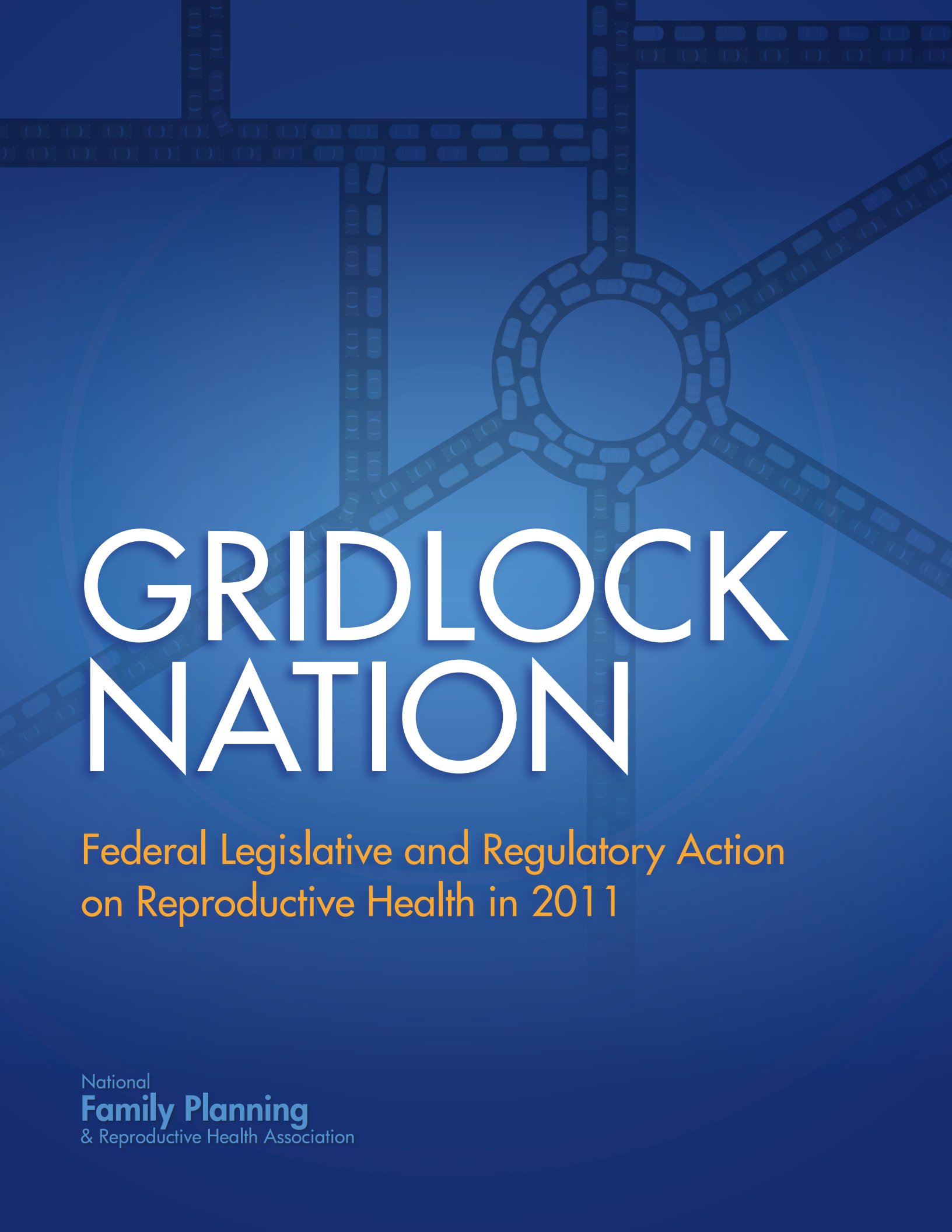

GRIDLOCK NATION

Federal Legislative and Regulatory Action on Reproductive Health in 2011

National
Family Planning
& Reproductive Health Association

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Introduction

The introduction of NFPRHA's 2010 federal legislative report, *Breakthrough/Breakdown*, concluded by saying, "[T]he 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 did not take long for those words to be proven right. The consequences of the 2010 elections made a powerful impact in Washington, DC, and around the country, as a wave of newly elected officials swept into the halls of power intent on downsizing government, slashing spending, and derailing 2010's landmark federal legislation, the "Affordable Care Act" (ACA).

The biggest Capitol Hill story of the year, however, was not all the things the new Congress did, but instead all that they *did not* do. In 2011, the United States became a *Gridlock Nation*, with Congress locked in an unending stalemate over anything and everything. The stage was first set when, within weeks of taking office, the US House of Representatives' newly minted Republican majority announced plans to cut $100 billion in federal spending. Those plans culminated in H.R. 1, a continuing appropriations bill to fund the remainder of fiscal year (FY) 2011 – which formally began on October 1, 2010. Among other major cuts, H.R. 1 called for the complete elimination of the Title X national family planning program and the defunding of Planned Parenthood.

H.R. 1 was the opening salvo in a protracted war over the size and scope of government spending. The federal government came within hours of shutting down over and over again in the spring of 2011 before a deal on FY 2011 spending was finally reached. Title X and Planned Parenthood survived, though not without cost, and safety-net programs experienced significant funding cuts. Not content with the cuts made in the FY 2011 spending fight, House Republicans quickly turned their attention to the nation's growing debt. In April 2011, the House passed an FY 2012 budget that called for trillions of dollars in federal spending cuts over ten years, with proposed savings generated in part from major changes and cuts to Medicare and Medicaid.

The debate over the perceived need to cut federal spending was further fueled by an impending congressional vote to raise the nation's debt ceiling to avoid default. What is usually a routine congressional act became a politically charged nightmare in the summer of 2011, with the most conservative of the House Republicans making clear their intention to block any vote to raise the debt ceiling without making substantial cuts to spending. As the clock on the nation's debt limit ticked down, Congress and the White House attempted to negotiate in bipartisan committees in an effort to overhaul federal spending and bring down the nation's debt.

The biggest question was not how much spending would be cut, but *how* it would be cut. Democrats decried rumored cuts to Medicare, Medicaid, and Social Security, while Republicans stood firm against any tax increases and to holding the debt ceiling hostage. The White House consistently pressed Congress to put forward a "balanced approach" that would generate savings from a mixture of cuts to programs like Medicare and defense and revenue raised through increased taxes, preferably on wealthier Americans. As Congress approached the August recess and came dangerously close to a default on the nation's loan obligations, the framework of a workable plan emerged in the form of the "Budget Control Act" (BCA).

The BCA included $917 billion in scheduled cuts to non-security discretionary spending over ten years beginning in FY 2012, and also contained a complicated mechanism by which President Obama could raise the nation's debt limit. In addition to the cuts contained in the bill, the BCA established a bi-partisan committee - the Joint Select Committee on Deficit Reduction, or so-called "Super Committee" – which was tasked with recommending $1.2 to $1.5 trillion in further spending reductions over the next ten years through any combination of cuts to discretionary funds, increased revenue, or cuts to entitlement spending.[1] If a bill that included at least $1.2 trillion in cuts was not signed into law by January 15, 2012, a series of automatic across-the-board cuts to federal spending would be triggered beginning in January 2013, to be divided

between defense and non-security discretionary spending. The addition of the defense cuts was intended to incentivize Republicans to agree to some revenue-raising policies. Under the BCA, Social Security, Medicaid, Medicare benefits, unemployment insurance, and additional programs for low-income families and civilian and military retirement were exempted from the automatic cuts.

Congress passed the BCA with the same level of drama that accompanied the FY 2011 spending debate.[2] The bill passed at the eleventh hour, just in time to prevent the US from defaulting on its debts, and Congress quickly adjourned for a month-long recess. Congress returned in September to face two major pieces of work with the potential to have significant implications for the Title X family planning program. First, the Super Committee began examining which programs would be cut to meet its legislative charge to find at least $1.2 trillion in spending reductions. Second, with the end of the 2011 fiscal year approaching, Congress needed to pass its FY 2012 appropriations bills, which had been stalled because of the debt ceiling crisis.

Recognizing that the Super Committee's decisions could impact both discretionary and mandatory family planning spending, NFPRHA organized a strategy to address cuts that could be imposed during both the appropriations and Super Committee processes. NFPRHA turned to its membership in partnership for its efforts to make the case to Congress that publicly supported family planning funding should be protected. Representatives Barbara Lee (D-CA), Mike Honda (D-CA), Nita Lowey (D-NY), and Rosa DeLauro (D-CT) - the Democratic members on the House Labor, Health and Human Services, Education, and Related Agencies (Labor-HHS) Appropriations Subcommittee - worked with NFPRHA to circulate a letter from members of Congress calling on the Super Committee to protect Title X funding. NFPRHA augmented this effort by sending Super Committee members a letter from nearly 30 allied organizations that advocated for protection of Medicaid and Title X.

Given the competing interests and intensive lobbying efforts surrounding the myriad federal programs that might be impacted by the Super Committee's work, it soon became clear that it would be next-to-impossible for the members of the Super Committee to reach a deal. In a joint statement released two days before its November 23 deadline, the Super Committee declared it would not produce a $1.2 trillion deficit reduction plan as required by the BCA. As expected, each party blamed the other for the breakdown.

Although 2011 was a year overwhelmed by the inability of Congress to move forward, some important progress was made. The Obama administration pushed forward with implementation of the ACA. Some states slashed the budgets of family planning and other safety-net programs, while others pressed forward with setting up the systems necessary to expand access to health care and coverage as required under the ACA starting in 2014. A Bush-era provider refusal rule was finally repealed (for the most part), and the US Department of Health and Human Services (HHS) adopted the Institute of Medicine's (IOM) recommendations that contraceptive methods, counseling, and associated visits be covered in new commercial insurance plans, without patient co-pays.

2012 will bring with it a new set of challenges, but also many answers and, one can hope, further victories. It was Amos Bronson Alcott who said, "Success is sweet and sweeter if long delayed and gotten through many struggles and defeats." If this is true, then surely the trials and tribulations of 2011 will make any successes in 2012 all the more sweet.

1 The Super Committee's membership was divided evenly between the House and Senate and between Democrats and Republicans. Senator Patty Murray (D-WA) and Representative Jeb Hensarling (R-TX) co-chaired the Super Committee; the remaining committee members were Senators Max Baucus (D-MT), John Kerry (D-MA), Jon Kyl (R-AZ), Pat Toomey (R-PA), and Rob Portman (R-OH), and Representatives Dave Camp (R-MI), Fred Upton (R-MI), James Clyburn (D-SC), Xavier Becerra (D-CA), and Chris Van Hollen (D-MD).

2 Budget Control Act of 2011, Pub. L. No. 112-25, 125 Stat. 240 (2011).

Publicly Funded Family Planning

Policies promoted by fiscal conservatives at the start of the 112th Congress quickly reinforced the concerns voiced by public health advocates when Republicans took control of the US House of Representatives in the 2010 midterm elections. Newly elected members of Congress claimed they were sent to Washington with a mandate to dramatically shrink the federal government.

Title X Targeted in FY 2011

Before members of the 112th Congress were sworn in, House Republicans, led by newly elected Speaker of the House John Boehner (R-OH), announced their plans to cut $100 billion from federal spending. House Majority Leader Eric Cantor (R-VA) posted a website entitled "You Cut" which encouraged Americans to propose cuts to federally funded programs.[3] Shortly after Congress was sworn in, major news outlets began reporting that the $100 billion in cuts would be based on a report issued in October 2010 by the Heritage Foundation, a well-known conservative think tank in Washington, DC. The report called for $343 billion in domestic spending cuts,[4] including the complete elimination of Title X. The report also called for the elimination of the Title V Maternal and Child Health (MCH) Block Grant and the National Health Service Corps, a federal workforce support program for clinicians in some safety-net settings.

It was not surprising that the Heritage Foundation would call for eliminating many of the social safety-net programs upon which millions of people rely. However, the public health community was stunned when House Republicans proposed a spending bill, H.R. 1 ("Full-Year Continuing Appropriations Act of 2011") for the remainder of Fiscal Year (FY) 2011 that zeroed out Title X.[5]

NFPRHA began the year preparing for a proposed cut to Title X but immediately accelerated its work after House Republicans published H.R. 1. NFPRHA staff organized a meeting of the DC-based Family Planning Coalition and, with the help of coalition partners, organized dozens of Capitol Hill visits to build a case against cuts to the Title X program and other vital safety-net and public health programs that were targeted in H.R. 1.

House Republicans compounded their attack on family planning when they allowed Representative Mike Pence (R-IN) to propose an amendment to H.R. 1 that would strip Planned Parenthood Federation of America (PPFA) and Planned Parenthood-affiliated organizations of all federal funds. Representative Pence had introduced his signature anti-Planned Parenthood bill, the "Title X Abortion Provider Prohibition Act," at the start of the 112th Congress. However, the proposed elimination of Title X in H.R. 1 removed the option for Representative Pence to launch his annual attempt to remove Title X funds from Planned Parenthood providers, so he instead proposed an amendment to H.R. 1 to bar Planned Parenthood from receiving federal funds altogether.

Working with PPFA, NFPRHA again revised its advocacy message to include the protection of Planned Parenthood in its Title X strategy. NFPRHA CEO Clare Coleman and NFPRHA member Rick Baird, CEO of Adagio Health, participated in a press conference with PPFA and several Democratic members of the House assailing the Republicans' attack on women's health.

3 "You Cut Phase II," Eric Cantor, Majority Leader, http://majorityleader.gov/YouCut/.

4 Brian Reidl, *How to Cut $343 Billion from the Federal Budget* (Washington, DC: Heritage Foundation, October 2010), available at http://report.heritage.org/bg2483.

5 Full-Year Continuing Appropriations Act of 2011, H.R. 1, 112th Cong. (2011).

Despite a vigorous debate, the House passed H.R. 1 on Saturday, February 19, 2011, by a vote of 235-189. Every Democrat and three Republicans voted against the bill. The House also passed the amendment defunding Planned Parenthood by a vote of 240-185. Seven Republicans voted against this amendment and ten Democrats supported the measure.[6]

Leaders in the Senate, however, made clear that the House bill was unacceptable to Senate Democrats. The White House also issued a "Statement of Administration Policy" threatening to veto H.R. 1 should it reach the president's desk. The Senate's and the White House's opposition to the House Republican spending bill set up what would ultimately be a seven-week debate over the federal government's priorities. Between February and April 2011, the House and Senate battled over a series of short-term spending bills to keep the government funded while Democrats and Republicans fought the larger war over the depth and focus of spending cuts. Each short-term bill contained small reductions in spending but made no cuts to safety-net programs. In early March, Senate Majority Leader Harry Reid (D-NV) introduced a Democratic alternative to the House Republican bill. In an attempt at meeting the House "halfway," the Senate bill would have cut $51 billion in spending from President Obama's originally proposed FY 2011 budget, level-funded the Title X program at $317.5 million, and restored funding for other important programs cut in the House bill including the Teen Pregnancy Prevention Initiative. Majority Leader Reid introduced the bill knowing he lacked the votes to pass the measure but wanting to present House Republicans with a negotiating alternative.

Over time it became clear, as leaders in the House and Senate met to iron out their differences, that Speaker Boehner was going to have a difficult time organizing a coalition of Republicans and Democrats in the House to pass any bill to which the Senate would agree. The House's freshman Republicans were vocal about their unwillingness to support a spending bill that fell short of cutting the $100 billion that new members promised they would cut during the 2010 midterm election. Another obstacle to a compromise was the targeted cut to the Title X family planning program and the policy riders contained in the House Republican bill, not the least of which was the defunding of Planned Parenthood.

Recognizing that Congress was more than halfway through the FY 2011 spending year, lawmakers' patience over the never-ending FY 2011 funding cycle began to wane. Participation in negotiations narrowed to President Obama, Majority Leader Reid, and Speaker Boehner. The federal government faced yet another shutdown on April 15, 2011, as news broke that the negotiating parties were close to a final FY 2011 deal but for a few politically charged items. It was not long before members of Congress and women's health advocacy groups realized that the Title X family planning program and Planned Parenthood were in the small set of items holding up a final deal.

> While this funding level represented a significant victory given House Republicans' attempt to eliminate the program, the $18.1 million cut proved to be difficult for many NFPRHA members to absorb, especially with the increased patient demand for services due to the recession. Many Title X grantees and delegates reduced staff, reduced health center hours, or limited services to compensate for the loss of federal funds.

Family planning supporters around the country, in the federal advocacy community, and Congress quickly mobilized to protect Title X and Planned Parenthood from drastic cuts. In the final FY 2011 spending bill released on April 11, 2011, Congress and the White House agreed to cut $38 billion from the federal budget, including $13 billion in cuts to programs in the Departments of Labor, Education, and Health and Human Services. Title X was ultimately cut by $18.1 million (5.5% plus an across-the-board rescission) from the FY 2010 funding level of $317.5 million, for a final FY 2011 funding level of $299.4 million.

Attacks on Women's Health Continue in FY 2012

As FY 2011 appropriations were concluded, and amid the larger debate over federal spending and the national debt, the FY 2012 appropriations cycle began with the release of President Obama's proposed FY 2012 budget in February. It was a welcome, but short-lived victory, when the president called for Title X to be funded at $327.4 million in FY 2012, an increase of $9.9 million over the FY 2010 level.

6 Republicans voting against: Charles Bass (NH), Judy Biggert (IL), Mary Bono Mack (CA), Charles Dent (PA), Robert Dold (IL), Rodney Frelinghuysen (NJ), and Richard Hanna (NY). Democrats voting for: Dan Boren (OK), Jerry Costello (IL), Joe Donnelly (IN), Daniel Lipinski (IL), Mike McIntyre (NC), Collin Peterson (MN), Nick Rahall (WV), Silvestre Reyes (TX), Mike Ross (AR), and Heath Shuler (NC).

The bruising fight over FY 2011 spending, however, followed by the budget debate, left appropriators in both the House and Senate with little appetite for more public funding debates, and the regular FY 2012 appropriations process was essentially punted to the fall of 2011.

Having successfully protected Title X from elimination during the FY 2011 funding fight, NFPRHA and other health advocacy organizations approached the FY 2012 funding cycle with a renewed sense of energy and cautious optimism – which was quickly tested by the House Republican majority's continued attempts to end the Title X program.

In September, House Labor, Health and Human Services, Education, and Related Agencies (Labor-HHS) Appropriations Subcommittee Chairman Dennis Rehberg (R-MT) released a Labor-HHS bill that once again eliminated the Title X family planning program. The Rehberg bill also included several harmful anti-choice policy riders, including a policy that would result in the defunding of Planned Parenthood and its affiliated organizations.

As quickly and quietly as the bill was produced, Chairman Rehberg's colleagues in both parties began distancing themselves from the bill. Appropriations committee members claimed no knowledge of the bill, and assured angry constituents that the bill was unlikely to be considered; indeed, no subcommittee or full committee markup was ever held on the Rehberg bill.

In contrast to the House's failure to create a Labor-HHS appropriations process, Senate Appropriations Labor-HHS Subcommittee Chairman Tom Harkin (D-IA) produced a bill that was marked up and passed out of both the subcommittee and the full committee. The Senate bill level-funded the Title X family planning program at its final FY 2011 funding level of $299.4 million. The bill also included accompanying report language that asked that ACA funding be directed towards helping family planning providers prepare for ACA implementation, as well as language signaling support for the Office of Populations Affairs' (OPA) work to improve the Title X program.

Despite the flurry of FY 2012 appropriations activity in September, the ongoing and competing negotiations in the Super Committee further complicated the already difficult appropriations process. Appropriators were in a holding pattern, waiting for the Super Committee to instruct them on how much could be spent under the deficit reduction plan scheduled to emerge before the end of November. Following the Super Committee's failure, appropriators and congressional leaders scrambled to finish the FY 2012 spending bills before the end of the year. The short timeframe set up yet another heated and potentially irreconcilable debate over federal spending priorities.

Congress chose to try to pass the less controversial spending bills in bundles, dubbed "minibuses." However, only one minibus of three appropriations packages successfully passed both chambers of Congress. The controversial and expensive nature of other spending packages, specifically Labor-HHS, as well as Energy and Water and State, Foreign Operations, and Related Programs (State-Foreign Ops), resulted in stalled negotiations over the remaining nine appropriations bills.

NFPRHA again called on its champions in Congress to protect Title X funding, especially in light of the targeted cut the program sustained in FY 2011.

As with all of the must-pass legislation to come before Congress in 2011, the FY 2012 Labor-HHS discussions occurred behind closed doors between a bipartisan group of appropriators. With just two short weeks before the end of 2011, the House and Senate finalized a FY 2012 omnibus appropriations bill to complete the process of funding the remaining nine appropriations bills for the duration of the fiscal year which began on October 1, 2011. The omnibus cut the Title X program by $2 million (0.6%) from FY 2011, to $297.4 million, plus an additional 0.189% across-the-board cut to all programs within the Departments of Labor, Health and Human Services, and Education, bringing the funding level to $296.8 million. That number was ultimately further reduced to $293.9 million - $5.5 million (1.9%) less than the final FY 2011 funding level of $299.4 million.[7] The bill did not contain the harmful anti-choice policy riders in the Rehberg bill nor did it defund Planned Parenthood.

7 While a portion of the additional $2.9 million loss of Title X funding is a result of the continuing resolutions that funded the federal government for three months from October – December 2011, the majority of the funding reduction is due to HHS Secretary Kathleen Sebelius exercising her authority to shift up to 1% of program funding levels to other programs within HHS.

Public Health Funding Threatened

2011 was a very difficult year for public health funding, with a number of programs related to reproductive and sexual health facing significant cuts and outright elimination. However, by the end of the calendar year and the FY 2012 appropriations cycle, most programs had escaped substantial reductions – providing some relief to family planning providers and systems trying to absorb the Title X cuts of FY 2011.

The Maternal and Child Health (MCH) Block Grant lost $16.9 million between FY 2010 and FY 2012. The Title XX Social Services Block Grant was essentially flat-funded at $1.7 billion, reduced only by a rescission amount of 0.189%. The Teen Pregnancy Prevention Initiative (TPPI), which had been targeted for elimination along with Title X in H.R. 1, ended FY 2012 with a $5.4 million (4.9%) cut from FY 2010 levels, though the funds for evaluation were increased from $4.5 million to $8.48 million, per the president's FY 2012 budget request.

The Centers for Disease Control and Prevention's (CDC) National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention's (NCHHSTP) had an overall increase of $59 million between FY 2010 and FY 2012. FY 2012 funding for the Division of STD Prevention – chronically underfunded for a number of years – was nearly unchanged from FY 2010 levels. However, NCHHSTP's Division of Adolescent School Health (DASH), which funds HIV/STD prevention programs across the country, received a $10.1 million reduction in FY 2012 from FY 2011. When combined with its $17.6 million reduction in FY 2011, DASH was cut by 48% ($27.7 million) over two years.[8]

Fiscal Years 2011 and 2012 Funding for Selected Public Health Programs ($ in millions)

Program	FY 2012 Actual[I]	FY 2011 Final	FY 2010
Title X Family Planning	$293.9[II]	$299.4	$317.5
Title V MCH Block Grant	$645.1	$656.3	$662
Title XX Social Services Block Grant	$1,697	$1,700	$1,700
Teen Pregnancy Prevention Initiative	$104.6	$104.8	$110
TPPI Evaluation	$8.48	$4.5	$4.5
Personal Responsibility Education Program (PREP)	$75	$75	$75
Title V State Abstinence Grant Program	$50	$50	$50
Abstinence-Only Until Marriage Program	$4.9	—	—
CDC HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	$1,104	$1,116	$1,045
HIV/AIDS	$788.9	$800.5	$728
School Health (DASH)	$29.9	$40	$57.6
Viral Hepatitis	$19.76	$19.8	$19
STD	$154.4	$154.7	$154
TB	$140.8	$141.1	$144
HRSA HIV/AIDS Bureau (Ryan White AIDS Programs)	$2,327	$2,312	$2,266
Community Health Centers (FQHCs)[III]	$2,780	$2,580	$2,146
Prevention and Public Health Fund (PPHF)[IV]	$1,000	$750	$500

I All FY 2012 funding levels include a 0.189% rescission to Labor, Health and Human Services, Education and Related Agencies programs, except for Ryan White, Community Health Centers, Prevention and Public Health Fund, and Personal Responsibility Education Program.

II Reflects the omnibus funding level of $296.8 million (appropriation minus rescission) minus a further cut of $2.9 million.

III Includes both discretionary funding as well as mandatory funding authorized through the ACA.

IV CDC received the majority ($244 million) of the increase for FY 2012

8 For more on DASH, see "STDs and HIV/AIDS Prevention and Treatment" beginning on page 22.

Medicaid Dodges a Bullet

One of the more remarkable aspects of the federal spending fights of 2011 was that Medicaid - once thought of as largely "safe" as a mandatory spending program - was suddenly and significantly endangered. In April, the House passed a FY 2012 budget authored by House Budget Committee Chairman Paul Ryan (R-WI). The Ryan budget called for $6 trillion in federal spending cuts over ten years; those savings would be generated from, among other things, major changes to Medicare and Medicaid. The proposal called for converting Medicaid from a mandatory spending program into a block grant and capping spending annually, meaning that states would be given a fixed, and ultimately smaller, sum of money for their Medicaid programs. Rather than saving public money, these proposals would have only shifted risks and costs to states and reduced needed funding, forcing many poor and low-income individuals to go without care or to seek care in our nation's emergency rooms, resulting in increased health care costs.

In response to the Ryan budget, NFPRHA and the National Health Law Program (NHeLP) organized a group sign-on letter to congressional leaders strongly opposing attempts to cap or reduce funding for the Medicaid program, or to in any way weaken its coverage of family planning services and supplies. The letter was signed by 48 organizations.

As the summer wore on and debt-ceiling negotiations heated up, there was growing concern that House and Senate Republicans were eyeing Medicaid as a prime target for spending cuts. Senator Jay Rockefeller (D-WV) led an effort by Senate Democrats to denounce attempts to cut Medicaid funding. More than half of the Senate's Democrats signed a letter to President Obama opposing any attempt to cap funding for or block grant Medicaid.

When the "Budget Control Act" (BCA) became law in the late summer, Medicaid advocates breathed a small sigh of relief because, while the BCA cut many public health programs, Medicaid was not included in the automatic cuts that would be triggered if the Super Committee failed in its task. That relief was short-lived, however, as the Super Committee negotiations intensified in the fall and even "friends" to Medicaid that sat on the committee seemed to be looking to the program to generate cost savings. In the end, the failure of the Super Committee to come up with a deficit reduction plan – although potentially harmful to other public health programs like Title X – helped protect Medicaid, at least in the short term.[9] Although Medicaid escaped injury in 2011, it is clear that congressional Republicans now have the safety-net program on their radar screens, and continued vigilance will be needed going forward.

HHS Issues Regulations Implementing 2014 Medicaid Expansion

Even as Congress was debating cutting Medicaid funding, HHS was preparing for the expansion of full-benefit Medicaid eligibility to those with incomes up to 133% of the federal poverty level (FPL) in 2014. Prior to the ACA, full-benefit Medicaid eligibility was limited to certain "categories" or "categorical groups" of individuals. Being low-income was not enough to qualify an individual for full-benefit Medicaid; that person had to be low-income AND fall into an additional category (e.g., children, pregnant women, parents, seniors, or people with disabilities), which left millions of low-income Americans in need of health coverage ineligible for Medicaid.

The ACA changes this limitation by expanding full-benefit Medicaid income eligibility to 133% of the FPL and simplifying Medicaid eligibility requirements. Beginning in 2014, low-income individuals under age 65 with incomes at or below 133% of the FPL (in 2011, that equaled an income of $14,484 a year for an individual) will be eligible for full-benefit Medicaid, regardless of any qualifying category.

In August 2011, HHS and the Department of the Treasury released a set of three proposed rules implementing eligibility criteria for the 2014 expansion of full-benefit Medicaid and state-based insurance exchanges. The proposed Medicaid rule, among other things, simplified eligibility and detailed financial incentives to states – in the form of an enhanced Federal Medical Assistance Percentage (FMAP) payment – to facilitate the expansion of full-benefit Medicaid eligibility.[10] More rules and guidance are expected in 2012.

9 The BCA was the deal reached to raise the nation's debt ceiling in the summer of 2011. In addition to a complicated mechanism by which President Obama could raise the debt limit, the BCA included $917 billion in scheduled cuts to non-security discretionary spending over ten years beginning in FY 2012, and established a bi-partisan "Super Committee" tasked with recommending $1.2 to $1.5 trillion in further spending reductions over the next ten years. For more on the BCA and Super Committee, see "Introduction" beginning on page 5.

10 For more on ACA implementation and NFPRHA's work related to the Medicaid expansion, see "The Affordable Care Act" beginning on page 16.

States Secure Medicaid State Plan Amendments to Expand Family Planning Access

For nearly two decades, states have been granted Section 1115 demonstration waivers by the Centers for Medicare & Medicaid Services (CMS) to expand Medicaid coverage of family planning services. Beginning in 2010, the ACA provided states with a new option for expanding family planning access: to amend their state Medicaid plans through a state plan amendment (SPA). By the end of 2011, six states had transitioned from family planning waivers to SPAs: California, New Mexico, Oklahoma, South Carolina, Virginia, and Wisconsin. In addition, Ohio had its family planning SPA approved by CMS in 2011, becoming the first state to obtain a SPA without first having a family planning waiver. Ohio's family planning SPA is expected to go into effect in 2012.

Not including Ohio, 28 states have expanded Medicaid coverage of family planning services. Twenty-two states have expanded coverage through a waiver, the majority of which are income-based waivers, meaning that eligibility for family planning services in those states is determined based on income. In 2011, Georgia became the newest state to obtain a Medicaid family planning waiver. Expansions of Medicaid eligibility for family planning have firmly proven their value, reducing unintended pregnancy and improving public health while saving millions of dollars.

NFPRHA's Medicaid Peer-to-Peer Learning Network, which brings together NFPRHA members and state Medicaid professionals to discuss key issues related to Medicaid-funded family planning, has provided information and resources to providers and states seeking to expand Medicaid coverage of family planning through both waivers and SPAs. Even as NFPRHA's work turns increasingly toward the 2014 Medicaid expansion, NFPRHA continues its work to improve and expand Medicaid coverage of family planning through waivers and SPAs.

Title X Guidelines Revision Process Continues

Throughout 2011, OPA advanced the Title X guidelines revision process it began in 2010, working toward its goal of reviewing, revising, and updating the Title X program guidelines by the end of 2012. In mid-2011, OPA and CDC convened technical panels to examine particular areas of the program, including counseling and education; community outreach, participation and access; adolescents; quality assurance; male services; and clinical services.

Since 2010, NFPRHA President & CEO Clare Coleman has represented NFPRHA on OPA's expert work group, which is tasked with informing OPA's guidelines revision process. The expert work group met twice in 2011, and Coleman also participated in the May 2011 community access technical panel as an invited expert.

Modernizing the guidelines in all of these areas will make it simpler for program administrators and health center staff to work with both Medicaid and Title X funds to offer the most appropriate care for a particular patient. A first draft of the revised guidelines was expected to be completed in November. However, as of December 2011, a draft had not been released. Stakeholders continue to have high hopes that the guidelines revisions process will strengthen the Title X program.

Victory on Bush-Era Refusal Regulations

Just over two years after it went into effect, the Obama administration rescinded in part and revised the Bush-era provider refusal rule that would permit institutions and individuals employed at federally funded health care entities to refuse to provide a variety of basic health care services.

NFPRHA, along with PPFA, Planned Parenthood of Connecticut, and 8 state attorneys general, brought a lawsuit in federal court on January 15, 2009, to prevent the rule from taking effect five days later. *National Family Planning & Reproductive Health Association, Inc. v. Leavitt* argued that the Bush rule had numerous legal flaws and should be invalidated.

The revised rule, which took effect on March 25, 2011, retained the part of the Bush regulation that established enforcement of existing federal health care provider conscience statutes, but rescinded "unclear" and "potentially overbroad" provisions of the Bush regulation "based on concerns expressed that it had the potential to negatively impact patient access to contraception and certain other medical services without a basis in federal conscience protection statutes."

The revised rule eliminated the most troublesome provisions of the Bush rule, clarifying that the regulation does not authorize health care providers to abandon patients in emergencies and does not expand the definition of abortion to cover birth control. Most importantly, the revised rule maintains obligations of Title X providers regarding the provision of contraception and non-directive options counseling.

The Obama administration originally proposed rescinding the Bush rule in March 2009. Due to this proposal, NFPRHA's lawsuit was put on hold – but in December 2010, the judge in the case asked HHS to report on the progress of its final rulemaking. HHS responded that it expected to publish a final rule within 60 to 90 days. After publication of the final rule, NFPRHA and its co-plaintiffs moved to dismiss the lawsuit.

Although a victory for family planning, NFPRHA was disappointed that the Obama administration did not fully repeal the rule as originally proposed in March 2009. Despite the early victory, the administration's decision to not fully repeal the Bush rule foreshadowed a larger fight to come over religious refusals.[11]

11 Throughout 2011, the issue of religious refusals versus access to health services came up again and again, from regulations implementing parts of the ACA to federal human trafficking laws. For more on religious refusals, see "Family Planning Services and Supplies" beginning on page 14.

Family Planning Services and Supplies

Despite the numerous ideological battles waged with Congress over reproductive and sexual health, 2011 included an important acknowledgment by the federal government of family planning as an integral part of preventive care. HHS adopted recommendations that family planning visits, methods, and counseling should be covered by commercial insurance without co-pays, a major victory. However, this victory was tempered by the Obama administration's inclusion of an unwarranted exemption from the requirement for certain religious employers, re-igniting the larger war over religious refusals. Further confounding reproductive, sexual, and women's health advocates was a late 2011 decision by HHS Secretary Kathleen Sebelius to put politics ahead of science by overruling the Food and Drug Administration's (FDA) decision to allow Plan B to be sold over-the-counter to people of all ages.

HHS Approves IOM Recommendation that Birth Control be Covered without Co-Pays

In July, the Institute of Medicine's (IOM) Committee on Preventive Services for Women released its report detailing which women's preventive health services and screenings should be included in new commercial insurance plans available under the ACA without co-pays.[12]

The IOM report recommended that health plans cover "the full range of Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity" and "[a]t least one well-woman preventive care visit annually for adult women."[13] The IOM report also recommended that annual HIV tests for sexually active women, annual counseling on other sexually transmitted diseases, testing for human papillomavirus (HPV) for women over 30, and screening for domestic violence should all be covered.[14]

In August, HHS accepted the IOM's recommendations, issuing a proposed rule for public comment. In a surprise move,[15] however, the proposed rule included an exemption not recommended by the IOM, which would allow certain religious employers to opt out of providing insurance coverage for contraception to their employees.[16] Religious groups quickly argued that the exemption did not go far enough and that their "religious liberty" was under attack, putting intense pressure on the Obama administration to broaden the exemption.[17] As of the end of 2011, HHS had not issued a final rule.[18]

12 Institute of Medicine, *Clinical Preventative Services for Women: Closing the Gaps*, accessed October 31, 2011, http://www.iom.edu/~/media/Files/Report%20Files/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps/preventiveservicesforwomenreportbrief_updated2.pdf.

13 *Ibid.*

14 *Ibid.*

15 The exemption for religious employers was not recommended by the IOM, and seemed contradictory to the Obama administration's position earlier in the year when it rescinded and revised the Bush-era provider refusal rule. Entering 2012, it is unclear how the administration will balance promoting health care policies that improve access to services with the goals of influential religiously affiliated organizations. For more on the Bush provider refusal rule, see "Publicly Funded Family Planning" beginning on page 7.

16 US Department of Health and Human Services, "Affordable Care Act Ensures Women Receive Preventive Services at No Additional Cost," news release, August 1, 2011, http://www.hhs.gov/news/press/2011pres/08/20110801b.html.

17 Ricardo Alonso-Zaldivar, "Birth Control Coverage Provision In Health Care Law Draws Objections From Religious Groups," *The Huffington Post*, August 7, 2011, http://www.huffingtonpost.com/2011/08/07/birth-control-coverage-_n_920423.html.

18 For more on the women's health preventive services benefit, see "The Affordable Care Act" beginning on page 16.

USPSTF and National Cancer Institute Diverge on HPV Testing Effectiveness

A National Cancer Institute (NCI) study released in August showed that women tested only for HPV have a lower 5-year cancer risk than women who have only a Pap test.[19] The study also found that women with a negative HPV test and normal cytology can safely and appropriately have a follow-up every three years. The NCI study of more than 330,000 women who obtained HPV and Pap tests for five years concluded that only about three out of 100,000 women developed cervical cancer after a negative HPV and Pap test, and women who had only HPV tests had half the cancer risk of women who had only Pap tests. According to the NCI research, adding a Pap test after a negative HPV test did not significantly improve the risk prediction. However, a Pap test following a positive HPV test did help to confirm or rule out the need for follow-up care.

In October, the US Preventive Services Task Force (USPSTF) published new draft cervical cancer-screening guidelines.[20] The recommendations outlined guidelines for Pap testing, which include testing women ages 21 to 65 every 3 years, and not testing women younger than 21. In contrast to the NCI study, the USPSTF guidelines recommend against HPV testing, alone or as a co-test with a Pap test, in women younger than 30, and conclude that there is insufficient evidence to make a recommendation for HPV testing or co-testing in women 30 and older.

HHS Secretary Sebelius Overrules FDA Decision to Approve Plan B for Over-The-Counter Use

In December, HHS Secretary Kathleen Sebelius overruled the US Food and Drug Administration's (FDA) recommendation to allow Plan B One-Step, an emergency contraceptive pill, to be sold over-the-counter to women and men of all ages. Plan B remains available with a prescription to women under 17 years of age and without a prescription to women and men 17 years of age and older.

After an exhaustive 10-month review, the FDA's Center for Drug Evaluation and Research (CDER) determined that Plan B was safe and effective for adolescent females. In addition, CDER found that adolescent girls could use Plan B properly without the intervention of a health care provider and understand that Plan B should not be used as a routine form of birth control. FDA Commissioner Margaret Hamburg agreed with CDER's recommendations to approve over-the-counter sales of Plan B to all ages, arguing that "there is adequate and reasonable, well-supported, and science-based evidence that Plan B One-Step is safe and effective and should be approved for nonprescription use for all females of child-bearing potential."

Sebelius, however, in an unprecedented move, rejected the FDA's decision, claiming that there was "not enough evidence to show that those who use this medicine can understand the label and use the product appropriately." Shortly thereafter, President Obama publicly supported Sebelius's actions, but denied any White House involvement in the deision.

NFPRHA and other reproductive and sexual health advocates are working to get President Obama to overturn Sebelius' unwarranted and harmful decision.

ACIP Recommends Gardasil for Routine Use in Boys

In October, the CDC's Advisory Committee on Immunization Practices (ACIP) recommended that boys age 11-12 be routinely vaccinated with the HPV vaccine Gardasil. The ACIP also voted to recommend that males between the ages of 13 and 21 who have not been vaccinated be given a catch-up vaccination. The three-dose vaccine was approved in 2006 for girls and women ages 9 to 26 to prevent the strains of HPV most commonly responsible for causing cervical cancer. Gardasil was approved for use in males ages 9 to 26 in 2009 and, in addition to cervical cancer prevention, can be used to protect against certain other cancers and genital warts. The ACIP's October decision overturns its original decision in 2009 to only recommend the vaccine for optional, not routine, use in boys.

19 Marilynn Marchione, "HPV test beats Pap for cervical cancer screening," *Associated Press*, May 18, 2011, http://www.msnbc.msn.com/id/43085393/ns/health-cancer/t/hpv-test-beats-pap-cervical-cancer-screening/#.Tq7wt9Qag_c.

20 US Preventive Services Task Force, "Screening for Cervical Cancer: Recommendations and Rationale," US Preventive Services Task Force, last modified 2011, http://www.uspreventiveservicestaskforce.org/3rduspstf/cervcan/cervcanrr.htm.

The Affordable Care Act

In 2011, House Republicans took every opportunity to attack the ACA. With a divided Congress, however, their attempts to undermine the health reform law were largely thwarted. Despite the gridlock in Congress, policymakers at both the federal and state levels made substantial progress in their efforts to implement the ACA. HHS invested millions of dollars in grants and loans for implementation and published guidance documents to help all stakeholders begin preparing for ACA provisions that will take effect in 2014. Several states moved forward with designing and implementing state-based exchanges, and a small number of states expanded their Medicaid programs in anticipation of the public insurance program becoming available to millions of people who currently lack coverage.

After fighting an 18-month battle as the ACA wound its way through Congress, sexual and reproductive health advocates eagerly turned their attention toward efforts to protect and promote family planning access in ACA implementation policies. Unfortunately, some in Congress decided to use ACA implementation to resurrect the fight over insurance coverage of women's health services. In addition to fighting over abortion, anti-choice members in Congress widened their target to include contraceptive coverage, threatening to erect harmful barriers to women's routine preventive health care.

HHS Lays Groundwork for Medicaid Expansion

The ACA's expansion of full-benefit Medicaid eligibility to individuals with incomes up to 133% FPL in 2014 will significantly grow the program from its current enrollment of 60 million – or one in five Americans.[21] The Congressional Budget Office (CBO) estimates that, by 2019, Medicaid will cover 16 million additional people.[22]

NFPRHA's work on Medicaid family planning SPAs has laid the groundwork needed to help family planning providers transition to serving more Medicaid-covered patients when the program expands in 2014.

In 2011, HHS ramped up its ACA implementation work, issuing guidance and regulations designed to help states and health care providers prepare for the changes coming in 2014. Much of HHS' focus has been on primary care and ensuring that states have some flexibility in determining how they meet the requirements set forth by the ACA. However, some of HHS' implementation policies have created concern among sexual and reproductive health advocates.

In August 2011, HHS and the Department of the Treasury released a set of three proposed rules implementing eligibility criteria for the 2014 expansion of full-benefit Medicaid and state-based insurance exchanges. The proposed rules simplified Medicaid eligibility, detailed financial incentives to states in the form of an enhanced FMAP rates for those deemed "newly eligible," and provided guidance on eligibility for premium tax credits under the ACA, which are available to help individuals and families with incomes below 400% of the FPL "afford health insurance coverage."[23] As written, however, the proposed rules included language that family planning advocates were concerned could inadvertently penalize individuals enrolled in and eligible for certain limited-benefit programs under Medicaid - including family planning waivers and SPAs - potentially penalizing states for having expanded such coverage prior to the ACA's passage.

21 Kaiser Family Foundation, Faces of Medicaid, accessed November 20, 2011, http://facesofmedicaid.kff.org.

22 Matt Broaddus and January Angeles, *Medicaid Expansion in Health Reform Not Likely to 'Crowd Out' Private Insurance*, Center on Budget and Policy Priorities, June 22, 2010, http://www.cbpp.org/cms/index.cfm?fa=view&id=3218, accessed November 20, 2011.

23 US Department of the Treasury, Internal Revenue Service, "Health Insurance Premium Tax Credit," REG-131491-10, p. 50932.

NFPRHA submitted comments to the proposed rules expressing support for HHS' efforts, but expressing concern that certain sections of the proposed regulations were written too broadly and, as such, could inadvertently harm the precise populations the ACA was intended to help through its Medicaid expansion: the low-income, poor, and uninsured.

HHS also issued a separate proposed rule implementing other provisions related to the exchanges, including the requirement that health plans contract with essential community providers. As the ACA implementation process moves forward, it is imperative that family planning advocates, providers, and systems continue to work to protect and strengthen provisions of the ACA impacting family planning and sexual health.

National Prevention Strategy Released

In June, the National Prevention, Health Promotion, and Public Health Council (National Prevention Council) released the National Prevention Strategy, a roadmap for increasing prevention efforts across key areas of the health care spectrum. The National Prevention Council, chaired by Surgeon General Regina Benjamin, was created following the ACA's enactment to provide coordination and leadership at the federal level with respect to prevention, wellness, and health promotion practices.

Although initial drafts of the National Prevention Strategy did not mention sexual health in any way, the final strategy included a section on reproductive and sexual health, and specific 10-year targets for improved sexual health. The strategy recognizes the importance of reproductive and sexual health services in people's lives, stating:

"Healthy reproductive and sexual practices can play a critical role in enabling people to remain healthy and actively contribute to their community. Planning and having a healthy pregnancy is vital to the health of women, infants, and families and is especially important in preventing teen pregnancy and childbearing, which will help raise educational attainment, increase employment opportunities, and enhance financial stability. Access to quality health services and support for safe practices can improve physical and emotional well-being and reduce teen and unintended pregnancies, HIV/AIDS, viral hepatitis, and other sexually transmitted infections (STIs)."

NFPRHA submitted comments during the drafting process urging that the importance of family planning services and supplies, and the prevention of unintended pregnancy, be incorporated into the National Prevention Strategy.

Work Continues to Make HIT Available to Safety-Net Providers

The federal government continues to stress the need for providers to purchase and use health information technology (HIT) if they intend to participate in the changing health care delivery system. The ACA includes a number of provisions designed to encourage and assist health care providers adopt and utilize HIT systems. Unfortunately, many of the challenges and barriers to HIT use faced by family planning providers have yet to be rectified.

In 2011, the federal Office of the National Coordinator (ONC) for HIT published a five-year strategic plan that identified five goals for the purposes of promoting access to and increasing use of HIT:

- achieve adoption and exchange of information through the Medicaid "meaningful use" HIT incentives;
- improve public health and reduce health care costs through HIT;
- improve trust in HIT systems and use;
- empower the public to take control of their health; and
- identify ways to use HIT to improve learning and innovation in the health care system.[24]

24 US Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, *Federal Health information Technology Strategic Plan: 2011-2015*, accessed April 2011, http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_0_4318_1211_15583_43/http%3B/wci-pubcontent/publish/onc/public_communities/f_j/onc_website___home/fed_health_strategic_plan/fed_health_it_strategic_plan_home_portlet/files/final_federal_health_it_strategic_plan_0911.pdf.

NFPRHA submitted formal comments about the ONC strategic plan highlighting the concerns of family planning providers and systems associated with the implementation and use of HIT, especially the high costs associated with purchasing HIT systems and the privacy and confidentiality needs that are paramount in the provision of sensitive sexual and reproductive health services. NFPRHA urged the ONC to increase its efforts to inform patients of their rights regarding protected health information, and to include a policy giving minors and those seeking sensitive sexual health services options and authority for directing their personal health information.

The current electronic health records (EHR) meaningful use incentives program, which provides financial assistance to providers for the adoption and use of EHR, fails in a number of ways to meet the needs of many safety-net providers. The rule requires that an individual provider have a minimum of 30% Medicaid patient load in order to qualify for the incentive payments. It is well established that safety-net providers serve millions of low-income and/or uninsured individuals, many of whom do not meet the current eligibility criteria for Medicaid coverage or who are not enrolled in Medicaid even if eligible. While the 2014 Medicaid expansion will certainly increase Medicaid patient volumes for family planning providers, they may still have a patient mix that continues to put the EHR incentives out of reach.

NFPRHA continues to work with HHS and members of Congress to identify ways to modify the Medicaid EHR incentives to ensure that all safety-net providers can participate. However, the federal cost of expanding the program makes a straightforward legislative change a difficult proposition.

On the positive side, the current HIT strategic plan includes several provisions designed to add heightened protections for sensitive health information.[25] It remains an open question, however, whether states will include safeguards in their implementation efforts that will further safeguard patient health information, particularly as it applies to sexual and reproductive health services.

State-Based Exchanges Begin to Take Shape

With 2014 fast approaching, HHS ramped up its efforts to help states and insurance providers assess how they will make health insurance available to millions of new beneficiaries and thousands of small businesses. HHS envisions the state-based health insurance exchanges created by the ACA as a type of clearinghouse, where uninsured consumers can find information about and enroll in the appropriate public or private insurance coverage option. For family planning providers, the state-based exchanges will be an important means of contracting with commercial health plans in order to ensure that patients can continue to seek care from their preferred providers.

HHS solicited comments on the proposed rules for state-based health insurance exchanges in August. In the proposed rules, HHS asked for input on how to ensure that medically underserved patients and communities are not left out of the reforms initiated by the ACA, and sought input on how to include "essential community providers" in insurance networks. The proposed rule also contained the infamous "Nelson" abortion coverage provision, authored in 2009 by Senator Ben Nelson (D-NE), which requires individuals who purchase commercial insurance with abortion coverage to submit two separate payments for their health insurance. The proposed rule gave family planning providers an opportunity to ask HHS to strengthen policies that would allow them to continue serving the poor and low-income, and to limit the burden imposed on women by the Nelson provision.

NFPRHA commented on the proposed rule and asked for several important policy changes. Specifically, NFPRHA asked that HHS require health plans operating in state-based exchanges to contract with any willing safety-net provider. Requiring health plans to extend contracts to all providers that want to contract would protect family planning providers from being overlooked in favor of less "controversial" and better-resourced safety-net providers. NFPRHA also stressed the need for oversight of health plan contracting practices, and for policies that include family planning providers in the state-based exchange decision-making process. In addition, NFPRHA urged HHS to clarify the policies related to abortion coverage in the exchanges so that women can access all reproductive health services that they require to maintain good health.

25 *Ibid.*

IOM Recommends Approach to Determining Essential Health Benefits Package

The ACA includes a requirement that insurance plans within the state-based insurance exchanges provide a minimum set of services known as the essential health benefits (EHB) package. The ACA left decisions about what would be included in the EHB to HHS, and in 2010 the agency contracted with the IOM to provide a framework that could be used to design the package. After a year-long process, the IOM published a report in October 2011 with five recommendations to guide HHS' decision-making process. The IOM report, *Essential Health Benefits: Balancing Coverage and Costs*, recommended a balanced approach to determining mandatory benefits that considers both health insurance costs and commonly offered services in current health insurance coverage.[26] While the IOM report did not recommend specific services, it did examine several public and private health coverage options to determine which services are routinely covered. The report showed that family planning is a covered benefit in almost all insurance plans.

HHS is responsible for using the IOM framework to define the minimum set of benefits available in plans within the state-based exchanges. The decision could impact the health plans of more than 68 million people. The EHB package will be available to individuals and small businesses that purchase coverage through the state-based exchanges, in some Medicaid expansion plans known as "benchmark" plans, and state-created "basic health plans." As with most policy decisions, politics may interfere with HHS' EHB determination. Public health advocates and state health officials would like the EHB guidance sooner rather than later as they work to establish state-based exchanges, but the highly politicized nature of insurance coverage could delay the EHB decisions until after the 2012 elections.

Women's Preventive Health Services Benefit Victory Not without Concern

Another evidence-based health care decision unnecessarily weighed down by politics in 2011 was the ACA's hotly debated women's preventive health services benefit. Federal legislators, women's health advocates, and family planning providers worked tirelessly to include in the ACA a policy that would require coverage of a set of preventive services specific to women in health plans without patient co-pays or other cost-sharing. Such a provision was included.

In an effort to shield the women's preventive health services benefit from political influence during implementation, HHS again contracted with the IOM. Unlike the IOM's EHB work, the women's preventive services committee was tasked with identifying which services should be covered as necessary preventive care for women and making recommendations to HHS, which would then make the final decision.

The IOM organized a committee of physicians, medical school faculty, and public health researchers to examine which benefits and services should be offered in insurance plans to address the breadth of women's preventive health needs. The committee held both closed and public sessions which allowed interested stakeholders to provide comments on the process and the range of services being considered.

> Throughout the IOM review process, NFPRHA and other colleague organizations consistently urged the committee to recommend coverage of the full range of family planning services, including the visit, the contraceptive method, and the counseling associated with the visit.

26 Cheryl Ulmer, John Ball, Elizabeth McGlynn, and Shadia Bel Hamdounia, *Essential Health Benefits Package for Qualified Health Plans* (Washington, DC: Institute of Medicine, 2011).

After a little under a year, the committee published its report, *Clinical Preventive Services for Women: Closing the Gaps*.[27] The report recommended coverage of eight preventive health services for inclusion in all health plans. The women's health advocacy community and family planning providers were pleased by the report, which outlined a strong case for insurance coverage of all FDA-approved contraceptive methods, contraceptive counseling, and at least one annual family planning office visit. In addition, the report recommended that HHS require coverage of annual HIV tests for sexually active women, annual counseling on other sexually transmitted diseases, testing for HPV for women over 30, and screening for domestic violence.[28] The IOM recommendations and the research the committee identified to support its conclusions was a victory for family planning advocates and providers, who have for years championed the preventive health benefits of contraception.

In August, HHS adopted the IOM recommendations in full in the form of an interim final rule guaranteeing that all eight preventive services detailed in the IOM report would be covered by all commercial health plans, without cost-sharing, in plan years beginning on or after August 1, 2012.[29] However, concerned that some religious organizations that object to contraception would oppose the IOM recommendations, HHS also included a provision that would exempt some religious employers from the contraceptive coverage requirement.[30]

NFPRHA submitted comments to HHS' proposed rule supporting the adoption of the IOM's recommendations but also arguing that any exemption for religious employers was unnecessary. As religious groups ramped up their efforts to force the Obama administration to broaden the exemption, NFPRHA urged the White House to protect women's access to contraception by not expanding the religious exemption. As the fight intensified, NFPRHA activated its members to place calls both to the White House and supportive federal legislators to voice objections to expanding the religious exemption.

Despite the best efforts of family planning advocates and providers, religious organizations - led by the US Conference of Catholic Bishops - organized a strategic campaign against the contraception benefit. In addition to the direct pressure religious organizations placed on the White House, conservative members of US House of Representatives organized hearings on the issue of "religious freedom" and argued that the White House was intolerant of religion.[31] As of the end of 2011, advocates on both sides of this issue were awaiting a White House decision on the scope of the religious exemption. The decision could have serious implications not only for ACA health plans, but also for many other federal health programs that women rely on to access family planning services.

27 Institute of Medicine, *Clinical Preventative Services for Women: Closing the Gaps*, accessed October 31, 2011, http://www.iom.edu/~/media/Files/Report%20Files/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps/preventiveservicesforwomenreportbrief_updated2.pdf.

28 *Ibid.*

29 *See Code of Federal Regulations*, title 26, sec. 54.9815-1251T, *Code of Federal Regulations*, title 29, sec. 2590.715-1251 and *Code of Federal Regulations*, title 45, sec 147.140 (*Federal Register* 75:34538, June 17, 2010). The women's health preventive services benefits do not apply to grandfathered plans. A grandfathered health plan is a plan with at least one enrollee on March 23, 2010. Plans will lose their grandfathered status if, as compared to their policies in effect on March 23, 2010, they make changes including, but not limited to, significantly cutting or reducing benefits, raising co-insurance charges, significantly raising co-payments, significantly raising deductibles, or adding or tightening annual limits on what the insurer pays. The federal government estimates that between 39% and 69% of employer group plans will relinquish grandfathered status by 2013.

30 "Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act," *Federal Register 76:149* (August 1, 2011).

31 House Committee on Energy & Commerce, "Do New Health Law Mandates Threaten Conscience Rights and Access to Care," congressional hearing, November 2, 2011.

ACA Heads to the US Supreme Court

Even as implementation of the ACA intensified in 2011, the ultimate fate of the law was in doubt. The American public remained divided over the law, a division which was reflected in federal and state legislatures.[32] Republican legislators – especially in the US House - made numerous attempts in 2011 to weaken the law, opening the 112th Congress by passing a resolution repealing the ACA.[33] The repeal effort failed in the Senate, but was followed by several funding bills with language attempting to defund various pieces of the law. Senate Democrats remained unified against House-generated anti-ACA policies, leaving the law mostly intact by year's end. However, efforts to drastically reduce federal spending resulted in the White House supporting legislation that would use ACA funds to supplant other public health funding traditionally supported in the annual appropriations process.

Shrinking state revenues presented another challenge to the ACA. Governors supportive of the ACA voiced serious concerns in 2011 about their state's capacity to implement the insurance coverage in the law; namely the Medicaid expansion to all individuals with incomes below 133% of the FPL. Governors opposed to the ACA have been even slower to implement the law in the hopes that a political or legal intervention in 2012 would make the law irrelevant.

On the same day of the ACA's enactment in 2010, the Attorney General of Florida filed a federal lawsuit challenging the constitutionality of the ACA. The lawsuit, which ultimately included a total of 26 state attorneys general, worked its way through the court system, along with dozens of other lawsuits filed around the country. Several cases – both upholding the ACA and ruling it unconstitutional – were appealed to the US Supreme Court in 2011. In November, the high court announced that it would hear arguments on the constitutionality of several sections of the ACA, including the provision that requires individuals to purchase health insurance, known as the individual mandate. The court will also determine whether the law can survive should the individual mandate not be upheld. Although most legal observers anticipated the Supreme Court would review the individual mandate, the court surprised many by also agreeing to review the legality of the expansion of full-benefit Medicaid eligibility in 2014.

The court will hear oral arguments in March 2012. Federal appellate courts across the country have reviewed the ACA, and while no federal court has overturned the Medicaid expansion, they have come to different conclusions about the constitutionality of the individual mandate. A ruling in the case is not expected until late in the Supreme Court's term – which could mean shortly before the 2012 elections.

32 Jennifer De Pinto, "Americans' split on Obama health care law," *CBS News*, November 14, 2011, http://www.cbsnews.com/8301-503544_162-57324430-503544/americans-split-on-obama-health-care-law/ accessed November 20, 2011.

33 Repealing the Job-Killing Health Care Act, H.R. 2, 112th Cong. (2011).

STDs and HIV/AIDS Prevention and Treatment

Every year, 19 million Americans contract a sexually transmitted disease (STD).[34] In addition to the health effects that result directly from STD infections, individuals with STDs are also at an increased risk of contracting HIV. More than one million Americans are estimated to have HIV, with 50,000 more becoming infected every year.[35] The Centers for Disease Control and Prevention (CDC) has identified HIV prevention in the US and global elimination of mother-to-child transmission of HIV and syphilis as "winnable battles."[36] While FY 2011 saw a slight increase in federal efforts to combat these epidemics, the final FY 2012 funding bill resulted in minimal cuts for STD and HIV/AIDS efforts within CDC, but a dramatic 25% decrease in funding for DASH's school-based prevention efforts.

Dr. Gail Bolan Chosen as Director of CDC's Division of STD Prevention

The CDC Division of STD Prevention (DSTDP) welcomed its new director, Gail Bolan, MD, in early 2011. Bolan began working in public health in 1982, and over her distinguished career worked for CDC and the San Francisco Department of Public Health. She most recently as Chief of the STD Control Branch at the California Department of Public Health. In 2011, Bolan oversaw the launch of a newsletter, *DSTDP Connect*, and a series of webinars designed to disseminate information about advances in the field of STD treatment and prevention, including the latest STD Treatment Guidelines.[37] Bolan also attended NFPRHA's 2011 National Conference in March.

Funding for STD and HIV/AIDS Prevention and Treatment

CDC's National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention's (NCHHSTP) had an overall increase of $59 million between FY 2010 and FY 2012. NCHHSTP received $1.116 billion dollars in FY 2011 – up from $1.045 billion in FY 2010 - with $154.7 million going to DSTDP. The Senate Labor, Health and Human Services, Education, and Related Agencies (Labor-HHS) FY 2012 appropriations bill maintained these funding levels, although the appropriations bill introduced by Representative Rehberg in the House proposed cutting nearly $74 million from the center. The final FY 2012 omnibus bill funded NCHHSTP at $1.104 billion, a $12 million reduction from the FY 2011 level. DSTDP's FY 2012 funding level was $154.4 milion.

NFPRHA requested a significant increase in funding for the DSTDP and for the Infertility Prevention Project (IPP) during the FY2012 appropriations process.

34 US Department of Health and Human Services, National Prevention, Health Promotion and Public Health Council, *National Prevention Strategy*, June 2011, http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf.

35 *Ibid.*

36 "CDC Winnable Battles," Centers for Disease Control and Prevention, available at http://www.cdc.gov/WinnableBattles/index.html.

37 Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Division of STD Prevention, *DSTDP Connect* 1, no. 1 (October 2011), available at http://www.cdc.gov/std/dstdp/DSTDP-Connect-October-2011.pdf.

The majority of the cut sustained by NCHHSTP in FY 2012 - $10.1 million – was taken from DASH funding. DASH provides funding and technical assistance to HIV/STD prevention programs in 49 states, the District of Columbia, 16 large urban school districts, 6 territories, and 1 tribal government through various school-based activities. In 2010, there were efforts to fold DASH into an existing $250 million disease prevention initiative focused on obesity prevention activities during the congressional appropriations process, but due to Congress' failure to finalize its individual FY 2011 appropriations bills, DASH ultimately retained its separate, dedicated funding – albeit at reduced levels. In FY 2011, DASH was funded at $40 million, a $17.6 million cut from FY 2010. In FY 2012, DASH funding dropped further, to $29.9 million. The cuts to DASH between FY 2010 and FY 2012 total $27.7 million, or 48%.

HIV/AIDS funding fared somewhat better than STD funding in FY 2012. NCHHSTP's Division of HIV/AIDS Prevention received a substantial increase in FY 2011, going from $728 million to $800.5 million. Like other public health programs, however, in FY 2012 it lost some ground, with a final funding level of $788.9 million. The Ryan White AIDS programs within HHS' Health Resources and Services Administration's (HRSA) HIV/AIDS Bureau did better, receiving back-to-back increases in FY 2011 and FY 2012 for a final funding amount of $2.327 billion.[38]

Study Finds Link between Hormonal Contraceptives and HIV Infection

A study published in *The Lancet Infectious Diseases* in October showed a link between hormonal contraceptive use and HIV infection.[39] The study, conducted in seven African countries by the University of Washington in Seattle, examined nearly 3,800 heterosexual couples where only one partner was HIV-positive. Researchers looked at rates of HIV acquisition for both women and men, and found an increased risk associated with both injectable and oral contraception, although the increase associated with oral contraception was not statistically significant. While the results of the study could have a chilling effect on those considering using hormonal contraceptives, the researchers stressed the need for people to carefully consider all contraceptive methods when deciding how best to prevent disease and unintended pregnancy.

The Guttmacher Institute published a short paper, "Hormonal Contraceptives and HIV Risk—Emerging Evidence in Context," examining this study and other research about HIV and hormonal contraception.[40] The paper addressed flaws in the University of Washington study and argued that although the new evidence needed to be taken seriously, one study on its own did not warrant changes to current programs. Guttmacher's paper also included recommendations for service providers and for future research projects that may further explore any connection between hormonal contraceptives and HIV infection.

38 For more on FY 2011 and FY 2012 funding, see "Publicly Funded Family Planning" beginning on page 7.

39 Renee Heffron et al., "Use of hormonal contraceptives and risk of HIV-1 transmission: a prospective cohort study," Lancet Infectious Diseases 12, no. 1 (January 2012): 19-26, available at http://www.thelancet.com/journals/laninf/article/PIIS1473-3099%2811%2970247-X/abstract.

40 Guttmacher Institute, "Hormonal Contraceptives and HIV Risk-Emerging Evidence in Context," accessed October 31, 2011, http://www.guttmacher.org/media/resources/hormonal-contraceptives-HIV.pdf.

Access to Abortion Care

Abortion care is a safe, common procedure, and Americans in significant number support access to this service. However, anti-choice forces at the federal and state levels took every opportunity to undermine access to abortion care in 2011, enacting a record number of anti-choice measures with potentially far-reaching implications at home and abroad.

Abortion Care and the ACA: The Fight Continues

After a protracted debate that threatened to derail the entire health reform effort, the ACA ultimately included several restrictions on abortion care: at least one plan that does not cover abortion care must be available in each state-based exchange, abortion care cannot be included as part of the EHB, and insurance plans must maintain separate administrative costs and collect separate premium payments from enrollees for plans that include abortion care coverage (known as the Nelson provision). Since the ACA's passage, some states have enacted laws banning insurance plans in their exchanges from offering coverage for abortion care at all, regardless of whether or not the person purchasing the insurance is using federal subsidies

When the Department of Health and Human Services (HHS) released a proposed rule regarding the state-based insurance exchanges, NFPRHA offered comments about the Nelson provisions. NFPRHA asked HHS to establish reasonable compliance standards for the collection of separate payments, including allowing one payment mechanism per enrollee rather than physically separate payments, and for HHS to clarify that separate payments are required only from plan enrollees responsible for payments and not from all plan beneficiaries. In addition, NFPRHA asked that HHS clarify that states may not impose requirements beyond the federal restrictions on coverage already in place.

In December, HHS released a final rule regarding the medical loss ratio (MLR) provision under the ACA. The MLR requires health plans to have a medical loss ratio of less than 80-85%, meaning that 80 to 85 cents of every dollar of premium payments must be spent on actual health care costs. The final rule did not address rules for health insurance plans that offer abortion care, a concern since abortion is the only service that comes with stringent administrative requirements (i.e. the Nelson provision), resulting in increased costs that may cause plans that cover abortion care to likely fall below the 80-85% required MLR.

During the initial comment period for the MLR rule, NFPRHA joined coalition partners in urging HHS Secretary Sebelius to clarify the rule. NFPRHA asked that extra costs associated with the administrative requirements of plans that cover abortion care because of the Nelson provision be specifically stated as "administrative costs," so they could be exempt from the MLR calculation. Since the final rule was published without NFPRHA's requested changes, NFPRHA is again joining coalition partners in urging HHS Secretary Sebelius to clarify the MLR rule to ensure that plans that cover abortion care will not be additionally penalized.

Smith and Pitts and Pence, Oh My

With a majority of members intent on eliminating access to abortion care in America, the House took up a series of anti-choice measures in 2011. The first, H.R. 3 (the "No Taxpayer Funding for Abortion Act"), passed the House in May. Sponsored by anti-choice Representative Chris Smith (R-NJ), it would prohibit small employers from receiving tax credits if they offer insurance plans that cover abortion care, as well as prohibit individuals from receiving reimbursement of funds which paid for an abortion through a flexible spending account (FSA) or health savings account (HSA). These provisions would amount to a tax increase on women, families, and small businesses wishing to obtain or provide coverage of a legal medical procedure. It would also permanently codify the discriminatory Hyde Amendment, denying low-income women and families equal access to quality and affordable comprehensive health care.

The House also passed H.R. 358 (the "Protect Life Act"), which would restrict coverage for abortion care in the state-based exchanges and include unprecedented exemptions for providers who refuse to perform or even refer for abortion care. Under H.R. 358, any insurance provider offering a qualified health plan that covers abortion care would also have to offer an otherwise identical plan that does not cover abortion care. This requirement would not only place a significant administrative burden on insurance plans that choose to cover abortion care, but would also create a significant disincentive for any plan to cover abortion care, which most plans currently do. In addition, the broad "conscience" protections included in the bill could include any medical service that a provider finds objectionable, including contraception and HIV medication. Sponsored by Representative Joseph Pitts (R-PA), H.R. 358 passed the House in October.

As in years past, Representative Mike Pence (R-IN) introduced H.R. 217 (the "Title X Abortion Provider Prohibition Act"), which purports "only" to remove Title X funding from abortion providers but in reality could dismantle the entire Title X network. It would prohibit abortion providers from accessing Title X funding, and would deny family planning funding to any entity that provides resources (including non-federal funding) to an abortion provider. Pence introduced a similar bill in the previous three congresses, and a bi-partisan group of members defeated it each time. In 2011, Pence offered a modified version of his bill as an amendment to H.R. 1, which would have stripped all funding from PPFA and its affiliates across the country.

The Pence amendment passed the House, but – as with the Smith and Pitts bills – did not pass the Senate. The Democrat-controlled Senate served as a backstop for restrictive abortion-related measures coming out of the House, although that did not stop anti-choice Senators from introducing bills designed to endanger a woman's right to choose. The Smith, Pitts, and Pence bills each had companion bills in the Senate, which were introduced but never voted on: Senator Roger Wicker's (R-MS) "No Taxpayer Funding for Abortion Act" (S. 906, the companion to H.R. 3), Senator Orin Hatch's (R-UT) "Protect Life Act" (S. 877, the companion to H.R. 358), and Senator David Vitter's (R-LA) "Title X Family Planning Act" (S. 96, the companion to H.R. 217).

Other anti-choice bills of note in 2011 included the "Parental Notification and Intervention Act of 2011" (S. 1005) and the "Susan B. Anthony and Frederick Douglass Prenatal Nondiscrimination Act (PRENDA) of 2011" (H.R. 3541). S. 1005, introduced by Senator John Boozman (R-AR), would require parental notification via certified mail for minors seeking abortion services. Providers would also be required to wait four days before performing an abortion; these four days would allow a minor's parents or guardians to obtain a court order to stop the procedure. Providers in violation of the law would face fines of up to $1 million and imprisonment of up to 10 years. H.R. 3541, introduced by Representative Trent Franks (R-AZ), would make it illegal for a provider to perform an abortion if he/she thinks the mother is seeking the abortion because of the sex or race of the fetus. While neither of these bills saw floor action in 2011, they nonetheless represent serious attacks on choice and on the new coverage mechanisms provided through the ACA.

President Obama's Statements of Administration Policy

The Obama administration continued to provide support for access to abortion care in 2011, although some reproductive health advocates argued that the administration's support was not strong enough. The administration issued "Statements of Administration Policy" (SAP) for both H.R. 3 (the Smith bill) and H.R. 358 (the Pitts bill). These SAPs, issued in May and October respectively, stated the president's strong opposition to the bills and the high likelihood that he would veto them if they arrived on his desk for signature. A SAP was also issued in July after the FY 2012 Financial Services and General Government Appropriations bill (H.R. 2434) was released, stating the president's concern over the District of Columbia (DC) being denied the ability to use its own funds to provide low-income women with abortion care. However, the final FY 2012 funding bill passed in December did include the DC abortion ban.

FY 2012 Budget and Appropriations Fail to Lift Bans

As with his FY 2011 proposed budget, President Obama's FY 2012 proposed budget failed to strike any federal prohibitions on abortion access and coverage affecting a broad spectrum of women and their families, including: Medicaid and Medicare beneficiaries, federal employees and their dependents, Peace Corps volunteers, Native American women, and women in federal prisons. These restrictions – known as "riders" – must be passed each year with the annual appropriations bills. However, in his annual budget proposal, the president can signal his desire to eliminate such provisions, if he so chooses – which he did not in 2011.

The president's proposed budget also failed to signal his support for repealing the abortion ban for women in the military, which prevents Defense Department funds from being used for abortions, even in cases of rape and incest, and precludes abortions from being performed at military hospitals, even if the woman uses her own money to pay for the procedure. To address this issue, Representative Louise Slaughter (D-NY) and Senator Kirsten Gillibrand (D-NY) introduced the "Military Access to Reproductive Care and Health for Military Women Act" (or "MARCH for Military Women Act"), which would repeal the ban on abortion care for women in the military.

Senator Jeanne Shaheen (D-NH) also offered an amendment to the FY 2012 National Defense Authorization bill that would have permanently removed the ban on insurance coverage for women in the military who are seeking abortions to end pregnancies that were a result of rape or incest.[41] On its face, this amendment could have received bi-partisan support, as it only allows abortion under the same restrictions as the Hyde Amendment. Unfortunately, the Shaheen amendment – as with the MARCH for Military Women Act - was never brought up for a vote. Despite Congress' failure to act on these important measures, their introduction helped to keep a pro-choice message visible in 2011 – an important step toward eventually repealing the ban for good.

In addition, the Senate Appropriations Committee reported a FY 2012 State, Foreign Operations, and Related Programs (State-Foreign Ops) Appropriations bill that contained a provision that would have allowed abortion coverage for Peace Corps volunteers in cases of rape or incest, or in situations that threaten a woman's life. This provision was left out of the final bill ultimately passed as part of the larger FY 2012 spending package.[42]

State Abortion Care Bans Reach Record Levels

In 2011, more than 1,100 measures related to reproductive rights and health were introduced in the District of Columbia and all 50 states.[43] By the end of the year, 135 new provisions were enacted in 36 states and DC.[44] Ninety-two of these were anti-choice provisions and included abortion bans and abortion coverage bans, restrictions on state funding, mandatory waiting periods and required ultrasounds, expanded refusal clauses, and laws which will make it more difficult for providers to operate.[45] According to the Guttmacher Institute, "[t]he 92 new abortion restrictions enacted in 2011 shattered the previous record of 34 adopted in 2005."[46]

State Bans on Abortion Providers Receiving Title X/Medicaid

In addition to the attacks on abortion care and coverage, anti-choice forces in the states also copied tactics employed at the federal level in 2011 concerning health care providers. Several states banned, or attempted to ban, abortion providers – or even systems that fund abortion providers - from receiving Title X funds or participating in Medicaid.[47] Many of these attacks mirrored congressional efforts targeting Planned Parenthood, such as the Pence amendment.

The most visible of these attacks came in May in Indiana, when the state legislature passed a law banning abortion providers from receiving any state or federal funds, including Medicaid. The change required approval from CMS, which formally rejected Indiana's plan in June. In a letter to Indiana's Medicaid director, CMS Administrator Donald Berwick said that Indiana's plan would improperly prevent beneficiaries from receiving services. Under federal law, Medicaid beneficiaries must be able to obtain services from any qualified provider, and Medicaid programs may not exclude otherwise-qualified health care providers from providing services because of a provider's scope of practice. Berwick specifically noted the impact Indiana's law would have on Medicaid enrollees' ability to access family planning providers. Shortly after CMS' decision, a federal judge granted Planned Parenthood of Indiana's request to enjoin the state from enforcing its law.

41 National Defense Authorization Act for Fiscal Year 2012, Pub. L. No. 112-81, 125 Stat. 1298 (2011).

42 For more on FY 2012 appropriations, see "Publicly Funded Family Planning" beginning on page 7.

43 Guttmacher Institute, "States Enact Record Number of Abortion Restrictions in 2011," last modified January 5, 2012, http://www.guttmacher.org/media/inthenews/2012/01/05/endofyear.html.

44 *Ibid.*

45 *Ibid.*

46 *Ibid.*

47 Guttmacher Institute, "State Center, Monthly State Update: MAJOR DEVELOPMENTS IN 2011, Abortion-Related Restrictions on State and Family Planning Funds," last modified December 31, 2011, http://www.guttmacher.org/statecenter/updates/index.html#fprestrictions.

Colorado, New Hampshire, North Carolina, Ohio, and Wisconsin all tried in some way to prevent Planned Parenthood from receiving family planning funding in 2011. In Kansas, the state passed a measure to block federal money from going to organizations that specialize in family planning without also providing primary and preventive care – essentially cutting off funding to all Planned Parenthood affiliates in the state, even those that do not provide abortion care. A federal judge granted an injunction preventing the measure from taking effect.

In Tennessee, state legislators attempted to amend the state budget to ban Title X funding from going to Planned Parenthood. However, in the final hours of the budget debate, the amendment was gutted. In response, nearly every county in the state individually revoked Title X money that had been granted to Planned Parenthood.

Texas legislators took a slightly different approach. Instead of specifically barring funds from going to abortion providers or Planned Parenthood, the legislature passed a law establishing a three-tiered priority system of how family planning money is allocated. Health departments in the state receive top priority, followed by community health centers and finally, if any funding is left, family planning centers.

Global Gag Rule: Gone, But Not Forgotten

The partisan battle over the global gag rule – which prevents non-governmental organizations operating oversees and receiving US assistance from counseling women about all their reproductive health options, including abortion care - continued in 2011. Shortly after taking office in 2009, President Obama issued an executive order repealing the rule. However, a future president could countermand the executive order, paving the way for Congress to once again attach the global gag rule as a rider to the State-Foreign Ops bill, which was the typical practice prior to the president's executive order.

In order to make the repeal of the global gag rule permanent, Senator Frank Lautenberg (D-NJ) offered an amendment to the State-Foreign Ops bill to block any re-imposition of the global gag rule. The amendment passed the Senate Appropriations Committee, making it into the Senate's version of the bill, but was not included in the final FY 2012 appropriations package.[48]

48 Fiscal Year 2012 Final Consolidated Appropriations Bills, Pub. L. No. 112-74, 125 Stat. 786 (2011).

Abstinence-Only Programs and Comprehensive Sexuality Education

Comprehensive sexuality education addresses the root issues that help teens and young adults make responsible decisions regarding their reproductive health and safety. While the teen birth rate dropped 9% in 2010 – the steepest decline since 1947 – there were still 372,252 children born to mothers under age 20 in 2010.[49] Two federal programs were created after President Obama took office designed to provide sexual and reproductive health guidance to teens and young adults to further the trend in declining teen birth rates and improve the lives of adolescents. However, 2011 saw repeated threats to this funding, as well as the resurrection of community-based abstinence-only program funding.

Comprehensive Sexuality Education Programs Work to Reduce Teen Pregnancy

The Teen Pregnancy Prevention Initiative (TPPI) grant program, created as part of the "Consolidated Appropriations Act of 2010," provides two tiers of competitive grants to public and private entities for evidence-based and innovative programs that reduce teen pregnancy. Originally funded at $110 million in FY 2010, TPPI was targeted for elimination in 2011 as part of H.R. 1, the same bill that zeroed out Title X. In the end, funding for TPPI was cut by $5 million - to $105 million - in FY 2011, and essentially level-funded for FY 2012.[50] The program's evaluation funding, however, was increased from $4.5 million to $8.48 million, per the president's FY 2012 budget request.

HHS' Office of Adolescent Health, which administers the TPPI program, distributed $75 million in Tier 1 grant awards (for evidence-based programs) to 75 grantees in 32 states and Washington, DC. Another $15.2 million in Tier 2 grants, which are used for developing and testing additional program models and innovative strategies, was distributed to 19 grantees in 14 states.[51] A remaining $10 million was allocated for grants to support community-wide initiatives to prevent teen pregnancy in communities with the highest rates.[52]

The Personal Responsibility Education Program (PREP), created as part of the ACA, is intended to provide young people with medically accurate and age-appropriate sex education to help them reduce their risk of unintended pregnancy, HIV/AIDS, and other STDs. Administered by HHS' Administration on Children, Youth, and Families (ACYF), PREP provides for $75 million a year for FY 2010-2014 in formula grants to states and territories, and competitive grants to public and private entities, as well as Indian tribes or tribal organizations. In FY 2011, 45 states, as well as Washington, DC, Puerto Rico, the Virgin Islands, and the Federated States of Micronesia, accepted PREP funds.[53]

49 Brady Hamilton, Joyce Martin, and Stephanie Ventura, "Births: Preliminary Data for 2010," National Vital Statistics Reports 60, no. 2 (November 2011), http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_02.pdf.

50 TPPI was funded at $104.8 million in the omnibus bill, not including the 0.189% rescission, which reduces the final level to $104.6 million.

51 The National Campaign to Prevent Teen and Unplanned Pregnancy, Grants from the Office of Adolescent Health, "accessed January" 2012, http://www.thenationalcampaign.org/federalfunding/funding_announcements.aspx.

52 *Ibid.*

53 *Ibid.*

The Return of Abstinence-Only… Again

In 2010, the ACA restored the Title V State Abstinence Grant Program, which had expired on June 30, 2009. The program provides $50 million a year to states for FY 2010-2014 for abstinence-only-until-marriage programming. In 2011, 34 states and Puerto Rico, Guam, and the Federated States of Micronesia, received Title V abstinence grants.[54] The Title V abstinence-only guidance is more flexible than in previous years - states are able to support mentoring, counseling, or adult supervision with the funding – but still requires grantees to focus on abstinence promotion to the exclusion of other topics.

2011 saw the resurrection of more abstinence-only funding, this time in the form of discretionary funds for community-based abstinence-only programs, which were eliminated in FY 2010. The final FY 2012 appropriations omnibus included a $5 million earmark ($4.9 million after the rescission) for abstinence-only programs. Proposed discretionary funding for abstinence-only first appeared in the Rehberg FY 2012 Labor-HHS appropriations bill, which proposed what would have amounted to an $85 million cut to TPPI - $65 million in a direct cut, plus a mandate that half of the program's remaining $40 million be specifically allocated for abstinence-only-until-marriage programming. Fortunately, neither the cut nor the re-allocation of TPPI funds for abstinence-only survived to the final omnibus – but the $5 million earmark was ultimately included.[55]

Lautenberg/Lee Introduce Comprehensive Sexuality Education Bill

In November 2011, Senator Frank Lautenberg (D-NJ), joined by six co-sponsors in the Senate, and Representative Barbara Lee (D-CA), with 28 House cosponsors, introduced the "Real Education for Healthy Youth" Act (S. 1782 and H.R. 3324). The bill would expand on the science-based foundation of TPPI and PREP by defining what comprehensive sexuality education programs funded by the federal government should entail, and by providing grants for adolescent and young adult comprehensive sexuality education and sex educator training.

NFPRHA joined with coalition partners to endorse the Real Education for Healthy Youth Act and worked with partners to secure original co-sponsors for the legislation.

54 *Ibid.*

55 Advocates for Youth and Sexuality Information and Education Council of the United States, "House Attempts to Revive Failed Community-Based Abstinence-Only-Until-Marriage Programs," news release, December 15, 2011, http://www.siecus.org/index.cfm?fuseaction=Feature.showFeature&FeatureID=2098.

A Look Ahead

February 9, 2012

Every sign from the White House and federal legislators indicate that the gridlock and partisan standoffs of 2011 will continue into 2012. Despite a year of near-government shutdowns that adversely impacted financial markets and created tremendous public uncertainty, Republicans and Democrats have yet to indicate a greater willingness or intention to work together to advance policy. Unfortunately, more of the same in 2012 means greater uncertainty for safety-net providers and patients. As has been demonstrated by the recent attacks on the ACA's contraceptive insurance coverage requirement, family planning providers can expect more politically motivated attacks on their systems and additional threats to public funding. The pressure points and logjams that consumed 2011 will be intensified by the politics of a presidential election, which suggests that very little policymaking, legislatively or administratively, will be accomplished.

Congress will approach its second session much as it did the first, looking for ways to reduce the federal deficit. The "Budget Control Act" (BCA) passed in August 2011 mandates that Congress find at least $1.2 trillion in spending cuts over the next 10 years.[56] The failure of the Super Committee to come up with a plan, despite the January 15, 2012, trigger deadline, is far from the end of the story. In reality, Congress and the White House have until January of 2013 – when the BCA's automatic cuts are schedule to go into effect – to come up with a different solution.

Given the current political situation, however, it will be next to impossible for Congress to meet its legislative obligation without cutting public health programs. Additional federal spending cuts will place a further strain on state governments, most of which have faced budget gaps for consecutive cycles. Forty-two states and DC have a projected a budget gap for FY 2012.[57] Discretionary funding cuts will likely be coupled with cuts to entitlement programs, including Medicaid. Since the start of the recession, Medicaid spending has increased on average by 7.3 percent.[58] To account for this growth in enrollment, several states have cut provider payments, eligibility for certain populations, and optional benefits. Forty-seven states implemented at least one policy to help control Medicaid costs in FY 2011, and 50 states have plans to do so in FY 2012.[59] The 2014 Medicaid expansion will only add to states' budget anxieties.

Hit with reductions in both discretionary and mandatory revenue, family planning providers will continue to struggle to meet the needs of a growing number of patients as resources continue to dwindle. Although the US economy is beginning to show signs of life, it is hard to imagine that modest improvements in the economy will trickle down to the family planning safety net over the next year.

56 Budget Control Act of 2011, Pub. L. No. 112-25, 125 Stat. 240 (2011).

57 "State Budget Shortfalls, SFY 2012," Kaiser Family Foundation, last modified June 17, 2011, http://www.statehealthfacts.org/comparereport.jsp?rep=69&cat=1.

58 Vernon Smith, Kathleen Gifford, and Eileen Ellis, *Moving Ahead Amide Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends*, Kaiser Family Foundation, October 2011.

59 *Ibid.*

Although some states have made progress in their ACA implementation activities, many states are not as far along as expected. The White House has a unique opportunity to publish guidance to further shape states' implementation efforts. However, election-year decisions to downplay the unpopular law might delay the administration's policy decisions. Additionally, the Supreme Court's review of the law in the spring may significantly alter how the administration and state governments relate to the ACA. For now, lingering uncertainty is a challenge for safety-net providers as they try to prepare for the tremendous delivery system changes expected to take effect soon.

Congress will continue to debate the value of revamping the American health care system, but is unlikely to agree on any significant changes to the ACA, and election-year politics will most likely prevent any significant deviations from 2011's appropriations stalemate. However, the debates over federal spending will be instructive as to how Republicans and Democrats are evolving their thinking on the role of government in the everyday lives of Americans.

It is not yet clear how the ramping up of the "culture wars" – which has been cast by congressional and religious conservatives as an attack on "religious liberty" but is a blatant assault on family planning and women's health care – will ultimately play into the 2012 presidential and congressional elections. However, as polls show and common sense dictates, public support for family planning, access to contraception, and insurance coverage of preventive health services – including contraception – is extremely strong.

In 2012, NFPRHA will continue to work to protect the ability of every individual to access the family planning and sexual health services they want and need. To that end, NFPRHA will continue the work it has begun with its members to identify how health centers and networks might adapt to ensure access to high-quality, comprehensive family planning services in the changing health care delivery system. In December 2011, NFPRHA announced that its *Life After 40* initiative would continue for the next two years. This project is intended to help prepare publicly funded family planning service providers for the ACA and will augment NFPRHA's core work in federal advocacy and policy.

In 2012, NFPRHA will grow and sharpen its advocacy tools and resources to strengthen its alliances in Congress and with the administration. House conservatives will continue to attack the network of family planning providers, and it will be imperative for every stakeholder that supports publicly funded family planning to work together to protect patient access to care. Fortunately, NFPRHA and its members are battle-tested and well-prepared to meet the challenges to come from members of Congress intent on undermining access to family planning and sexual health care.

About NFPRHA

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

NFPRHA members have provided high-quality preventive health care services in thousands of health centers to millions of women and men annually - making them a critical component of the nation's public health safety net. Everyday our members help people act responsibly, stay healthy, and plan for strong families.

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