenting teens stay in school.

NFPRHA worked with Rep. Chu to introduce the Teen Parent Graduation and College Achievement Act. The grants authorized by the bill would be used for tutoring, pregnancy-related health care, child care, transportation, after-school support, academic counseling and family planning services.

The "Prevention First Act," introduced by Majority Leader Harry Reid (D-NV) in the Senate and Representatives Louise Slaughter (D-NY) and Diana DeGette (D-CO) in the House, would expand access to family planning services, education and counseling to help women, including teens avoid unplanned pregnancy. The "Preventing Unintended Pregnancies, Reducing the Need for Abortion and Support Parents Act," introduced by Representatives Tim Ryan (D-OH) and Rosa DeLauro (D-CT), would increase funding for the Title X family planning program and establish new supports for pregnant and parenting women. None of these bills came to a vote by the end of 2010.

DASH (Almost) Eliminated by the Senate

In a surprise move that frustrated many sexuality education and family planning advocates, the Senate Labor-HHS Appropriations Committee eliminated funding for the Division of Adolescent School Health (DASH) program at the CDC and instead folded it into an existing $250 million disease prevention initiative focused on obesity prevention activities.

The DASH program supports various school-based activities, ranging from asthma management to nutrition and obesity prevention, and is designed to improve the health and well-being of students across the country. Unlike other school-based health programs, however, DASH has a specific component dedicated to the prevention of STDs and unintended pregnancy by tracking and monitoring activities addressing these problems. Proponents of the move to eliminate the dedicated funding stream for DASH argued that states would access other funding from the CDC to continue their sexuality health school-based programs.

Thankfully, Congress' failure to finalize its FY 2011 appropriations bills, instead passing a CR at FY 2010 levels, meant that at the end of 2010, DASH retained its separate, dedicated funding stream.

Access to Abortion Care

2010 was perhaps the worst year on record for abortion rights in America. Anti-choice members of Congress continued to use a woman's right to choose as a wedge issue in the health care reform debate and beyond. With the GOP's significant gains in state legislatures, governorships and Congress, the attacks on access to abortion care will not end anytime soon.

The Nelson Language in the ACA

Health care reform, including the abortion restrictions passed by the House and Senate at the end of 2009, began on uncertain footing in 2010. The Senate bill, passed on the morning of December 24, 2009, contained abortion restrictions inserted to help garner Senator Ben Nelson's (D-NE) vote, the last one needed to clear a filibuster-proof 60-vote threshold and allow for a vote on passage. The Senate provision, or "Nelson language" as it is known, placed arbitrary restrictions on abortion services requiring individuals who purchase an insurance plan that includes abortion coverage to make two separate payments—one for abortion coverage and one for everything else. The Nelson language also provides a significant disincentive to insurance companies that wish to provide coverage of abortion by requiring plans participating in the new health care exchanges to segregate funds used for abortion services from all other funds..

The 2009 House-passed health care reform legislation went even further, containing the "Stupak-Pitts amendment," which would have effectively prohibited both private and public insurance plans in the health care exchanges from covering abortions. This amendment would have excluded abortion from any benefits package, denying this service to millions gaining coverage and forcing millions more to lose the abortion coverage they already had.

The Democrats' loss of its filibuster-proof majority in the Senate[29] temporarily stalled the health care reform process early in 2010, as congressional leaders grappled with how to secure the votes needed for passage. Congress finally moved forward with a plan for the House to pass the Senate's bill, and then to craft a "corrections" bill under budget reconciliation rules (requiring just 51 Senate votes instead of 60) to be passed first by the House and then by the Senate. This process allowed the House to address some of its concerns with the Senate bill, but made the Senate's ACA the base bill for health care reform.

Unfortunately, under budget reconciliation rules, only provisions that have a budgetary impact can be considered. This meant that in areas where the corrections bill was silent, the Senate bill language would remain in place—meaning that the Nelson language on abortion could not be changed under reconciliation. Before signing the corrections bill into law, President Obama signed an executive order that directed the White House Office of Management and Budget (OMB) and HHS to develop a set of segregation guidelines for state health insurance commissioners. On September 20, OMB issued these guidelines regarding the segregation of payments for abortion coverage for insurance plans in the state-based exchanges created under the ACA. The guidelines require health plans to submit a plan that explains their segregation processes and accounting systems for keeping abortion payments separate from payments for other services. The guidelines also require insurance commissioners to collect annual assurance statements from the insurers of health plans attesting to their compliance with segregation requirements, and to conduct periodic audits to verify compliance and maintain a file of those audits.

President Obama Signs Executive Order Reaffirming Abortion Restrictions in the ACA

Despite the Nelson language, some anti-choice members of Congress were unwilling to support the ACA and the reconciliation bill without the President also issuing an executive order further confirming the restrictive abortion language in the bill.[30] On March 24, President Obama signed *Executive Order 13535 – Ensuring Enforcement and Implementation of Abortion Restrictions in the Patient Protection and Affordable Care Act.* While the executive order essentially affirms the restrictions that were already passed into law, the fact that President Obama affirmed these abortion restrictions which harm women was another disappointment.

29 For more on the filibuster, see "Health Care Reform" beginning on page 8.

30 For more on the process that led to the executive order, see "Health Care Reform" beginning on page 8.

Administration Bans Coverage of Abortion in New High-Risk Insurance Pools

In another setback for abortion coverage in health care reform, on July 30, HHS published an interim final rule outlining how the Pre-Existing Condition Insurance Plan (PCIP) would be administered. The PCIP is a health insurance plan administered by either the federal government or a state for uninsured individuals with a pre-existing condition. Also known as "high-risk pools," the PCIP was created by the ACA to be a temporary bridge for millions of uninsured Americans who have had trouble accessing health care coverage because of a pre-existing medical condition. The law assumes that in 2014 these individuals will be eligible for other coverage options through newly created state-based insurance exchanges.

Unfortunately, the July 30 rule prohibited all PCIP plans from covering abortion services, regardless of whether the coverage is paid for with private funds. The Obama administration decided to apply a restriction not required by law to the PCIP. The federal restriction may prove problematic for states that intend to provide abortion coverage for women who have routinely had difficulty accessing comprehensive insurance coverage.

FY 2011 Budget and Appropriations

Unlike in his FY 2010 proposed budget, President Obama's FY 2011 proposed budget failed to strike any federal prohibitions on abortion access and coverage affecting a broad spectrum of women and their families, including: Medicaid-eligible women and Medicare beneficiaries, federal employees and their dependents, Peace Corps volunteers, Native American women and women in federal prisons. These restrictions are known as "riders," and must be passed each year with the appropriations bills. When President Obama struck two abortion-related riders from his FY 2010 proposed budget, he signaled his desire to eliminate the provisions, and Congress followed his lead by taking steps to eliminate the provisions.

The President's budget also failed to signal support for the repeal of the abortion ban at U.S. military facilities. However, there was still progress on this issue. On May 29, 2010, during the Senate Armed Services Committee mark-up of the National Defense Authorization Act, Senator Roland Burris (D-IL) offered an amendment that would repeal the ban on using private funds to obtain abortions at military treatment facilities. Prohibiting women from using their own money for abortion services endangers their health, safety and dignity. Under current law, servicewomen and military dependents can access abortion services at military facilities only in the cases of life endangerment, rape, or incest. The Burris amendment passed 16 – 10, but was unfortunately not included in the final legislation.

> NFPRHA requested that congressional appropriators strike from the FY 2011 appropriations bill language restricting funding of abortion services for Medicaid-eligible women. As an advocate for the low-income, NFPRHA deplores the denial of access to these services for women who depend on the federal government for their health care needs.

While abortion riders remained in the appropriations bills, several anti-choice amendments were defeated during the mark-ups of various appropriations bills. During the July 15 House Labor-HHS Appropriations Subcommittee mark-up, Ranking Member Todd Tiahrt (R-KS) offered an amendment that was essentially the same as the Stupak-Pitts Amendment offered during health care reform. The Tiahrt amendment was defeated 5 - 11 along party lines.

During the July 29 Senate Appropriations Committee mark-up of the State, Foreign Operations, and Related Programs (State-Foreign Ops) bill, Senator Frank Lautenberg (D-NJ) offered an amendment that would codify the repeal of the Global Gag rule.[31] Lautenberg's amendment passed 19 – 11 with Democratic Senator Ben Nelson (D-NE) voting against it but Republican Senators Susan Collins (R-ME) and, somewhat surprisingly, Lisa Murkowski (R-AK) voting in favor. Because the State-Foreign Ops bill was never voted on by the full Senate or the House, the Lautenberg amendment did not become law.

Abortion in the States

In 2010, more than 950 measures related to reproductive rights were introduced in DC and the 44 states in which the legislatures convened.[32] By the end of the year, 89 new laws had been enacted in 32 states and DC.[33] Most, though not all, of these were anti-choice laws and included abortion bans and abortion coverage bans, restrictions on state funding, mandatory waiting periods and required ultrasounds, expanded refusal clauses, and

31 One of President Obama's first acts upon taking office in 2009 was to issue an executive order repealing the Global Gag rule. 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.

32 Gold, R., & Nash, E. (2011, January 7). State Legislative Trends in 2010: Abortion Restrictions Once Again Dominate. *RH Reality Check*.

33 *Ibid*.

laws which make it more difficult for clinics to operate.[34] In a notably positive move, DC resumed its funding of abortion services for low-income women using its own, locally raised revenue, which it had been prohibited by Congress from doing since the 1980s.[35]

An important trend in 2010 was the introduction of legislation in 14 states to ban abortion coverage either in private insurance or in the state insurance exchanges. AZ, LA, MS, MO and TN enacted such laws; bans were vetoed in FL and OK.[36]

April 2010 saw one of the most controversial acts of the year, when Nebraska enacted a law banning abortion at 20 weeks' gestation, except in cases when the woman's life is endangered or her physical health is severely compromised.[37] The law runs contrary to U.S. Supreme Court decisions which hold that states may ban abortions only after viability and must include exceptions for the life and health of the woman. The law went into effect in October.

Elena Kagan Becomes Newest Supreme Court Justice

On May 10, President Obama announced the nomination of Solicitor General Elena Kagan to the Supreme Court to fill the seat of retiring Justice John Paul Stevens. Kagan was the first woman in history to serve as Dean of Harvard Law School, and the first woman to serve as Solicitor General. During the Clinton administration, Elena Kagan served as Counsel to President Clinton and as Deputy Director of the Domestic Policy Council. Despite moderate opposition, the Senate voted on August 5 to confirm Kagan by a vote of 63 – 37. Kagan is the first justice since William Rehnquist in 1972 to be confirmed without having served as a judge on a lower court and is only the fourth woman to serve on the Supreme Court.

While her personal views on the right to choose are not known, during her testimony Kagan demonstrated a respect for precedent and the reproductive rights community embraced her nomination and confirmation to the bench. In documents released by the Clinton administration archives, Kagan at that time opposed the so-called "partial-birth abortion ban" as unconstitutional unless it were to include exemptions for cases where there would be "serious adverse health consequences" for the woman.[38]

Two Bills to Ban Abortion Coverage Introduced in Congress

Emboldened by restrictions on abortion coverage and care in the ACA, anti-choice legislators introduced bills in both chambers of Congress that were designed to further undermine women's access to abortion services.

On July 29, Representative Chris Smith (R-NJ) introduced the "No Taxpayer Funding for Abortion" Act, which pledged to "prohibit taxpayer funded abortions and to provide for conscience protections." The bill (H.R. 5939), which had 186 co-sponsors at the close of the 111th Congress, would go well beyond current restrictions on abortion coverage and access, including those set to take effect as part of the implementation of the ACA. The bill would impose a broad ban on abortion coverage, prohibiting "funds authorized or appropriated by federal law" and non-federal funds "in any trust fund to which funds are authorized or appropriated by federal law" from being "expended" for any abortion. No federal funds could go to a health benefits plan that cover abortions, and the bill would prohibit any taxpayer benefit (such as through personal health savings accounts) from applying to abortion. The bill would also prohibit any federally owned or operated facility or federal employee from providing abortions, and would even ban the use of a state or locality's private funds from covering abortion services for low-income women through Medicaid.

In the Senate, Senator Tom Coburn (R-OK) introduced a similarly intentioned bill on August 5, which had 27 co-sponsors at the end of the 111th Congress. Sen. Coburn's bill (S. 3723), the "Excluding Abortion Coverage from Health Reform" Act, sought to amend the ACA to include the Stupak abortion ban, which would effectively prohibit both private and public insurance plans from covering abortion.

Although no votes were scheduled on either bill by year's end, they represent the kinds of attacks expected when Congress returns in 2011.

34 *Ibid.*

35 The ban on DC's use of its own funds to provide abortion services was eliminated by Congress during the FY 2010 appropriations process in 2009.

36 The Guttmacher Institute. (2010, December 31). *Monthly State Update: Major Developments in 2010.*

37 *Ibid.*

38 Stein, S. (2010, June 14). Elena Kagan Documents Leave Pro-Choice Group Pleased. *The Huffington Post.*

Family Planning Services and Supplies

Family planning services, including contraceptive drugs, devices and counseling, are a fundamental part of preventive health care. These services have been proven to improve health outcomes while simultaneously reducing the cost of health care provision. In 2010, the FDA approved several new contraceptive methods, while the CDC issued long-awaited guidelines regarding contraceptive use.

CDC Releases Medical Eligibility Criteria for Contraceptive Use

In May, the CDC released the long-awaited U.S. Medical Eligibility Criteria for Contraceptive Use (USMEC). The USMEC is the result of a formal adaptation process by the CDC of the World Health Organization's (WHO) Medical Eligibility Criteria for Contraceptive Use, the first edition of which was published in 1996. The WHO's document was designed to provide evidence-based guidance on the safety of contraceptive method use for women with specific characteristics and medical conditions.

The CDC has now adapted this document to assist U.S. family planning providers when counseling women, men and couples about contraceptive method choice. The adaptation process was spearheaded by CDC's Division of Reproductive Health, and involved a number of partner organizations, including NFPRHA. The USMEC was released in the May 28, 2010, edition of CDC's Morbidity and Mortality Weekly Report (MMWR).[39]

Ella Approved in U.S.

On August 13, 2010, the FDA approved a new form of emergency contraception for prescription use in the United States. With a unanimous vote by the FDA's Advisory Committee for Reproductive Health Drugs just two months earlier, the 30 mg tablet of ulipristal acetate, better known by its market name "ella," was praised as a new and effective method for the prevention of unintended pregnancy.

Prior to the decision, family planning and reproductive health advocates fought an uphill battle to correct misinformation from the anti-family planning community, which labeled ella an abortifacient rather than a form of emergency contraception that worked to inhibit or delay ovulation. Nevertheless, reproductive and sexual health advocates successfully made the case for the pill as a strong and important addition to the prescription drug market with the ability to prevent an unintended pregnancy longer than its levonorgestrel counterparts—up to five days or 120 hours after unprotected set.

Speaking in front of the FDA Advisory Committee for Reproductive Health Drugs in June, NFPRHA President & CEO Clare Coleman joined other family planning and sexual health organizations in testifying, urging the panel to consider the importance of access, safety and affordability when approving ella. She stated, "NFPRHA believes that women, and the men with whom they share responsibility for preventing unintended pregnancy, should have access to as many safe and effective options as possible. We also believe that these options must be affordable. The vast majority of Title X patients NFPRHA members serve at safety-net health centers across the country have incomes under $17,600 for a family of three."

Ella, which is sold and marketed by California-based Watson Pharmaceuticals,[40] became available to the public on December 1 at the wholesale price of $35.75. Women in the U.S. can obtain ella only through a prescription.[41]

39 United States, Department of Health and Human Services, Centers for Disease Control and Prevention. (2010, May 28). U.S. Medical Eligibility Criteria for Contraceptive Use, 2010: Adapted from the World Health Organization Medical Eligibility Criteria for Contraceptive Use, 4th Edition. *Morbidity and Mortality Weekly Report.* [MMWR Early Release].

40 Stein, R. (2010, August 14). FDA approves ella as 5-day-after emergency contraceptive. *The Washington Post.*

41 Stein, R. (2010, December 1). Controversial 'ella' contraceptive now available in U.S. for first time. *The Washington Post.*

Natazia: A New Oral Contraceptive

On May 6 Bayer Pharmaceuticals won approval for a new combined oral contraceptive pill, "Natazia," which will become the first four-phase oral contraceptive to be sold in the U.S. Four-phase oral contraceptives like Natazia work by providing different levels of estrogen and progestin throughout a 28-day cycle. Until Natazia's approval, all oral contraceptives contained ethinyl estradiol, but Natazia uses a combination of estradiol valerate and a progestin called dienogest. Walgreens and Target pharmacies stocked Natazia at $86.99 and $89.99 respectively.[42]

Counterfeit IUDs

In late June, it was reported that at least three medical practices in Rhode Island had been implanting Mirena or ParaGard intrauterine devices (IUDs) that were not FDA-approved. The practices obtained the IUDs from international sources, though it was not immediately clear whether the devices were approved for use in the other countries or were counterfeit. By mid-July, details began to emerge, revealing that as many as 10 percent of all obstetrician-gynecologists in the state of Rhode Island were importing IUDs from Canada.[43]

The counterfeit IUD problem uncovered a bigger issue facing consumers and providers alike. For years, a clear disconnect had existed between the expense of IUD provision and an increased demand for the devices among U.S. women, a problem which has only been exacerbated by the recession. Though IUDs have gained popularity, the devices still remain expensive and difficult for family planning providers to store for long periods of time. As a result, many providers and centers stopped carrying the devices altogether, therefore limiting the contraceptive choices being offered to patients.

In some cases, doctors began to look to IUDs manufactured in other countries as a way to provide a lower-cost contraceptive device. The FDA issued a statement after news broke about what had been happening in Rhode Island, and sent a letter to providers cautioning them of the safety hazards associated with IUDs not approved by the agency. The FDA is continuing to monitor the sale of IUDs, and has sought public assistance to help regulate the sale of counterfeit medical products.

New Recommendations for the HPV Vaccine

On May 28 the CDC's Advisory Committee on Immunization Practices (ACIP) recommended that a three-dose human papillomavirus (HPV) vaccine be administered routinely to all females 11-12 years of age, as well as 13- to 26-year-olds who were not previously vaccinated. On the same day, the ACIP recommended use of the quadrivalent HPV vaccine for males on a permissive basis, allowing but not universally recommending the vaccine for males.[44]

In August, the American College of Obstetricians and Gynecologists (ACOG) released new recommendations on the two types of FDA-approved HPV vaccines. ACOG suggests HPV vaccinations can be administered to girls as young as nine, but recommends the vaccinations for females beginning at 11 years of age, with "catch up" vaccinations between the ages of 13-26 for females not previously vaccinated. ACOG stresses the importance of vaccinations before exposure to STDs and lower the risk of cervical cancer, but still recommends vaccination for women and girls that are sexually active. While it is unlikely that a woman would be exposed to all forms of HPV, she may still benefit from vaccination as a preventive measure against contracting other strains.[45]

On December 22, the FDA approved the HPV vaccine Gardasil as a preventive measure against anal cancer and precancerous lesions for both men and women ages 9 to 26. Gardasil was approved in 2006 for the prevention of cervical, vulvar, and vaginal cancer in women, and in 2009 for the prevention of genital warts in both men and women. Advocates for gay men's health applauded the December approval for its potential to help prevent anal cancer in high-risk populations, such as gay and bisexual men.

42 AHC Media LLC. (2010, September 1). Estradiol valerate, dienogest OC gets nod. *Contraceptive Technology Update.*

43 Freyer, F. (2010, July 18). Rhode Island IUD scandal tip of iceberg. *The Providence Journal.*

44 Society for Adolescent Health and Medicine. (2010, June 17). Human Papillomavirus (HPV) Vaccine: An Updated Position Statement of the Society for Adolescent Health and Medicine.

45 The American College of Obstetricians and Gynecologists (2010, September). *Committee Opinion Number 467.*

STD and HIV/AIDS Prevention

According to the CDC, nearly 19 million Americans contract an STD every year. Half of all new infections occur in young people between the ages of 15 and 24.[46] Even though STDs are very common and add approximately $14.7 billion to America's health care costs each year,[47] most Americans are uneducated about the risks associated with these infections and how best to prevent them. While initiatives to prevent STDs have been chronically underfunded by Washington, 2010 marked some improvement in the federal government's commitment to these programs.

CDC Updates STD Treatment Guidelines

In December, the CDC issued updated guidelines for the treatment of STDs, *Sexually Transmitted Diseases Treatment Guidelines—2010*. The new guidelines, published in CDC's MMWR, provide an update to the 2006 treatment guidelines, and serve to advise clinicians on most effective diagnostic evaluation, treatment regimens, and prevention and vaccination strategies. The changes from the 2006 guidelines include new treatment recommendations for bacterial vaginosis and genital warts, assessments of the clinical efficacy of azithromycin for chlamydial infections in pregnancy and recommendations for diagnostic evaluation after sexual assault. The 2010 guidelines also update information on several antibacterial-resistant infections, an emerging problem in the study of STDs. The guidelines were developed through literature review and input from health professionals during a meeting in 2009 in Atlanta.

FY 2011 Appropriations

On July 15, the House Labor-HHS Appropriations Subcommittee met to mark up its FY 2011 Labor-HHS Appropriations bill. CDC's Division of STD Prevention, which has been seriously underfunded in recent years, received a significant increase of $8.3 million, which would bring the total funding to $162.3 million for FY 2011. This represents a $1.7 million increase over the President's budget request. On July 29, 2010, the Senate Labor-HHS Appropriations Committee approved the FY 2011 Labor-HHS Appropriations bill with a $6.7 million increase for the Division of STD Prevention, for a total of $160.6 million. This is $1.7 million less than the House bill. Unfortunately, an increase was never realized due to Congress' failure to pass its FY 2011 appropriations bills, and funding for the program remains at its FY 2010 level.

NFPRHA asked congressional appropriators to increase funding to the Division of STD Prevention by $213.5 million, for a total appropriation of $367.4 million. NFPRHA also requested an additional $10 million for the Infertility Prevention Project (IPP) at CDC, which provides funding to screen low-income women for Chlamydia in STD and family planning health centers.

AIDS Prevention Policy

On July 13, 2010, the White House released its National HIV/AIDS Strategy, which outlines three major goals: 1) reducing the number of people who become infected with HIV; 2) increasing access to care and optimizing health outcomes for those infected; and 3) reducing health disparities for people living with HIV. The administration's new plan sets an aggressive goal of reducing HIV infections by 25 percent over the next five years, and redirects funding to the most at-risk populations of contracting the virus. The White House also released an implementation plan of actions to be taken by key federal agencies, including the CDC and the Agency for Healthcare Research and Quality (AHRQ), to achieve the goals outlined in the National Strategy.

46 United States, Department of Health and Human Services, Centers for Disease Control and Prevention. (2009, November). *Sexually Transmitted Disease Surveillance, 2008*. Atlanta, GA: U.S. Department of Health and Human Services.

47 United States, Department of Health and Human Services, Centers for Disease Control and Prevention. (n.d.). *Trends in Reportable Sexually Transmitted Diseases in the United States, 2006*. Atlanta: U.S. Department of Health and Human Services.

A National HIV/AIDS Strategy was released after more than a year of collaboration between the White House Office of National AIDS Policy (ONAP), the President's Advisory Council on HIV/AIDS (PACHA) and activists across the country. While the strategy is long over-due and urgently needed, there is considerable concern among advocates that it reallocates existing funding to different populations or geographic regions of the country, rather than calling for increased resources to achieve its stated outcomes.

As a complement to the National Strategy, the CDC announced on August 3 that it would award $42 million to 133 community-based organizations to support HIV prevention. The average award will be approximately $323,000 per year for five years and targeted towards groups at high risk for infection including African-Americans, Latinos, gay and bisexual men, and injection-drug users.[48]

48 Pecquet, J. (2010, August 3). Federal Government Announces $42 million in HIV Prevention Grants. *The Hill*.

A Look Ahead

January 21, 2011

The 112th Congress is a significantly more hostile environment for family planning and reproductive health policy than the 111th. The 2010 midterm elections ushered in many new members with political philosophies that are antithetical to the policy priorities of NFPRHA and its members. The difficult political climate will challenge NFPRHA and the reproductive health community to work strategically, on and off Capitol Hill, to protect the policies and programs needed to ensure that the millions of poor and low-income individuals seeking services in a safety-net setting can still receive care.

In the 112th Congress, Republicans hold 242 seats in the House while Democrats hold 193, giving the GOP a 25-vote majority.[49] Conservative Representative John Boehner (R-OH) controls the gavel as Speaker of the House. In the Senate, Democrats hold a majority with 53 seats, and Senator Harry Reid (D-NV) continues in his role as Majority Leader. Former House Speaker Nancy Pelosi (D-CA) also continues in her role as the House Democratic Leader, and Senator Mitch McConnell (R-KY) serves as Republican Leader in the Senate.

The leadership in both chambers will impact the successes or failures of policies that promote family planning access; however, most of the battles over public health policy will be fought in the congressional committees. Representative Harold Rogers, (R-KY) is the new chair of the House Appropriations Committee, and Representative Norm Dicks (D-WA) is the Ranking Member. Representative Rogers has been a long-time adversary of the Title X program and has routinely cosponsored legislation authored by Representative Mike Pence (R-IN) that would strip all Planned Parenthoods of Title X funding (more commonly known in previous years as the "Pence amendment"). Although the Pence amendment was overwhelmingly defeated in previous Congresses with bi-partisan support, Representative Pence's bill (H.R. 217, introduced on January 7, 2011) is likely to pass the House in some form in 2011. Additional provisions harmful to family planning and abortion could also be added during the appropriations process in the House.

Most family planning advocates agree that the Senate and the White House will need to stand as the firewall against anti-family planning and reproductive health policies that may come out of the House. Along with the anticipated attacks, funding will also pose a significant challenge. Republicans and Democrats alike are advocating for cuts to the nation's discretionary spending, particularly as the recession drags on. President Obama requested small increases for the Title X program over the past two years, but has been vocal about the need to trim the federal budget and is expected to make cuts to many domestic programs in his FY 2012 proposed budget, due in February 2011.

Although the budget and appropriations processes will require special attention in the 112th Congress, the big public health discussions will center on the ACA. Republicans pledged during the 2010 campaign to repeal the ACA and replace it with a more conservative health reform bill. On January 19, the House voted to repeal the ACA by a vote of 245-189, almost completely along party lines—only three Democrats voted for repeal. Following the vote, the House turned to replacement, voting to direct four House committees to draft alternatives to the ACA. As of this writing, the Senate is not expected to repeal the ACA. In the event that a repeal bill does pass the Senate at some future date, President Obama has stated he will veto the bill.

Any ACA-replacement bill(s) will likely include policies limiting access to family planning services and banning insurance coverage of abortion. Representative Joseph Pitts (R-PA), who coauthored the Stupak abortion amendment during the ACA debate, is the Chair of the Health Subcommittee of the House Committee on Energy and Commerce, and it is expected that he will have the votes needed to move a new version of the Stupak amendment through the House. Anti-choice members of Congress—with the support of the Republican leadership—are likely to offer numerous measures in 2011 attacking abortion care, such as Representative Christopher Smith (R-NJ)'s "No Taxpayer Funding for Abortion" Act, which would ban any federal funds from being used for abortions. In a joint press conference on January 20, Speaker Boehner announced that Representative Smith's bill would be given the designation H.R. 3—bills numbered 1-10 are reserved for the Speaker of the House, and generally denote top priorities of the party in

49 218 seats are required to hold a majority in the U.S. House of Representatives.

power. According to Speaker Boehner, the bill would "make clear that taxpayer funding of elective abortion will not be the policy of this government."

The legislative fights that loom in the 112th will play out against the backdrop of a nation that is still struggling to gain its financial footing. Both the federal government and state governments are making cuts to their budgets at a time when people are increasingly dependent on governmental programs. The nonprofit Center on Budget and Policy Priorities reports that 46 states made up an FY 2011 budget gap totaling $130 billion by slashing spending and cutting vital public health and other social services, and 44 states and DC are projecting budget gaps totaling $125 billion for FY 2012.[50]

At the federal level, House Republicans are looking to make significant cuts to federal domestic funding, beginning in the remainder of FY 2011. On January 20, the House Republican Study Committee, which helps direct Republican decisions on policy matters, unveiled a proposal to reduce federal spending by $2.5 trillion over ten years. The "Spending Reduction Act of 2011" would cut FY 2011 non-security discretionary spending back to FY 2008 levels, and further cut funding for these programs back to FY 2006 levels for ten years beginning in FY 2012. Most notably, the bill calls for the elimination of numerous programs, including Title X.

NFPRHA is preparing for a number of public policy tests in 2011. Many members of Congress will continue to declare family planning a controversial issue and try to limit access to family planning care for their constituents. Fortunately, public health evidence is on the side of family planning care, and with that evidence and the support of its membership, NFPRHA will continue to advocate for greater access to the quality care that family planning providers deliver to millions of people throughout the country.

50 McNichol, E., Oliff, P., & Johnson, N. (Updated 2011, January 21). *States Continue to Feel Recession's Impact*. Washington, DC: Center on Budget and Policy Priorities.

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 40 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.

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