THE TURNING POINT

Federal Legislative and Regulatory Action on Sexual and Reproductive Health in 2012

National
Family Planning
& Reproductive Health Association

The Turning Point

Federal Legislative and Regulatory Action on Sexual and Reproductive Health in 2012

National
Family Planning
& Reproductive Health Association

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

Table of Contents

Introduction

In some ways, 2012 was a year of déjà vu, with Congress and the White House locked in a stalemate over the federal budget. However, a funny thing happened amidst the ideological impasse that consumed much of 2012 – family planning broke through the political miasma, representing a crucial turning point in the fight to promote and expand access to publicly funded family planning care.

After an unprecedented assault on family planning in 2011, a new wave of attacks in early 2012 over the Affordable Care Act's (ACA) contraceptive insurance coverage requirement awoke a sleeping giant: supporters of sexual and reproductive health. The callousness and vitriol with which opponents of the provision attacked its supporters, and the dismissive way in which the US House of Representatives' Republican majority blocked the lone female witness at a congressional hearing from testifying in support of the provision, struck an unpleasant chord across the country. The issue dominated the media online, over the airwaves, and in print, and most importantly, women and men were galvanized into action. Rather than running away from the issue, members of Congress and the White House were suddenly running toward it – a reality made even more remarkable by the fact that it was an election year.

If 2012 represented a turning point for family planning and sexual and reproductive health, it was equally pivotal for public health. In June, after months of speculation, the US Supreme Court upheld the bulk of the ACA. The ruling was a victory for public health, with the exception of the court's verdict that the ACA's Medicaid expansion – a cornerstone of the law's health insurance expansion and essential to millions of low-income individuals – was unenforceable, essentially making the provision optional for states. Overall, the Supreme Court's decision meant that the ACA had cleared one of the two remaining hurdles to the law's survival. The remaining hurdle was the November elections.

In part thanks to women voters stirred to action over contraception, President Barack Obama was re-elected to a second term, and Democrats made gains in both the House and Senate. In 2013, Republicans will lead the House, and Democrats will lead the Senate. Although the election resulted in the preservation of the status quo in many ways, it was also a turning point inasmuch as it represented a rejection of rolling back the ACA and a national recognition that women's health is a top issue for voters.

2012 saw its share of challenges. Attacks at the state level on the family planning network and providers resulted in uncertainty and, in some states, the undermining of low-income individuals' access to publicly funded family planning care. Funding for the Title X family planning program – which had sustained a major funding cut in fiscal year (FY) 2011 – was further reduced for FY 2012, down to $293.9 million. Election-year gridlock, coupled with an ongoing stalemate over the federal budget and deficit reduction, led Congress to fund the government through a series of continuing resolutions at FY 2012 levels until March 2013.

Despite the challenges of 2012, there is much to celebrate for family planning providers, patients, and advocates – successes made even sweeter by the struggles undertaken to secure them. Significant challenges remain ahead, as the ACA is more fully implemented and providers and patients work to navigate the new health care economy, and as Congress and the White House continue to grapple with the federal budget and deficit reduction. Yet, we must acknowledge the turning point that 2012 was for family planning, savor our victories, and build upon our successes to ensure a bright future for publicly funded family planning.

Publicly Funded Family Planning: Budget and Appropriations

As members of Congress began the second session of the 112th Congress in January 2012, it quickly became apparent that the gridlock that characterized the first session would continue, especially with the threat of across-the-board budget cuts looming in January 2013. Throughout the year, politically motivated cuts continued to plague publicly funded family planning programs.

Publicly Funded Family Planning Programs Targeted in Deficit Reduction Battles

The "Budget Control Act" (BCA), which became law in August 2011, included a series of caps on discretionary spending totaling $917 billion in cuts over ten years.[1] Additionally, the failure of the Joint Select Committee on Deficit Reduction to reach agreement on additional spending reductions started the country on the road to sequestration – a series of automatic, across-the-board cuts to federal spending that were scheduled to go into effect on January 2, 2013.[2] These cuts were anticipated to amount to $984 billion divided evenly between defense and non-defense programs – an estimated $110 billion for fiscal year (FY) 2013 alone.[3] Most mandatory spending programs, including Medicaid, were exempt from sequestration. Of the $110 billion in across-the-board sequestration cuts, approximately $54 billion were to come from spending on non-defense discretionary (NDD) programs, which includes programs such as Title X and the Title V Maternal and Child Health Block Grant.[4]

In 2011, NDD spending represented less than one-fifth of the federal budget and 3.4% of the United States' gross domestic product (GDP).[5] However, deficit reduction efforts, particularly since the passage of the BCA, had resulted in nearly 100% of the spending cuts coming from NDD programs.[6] According to a report by the federal Office of Management and Budget (OMB), sequestration would further cut discretionary health spending by 8.2%. Funding for the Health Resources and Services Administration (HRSA), the agency through which Title X funding flows, would face a reduction of $605 million overall.[7]

NFPRHA continued to publish Title X state snapshots, which featured key information on the Title X family planning program, for use during advocacy visits, town hall meetings, and other events to show elected officials and members of the public just how important the Title X family planning program is in each state.

Title X Continues to Face Attacks, Funding Cuts

Title X's funding continued to face attacks in Congress in 2012. In February, NFPRHA learned that FY 2012 funding for Title X received an additional cut beyond the level included in the final omnibus spending bill passed by Congress at the end of December 2011. The final FY 2012 appropriation for Title X was $296.8 million, a $2.6 million (0.9%) cut from the FY

1 Congressional Research Service, *The Budget Control Act of 2011: Effects on Spending Levels and the Budget Deficit*, accessed December 2012, http://www.fas.org/sgp/crs/misc/R42013.pdf.

2 National Women's Law Center, *A Roadmap to the Upcoming Federal Budget Debates, September 2012*, http://www.nwlc.org/sites/default/files/pdfs/federalbudgetroadmap.pdf.

3 Center on Budget and Policy Priorities, *How the Across the Board Cuts in the Budget Control Act Will Work*, April 27, 2012, accessed December 2012, http://www.cbpp.org/files/12-2-11bud2.pdf.

4 *Ibid*.

5 Coalition for Health Funding, *Do the Math: Avert Sequestration with Balanced Approach*, accessed November 2012, http://publichealthfunding.org/uploads/NDD-flyer.Final.pdf.

6 *Ibid*.

7 Office of Management and Budget, *OMB Report Pursuant to the Sequestration Transparency Act of 2012 (P. L. 112–155)*, accessed February 2013, http://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/stareport.pdf.

2011 funding level.[8] However, this amount was further reduced by $2.9 million, bringing actual Title X funding for FY 2012 to $293.9 million – $5.5 million (1.9%) less than the final FY 2011 funding level of $299.4 million. While a portion of the additional $2.9 million loss was a result of the Continuing Resolutions that funded the federal government for three months from October to December 2011, the majority of the additional reduction was due to the Department of Health and Human Services (HHS) exercising its authority to shift up to 1% of program funding levels to other programs within HHS. This decrease in funding, combined with the other budget cuts, resulted in a total of $23.6 million in cuts to the Title X program, a 7.4% loss, in just two fiscal years.

In a letter to OMB, NFPRHA requested $327.4 million for Title X, for FY 2013, which would be a $30.6 million increase over the final FY 2012 appropriation for Title X. NFPRHA's letter to OMB also called for increases to other critical programs such as the Teen Pregnancy Prevention Initiative (TPPI), the Title V MCH Block Grant, the Centers for Disease Control and Prevention (CDC) Division of STD Prevention (DSTDP), and the Division of Adolescent and School Health (DASH). NFPRHA also led 34 Family Planning Coalition partners in a separate coalition letter, which also requested $327.4 million for Title X.

President's Fiscal Year 2013 Budget Proves Disappointing

When the president released his FY 2013 budget on February 13, 2012, NFPRHA was disappointed to learn that the proposal called for Title X to be level funded at the FY 2012 appropriated funding level of $296.8 million, a $30.6 million reduction from the president's FY 2012 request for Title X ($327.4 million).[9] Despite strong public support for family planning, the president failed to take the opportunity to send a signal of support for the Title X network. Additionally, the president's budget proposed reduced funding levels for several other public health programs and prevention efforts, including the TPPI, CDC's National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP), and the MCH Block Grant.[10] The president's budget did include a generous increase over both FY 2012 estimated funding and his FY 2012 budget request for the Ryan White HIV/AIDS program.

In April, NFPRHA and Planned Parenthood Federation of America (PPFA) held a briefing on Capitol Hill entitled, "Family Planning Funding: A Critical Need." The briefing was hosted by Senators Barbara Boxer (D-CA) and Patty Murray (D-WA), and Representative Joseph Crowley (D-NY). More than 70 attendees learned about the important role that Title X and Medicaid-supported family planning services play in the lives of millions of poor and low-income women and men. The panel of speakers included NFPRHA President & CEO Clare Coleman, Planned Parenthood of Metropolitan Washington CEO Laura Meyers, and Adam Thomas, a visiting professor at the Georgetown Public Policy Institute who presented new research on federal savings tied to investments in publicly funded family planning.

Ryan Budget Jeopardizes Funding for Women's and Public Health

On March 20, 2012, Representative Paul Ryan (R-WI), Chairman of the House Committee on the Budget, unveiled the Republican budget plan for FY 2013. This sequel to FY 2012's "Path to Prosperity" budget drew a large amount of "savings" from changes and cuts to Medicare, Medicaid, discretionary spending, and the elimination of the Affordable Care Act (ACA).[11] The plan would have reduced spending by nearly $20 billion more than the budget cap approved in 2011, and it included a new proposal to exempt defense spending from sequestration cuts. The Ryan plan would have placed the burden of cuts solely on non-defense agencies, including HHS. The plan also proposed converting Medicaid into a block grant program that would effectively cap the amount of money spent on Medicaid each year, cutting federal Medicaid spending by

8 "Title X Funding History," Department of Health and Human Services, Office of Population Affairs website, accessed February 2013, http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/title-x-funding-history/.

9 "The President's Budget for Fiscal Year 2013," White House website, accessed February 2013, http://www.whitehouse.gov/omb/budget.

10 *Ibid.*

11 House of Representatives Budget Committee, *The Path to Prosperity: A Blueprint for American Renewal: Fiscal Year 2013 Budget Resolution*, accessed February 2013, http://budget.house.gov/uploadedfiles/pathtoprosperity2013.pdf. For more on health care reform, see the "Affordable Care Act" section starting on page 12.

$810 billion over 10 years.[12] On March 21, 2012, the House Budget Committee approved the plan 19-18. All 16 of the committee's Democrats voted against the plan. They were joined by Representatives Tim Heulskamp (R-KS) and Justin Amash (R-MI), who thought that the budget did not cut spending enough.[13] One week later, on March 29, the House passed H. Con. Res. 112, Chairman Ryan's budget, by a largely party line vote of 228-191, with ten Republicans voting against the bill and no Democrats voting for it.[14] The bill failed in the Senate by a vote of 58-41.[15]

House Appropriations Subcommittee Proposes Total Elimination of Title X

On July 17, 2012, the House Appropriations Labor, Health and Human Services, Education, and Related Agencies (Labor-HHS) Subcommittee released its proposed funding bill for FY 2013.[16] For the second year in a row, the Republican-authored proposal zeroed out Title X, included dramatic cuts to preventive health programs, and harmful language that would have dramatically decreased women's access to health care. The bill also reduced overall funding for the CDC by 10%; reduced TPPI funding by $85 million, but included a $15 million increase for abstinence-only-until-marriage programs; and eliminated the Prevention and Public Health Fund.[17]

NFPRHA assisted Senator Boxer and Representative Crowley in circulating "Dear Colleague" letters requesting increases for the Title X program for FY 2013. The letters had a record number of signatures – the House version contained 112 signatures, compared to 70 the previous year, while the Senate letter garnered 33 senators' support, ten more than in 2011.

Harmful provisions, attached to the bill as "policy riders," were also included that would have essentially prohibited any federal funds for Planned Parenthood affiliates; prohibited funds to enforce the ACA requirements for coverage or certain services if there were religious or moral objections; and broadened current law regarding health care providers' refusal to perform or participate in abortion care.[18] The bill also included language that would have prohibited any funds from being used to implement the ACA, with minor exceptions.

The subcommittee passed the Labor-HHS Appropriations bill on a vote of eight to six, with Representative Jeff Flake (R-AZ) joining the Democrats in voting against the bill due to his opposition to the total funding level. The full House Appropriations Committee never considered the legislation.

12 Families USA, *Republicans Again Propose Slashing Funding for Medicaid, Medicare, and Other Health Programs*, April 2012, accessed December 17, 2012, http://familiesusa2.org/assets/pdfs/budget-battle/Republican-Budget-Slashes-Health-Programs.pdf. An April 2011 analysis by the Congressional Budget Office (CBO) predicted that a similar proposal "would probably require states to decrease payments to Medicaid providers, reduce eligibility for Medicaid, provide less extensive coverage to beneficiaries, or pay more themselves than would be the case under current law." Congressional Budget Office, Long-Term Analysis of a Budget Proposal by Chairman Ryan, April 5, 2011, accessed December 17, 2012, http://cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12128/04-05-ryan_letter.pdf.

13 Erik Wassson, "Ryan budget passes committee by one vote," *The Hill*, March 21, 2012, http://thehill.com/blogs/on-the-money/budget/217503-ryan-budget-passes-committee-by-single-vote.

14 "H.Con.Res. 112 (112th): Establishing the budget for the United States Government," govtrack.us, accessed December 2012, http://www.govtrack.us/congress/votes/112-2012/h151.

15 Andrew Taylor, "House GOP Budget Plan Rejected By Senate Democrats," *Associated Press*, May 16, 2012, http://www.huffingtonpost.com/2012/05/16/house-gop-budget-plan-senate_n_1522393.html.

16 House Labor, Health and Human Services Appropriations Subcommittee draft bill, July 15, 2012, http://appropriations.house.gov/uploadedfiles/bills-112hr-sc-ap-fy13-laborhhsed.pdf.

17 The Prevention and Public Health Fund was created as part of the Affordable Care Act tasked with "promoting wellness, preventing disease, and protecting against public health emergencies." For more information about the Prevention Fund, please visit: http://www.healthcare.gov/law/full/title/iv-amendments.pdf.; The National Campaign to Prevent Teen and Unplanned Pregnancy, "House Appropriations Subcommittee Approves FY 2013 Labor, Health and Human Services and Education Appropriations Bill that Severely Cuts or Restricts Programs to Prevent Teen and Unplanned Pregnancy: A Statement from The National Campaign to Prevent Teen and Unplanned Pregnancy," news release, July 19, 2012, http://www.thenationalcampaign.org/press/pdf/statement-house-subcomittee-approps.pdf.

18 National Partnership for Women and Families, "House Subpanel Approves Funding Ban for Planned Parenthood, Title X as Part of FY 2013 Labor-HHS Spending Bill," *Women's Health Policy Report (blog)*, July 19, 2012, http://www.nationalpartnership.org/site/News2?page=NewsArticle&id=34575&news_iv_ctrl=0&abbr=daily2_.

House Title X Advocates Fight Back

In response to the House Labor-HHS bill to eliminate Title X and reduce funding for many other vital programs, subcommittee Democrats pushed back. Representatives Nita Lowey (D-NY) and Barbara Lee (D-CA) both raised concern about the elimination of Title X during the Labor-HHS Appropriations Committee markup. Additionally, all of the Democrats on the committee present voiced their concern over the bill's attacks on the public health safety net.[19]

In response to continued attempts by the House of Representatives to eliminate all funding for Title X, NFPRHA developed a toolkit which helped NFPRHA members to educate members of Congress and their staffs about the importance of supporting Title X, Medicaid, and other public health programs that improve access to family planning services.

House Appropriations Committee Ranking Member Norm Dicks (D-WA) introduced an amendment to strip the ideologically based policy riders from the bill and reinstate Title X funding.[20] Democratic members also offered amendments designed to rid the bill of the health care riders. These amendments failed on party-line votes.[21] Additionally, Representatives Louise Slaughter (D-NY) and Diana DeGette (D-CO), co-chairs of the Congressional Pro-Choice Caucus, sent a letter to House Speaker Boehner, House Appropriations Committee Chairman Hal Rogers (R-KY), and Labor-HHS Appropriations Subcommittee Chairman Denny Rehberg (R-MT), regarding the elimination of Title X and requested that they provide clarification on their "party's position on access to and availability of contraceptive methods for American men and women."[22] The Republican leaders did not respond.

In a surprising break from party lines and in response to the growing attacks on Title X, on May 9, 2012, Rep. Robert Dold (R-IL) introduced H.R. 5650, the "Protecting Women's Access to Health Care Act."[23] The legislation would have prohibited discrimination against a hospital, health center, or other health care provider based upon that provider or entity's provision of abortion care with non-Title X funding. A press release accompanying the bill stated, "In response to the growing number of efforts to discriminate against and exclude organizations like Planned Parenthood from participating in health care programs, Dold's legislation would protect the inclusion of any hospital or health care entity that seeks to participate in the Title X family planning program."[24] Recognizing that the bill would see no legislative action in the Republican-controlled House, Dold stated that he introduced the bill in an effort to find common ground on the issue of health care access for women.[25]

Senate Proves More Supportive of Publicly Funded Family Planning

In contrast to the House of Representatives, the Senate markup of the Labor-HHS appropriations legislation was far less hostile to sexual and reproductive health. On June 12, the Labor-HHS Subcommittee approved its bill[26] on a party-line vote, and on Thursday, June 14, the full Appropriations Committee adopted the measure by a vote of 16 to 14, again along party lines.[27] Unfortunately, the bill included $293.9 million for Title X, a reduction from the previous year's appropriated funding level of $296.8 million and $2.9 million less than President Obama's FY 2013 budget request. Highlights from the legislation included:

- The Title V MCH Block Grant receiving a $1 million increase in funding to $640 million in FY 2013, up from $639 million in FY 2012, and in line with the president's budget request.

19 For more on the attacks on women's health services, see the "Family Planning Services and Supplies" section starting on page 26.

20 Erik Wasson, "Controversial labor, health bill clears House subcommittee," *The Hill*, July 18, 2012, http://thehill.com/blogs/on-the-money/appropriations/238683-labor-hhs-bill-clears-house-subcommittee.

21 *Ibid*.

22 Office of Representative Diana DeGette (D-CO), "Slaughter and DeGette Blast Republican Efforts to Cut Title X Funding," news release, July 18, 2012, http://degette.house.gov/index.php?option=com_content&view=article&id=1218:slaughter-and-degette-blast-republican-efforts-to-cut-title-x-funding&catid=76:press-releases-&Itemid=227. For more on the controversy over contraceptive coverage, see the "Women's Preventive Health Services Begin Amidst Challenges to Contraceptive Coverage" section on page 18.

23 Protecting Women's Access to Health Care Act, H.R. 5650, 112th Cong. (2012), http://www.gpo.gov/fdsys/pkg/BILLS-112hr5650ih/pdf/BILLS-112hr5650ih.pdf.

24 Office of Representative Robert J. Dold, "Representative Dold Introduces the Protecting Women's Access to Health Care Act," news release, May 9, 2012, http://dold.house.gov/press-release/representative-dold-introduces-protecting-women%E2%80%99s-access-health-care-act.

25 For more information about Dold's bill and abortion – related measures, see the "Access to Abortion Care" section on page 30.

26 Fiscal Year 2013 Senate Appropriations Bill for the Departments of Labor, Health and Human Services, and Education, S. 3295, 112th Cong., (2012), http://www.gpo.gov/fdsys/pkg/BILLS-112s3295pcs/pdf/BILLS-112s3295pcs.pdf.

27 "Washington Highlights," Association of American Medical Colleges website, June 15, 2012, accessed February 2013, https://www.aamc.org/advocacy/washhigh/highlights2012/286128/061512senateappropriationspanelprovidesmodestincreasefornihelimi.html.

- The TPPI was level-funded at approximately $105 million and TPPI evaluation funding maintained at the FY 2012 level of $8.5 million, a $4 million increase over the president's budget request.
- Abstinence-only-until-marriage discretionary funding zeroed out for FY 2013.
- A $2 million increase for CDC's DSTDP, dedicated for infertility prevention.
- Level funding for CDC's DASH at the FY 2012 level of $30 million.
- A $300 million increase in FY 2013 for community health centers, bringing their total funding up to $3.07 billion from $2.77 billion in FY 2012. This funding would have included discretionary funds and funds mandated by the ACA.
- Level funding for the Prevention and Public Health Fund, at $1 billion for FY 2013, the same as in FY 2012 and $250 million less than requested by the president.

Unfortunately, none of the appropriations bills that passed out of the Senate Appropriations Committee progressed to a full Senate vote. In the fall of 2012, Congress and President Obama agreed to a temporary, six-month continuing resolution (CR). The CR will essentially keep the government funded at its FY 2012 funding levels through March 2013, consistent with the budgetary funding caps established in the BCA.[28] The House passed the stopgap spending bill by a vote of 329-91.[29] The CR then passed the Senate by a 62-30 vote and was signed into law by President Obama.[30] However, later that week, the House passed other legislation that would protect defense programs from sequestration by making deeper cuts to discretionary spending programs. The Republican-backed bill reflected the year-long fight with Democrats over where to find reductions in federal spending.

Facing the Fiscal Cliff: A Year of Funding Uncertainty

After a tumultuous election cycle, members of both the House and Senate returned to Washington, DC, in November for a lame-duck session overshadowed by the looming "fiscal cliff." Congressional leaders remained at odds on how best to avoid the cuts in sequestration scheduled to take effect in early January 2013, as well as the expiration of a number of tax and payment extensions set to expire at nearly the same time, including the Bush tax cuts of 2001 and 2003.

Lines in the sand were quickly drawn. President Obama, with support from many congressional Democrats, stated he would not sign legislation halting the sequester if the deficit reduction package was not balanced, meaning including both spending cuts and tax increases, particularly for the wealthiest Americans.[31] Speaker Boehner spoke out in opposition to raising any taxes in order to decrease the deficit but said he would support a simplification of the tax code that would eliminate loopholes.[32] Many of his Republican colleagues, however, continued to strongly oppose any changes to the tax code, instead supporting deep cuts to federal spending.[33]

In late November 2012, Treasury Secretary Timothy Geithner and other top White House aides presented Republican congressional leaders with an offer from President Obama that included an estimated $400 billion in savings, primarily from changes to Medicare.[34] As a counter offer, Speaker Boehner and other top House Republican members sent a letter to President Obama that contained a framework for a deal totaling $2.2 trillion.[35] The "framework" included $600 billion in unspecified "health savings" from mandatory spending programs like Medicaid and Medicare, and $300 billion in further cuts to discretionary funding.[36] During this time, President Obama and Speaker Boehner met a number of times to discuss these options in an attempt to establish a path forward.

28 FY 2013 Continuing Appropriations Resolution, H.J. RES. 117, 112th Congress (2012), http://www.gpo.gov/fdsys/pkg/BILLS-112hjres117enr/pdf/BILLS-112hjres117enr.pdf.

29 David Rogers, "Paul Ryan, House Republicans OK Spending Increase," *Politico*, September 14, 2012, http://www.politico.com/news/stories/0912/81191.html.

30 American Public Health Association, *APHA Legislative Update*, October 2012, accessed February 2013, http://www.vtpha.org/file-downloads/apha/LEGISLATIVE/october.pdf.

31 White House Office of the Press Secretary, "Statement by the President on the Supercommittee," news release, 11/21/11, http://www.whitehouse.gov/the-press-office/2011/11/21/statement-president-supercommittee.

32 Press Office of Speaker John Boehner, "The GOP 'Supercommittee' Plan for Pro-Growth Tax Reform: More Tax Revenue, More Jobs, Lower Tax Rates for All Americans," Official Blog (blog), November 18, 2011, http://boehner.house.gov/news/documentsingle.aspx?DocumentID=270286.

33 "Cutting Spending, Reducing the Size of Government," Official GOP Website, accessed February 2013, http://www.gop.gov/indepth/pledge/cutspending.

34 Jonathan Weisman, "G.O.P. Balks at White House Plan on Fiscal Crisis," *New York Times*, November 29, 2012, http://www.nytimes.com/2012/11/30/us/politics/fiscal-talks-in-congress-seem-to-reach-impasse.html?_r=0.

35 Russell Berman, "House GOP makes a $2.2 trillion debt counteroffer to Obama on cliff," *The Hill*, December 3, 2012, http://thehill.com/homenews/house/270649-house-republicans-make-22t-counter-offer-to-obama-in-debt-talksklj.

36 John Parkinson, "Boehner Counters Obama Deficit-Cutting Deal With 'Credible Plan,'" *ABC News*, December 3, 2012, http://abcnews.go.com/blogs/politics/2012/12/boehner-counters-obama-deficit-cutting-deal-with-credible-plan/.

In response to the fiscal cliff negotiations, NFPRHA policy staff participated in a number of budget-related activities, including numerous Hill visits, a weekly budget series in *Reproductive Health Watch*, a membership-wide call, action alerts for Congress, and a presentation at the NFPRHA regional conference in New Orleans that outlined the most up-to-date information surrounding the negotiations and a look ahead at the FY 2014 appropriations season.

The "American Taxpayer Relief Act": A Temporary Solution

After a long and drawn out debate over deficit reduction, on December 31, 2012, H.R. 8, the bipartisan "American Taxpayer Relief Act of 2012," passed the Senate 89-8.[37] The bill included a permanent extension of the Bush-era tax cuts for individuals earning less than $400,000 a year and couples earning under $450,000, and a delay of the sequestration cuts until March 1, 2013, along with other provisions. The House passed the measure 257-167, on January 1, 2013, and President Obama signed the bill into law, delaying sequestration. At the last minute, Congress averted another fiscal emergency by again dodging big decisions on deficit reduction.

Federal Funding for Family Planning & Sexual Health (in millions)

Program	FY 2012 Actual	Change from FY 2011	FY 2013 NFPRHA Request	FY 2013 President's Budget	FY 2013 Senate Appropriations Committee	FY 2013 House Labor-HHS Appropriations Subcommittee
Title X Family Planning	$293.9	*-$5.5 (1.8%)*	$327.4	$296.8	$293.9	0
Title V MCH Block Grant	$639	*-$17 (2.6%)*	$645	$640	$640	Unknown
Title XX Social Services Block Grant	$1,700	*0*	$1,700	$1,700	$1,700	$1,700
Teen Pregnancy Prevention Initiative (TPPI)	$104.6	*-$0.2 (0.189%)*	$130	$104.8	$104.6	$20
TPPI Evaluation	$8.5	*+$4 (88%)*	$8.5	$4.2	$8.5	Unknown
Abstinence - Only Until Marriage Program	$4.9	*+4.9 (100%)*	0	0	0	$20
CDC Division of STD Prevention (DSTDP)	$153.8	*-$0.9 (0.6%)*	$180	$153.9	$155.8	Unknown
CDC Division of Adolescent School Health (DASH)	$29.8	*-$10.2 (25.5%)*	$50	$39.9	$29.8	Unknown

37 "H.R. 8 (112th): American Taxpayer Relief Act of 2012," GovTrack.us website, accessed February 2013, http://www.govtrack.us/congress/bills/112/hr8#overview.

The Affordable Care Act

At the start of 2012, the future of the Affordable Care Act (ACA) was unclear. The presidential election, coupled with the US Supreme Court's December 2011 announcement that it would review the constitutionality of the law, halted much of the administrative and legislative action on the law that could have occurred throughout the year. Despite the temporary reprieve from administrative and legislative action, policymakers still found time to dispute the value of contraception, sparking a year-long public debate about the importance of protecting women's access to the basic health services they need.

Republicans in Congress scaled back their attempts to repeal the ACA and chose to argue their opposition to the law in the court of public opinion and on the campaign trail. Democrats in Congress continued to champion their role in implementing national health reform. The Obama administration, fighting for a second term in the White House, increased its education around benefits in the ACA and the role the law would play in expanding coverage for millions of uninsured Americans and improving health insurance for everyone.

Supreme Court Reviews the ACA

In December 2011, the Supreme Court announced that it would hear oral arguments on the federal health care reform law over the course of three days (March 26-28, 2012).[38] The court's declaration was unprecedented in two important ways. First, the court agreed to hear six hours of oral arguments – a departure from the one hour traditionally allotted for oral arguments. Second, the court shocked public health advocates by agreeing to hear arguments on the constitutionality of the Medicaid expansion – raising questions about a public insurance program in existence for 47 years.

By the time the Supreme Court heard the ACA challenge, dozens of cases had been heard in the lower courts, the bulk of which either upheld the law or dismissed the challenges on procedural grounds. The case that reached the Supreme Court attracted the most public attention because it was filed by attorneys general from 26 states, demonstrating that more than half of the states opposed the health reform law. The National Federation of Independent Business also joined the suit, representing a diverse group of business interests in opposition to the ACA. The principal argument from the petitioners asserted that the individual mandate was unconstitutional and could not be removed from the law without the law becoming unworkable, thus invalidating the ACA entirely. The secondary argument from petitioners challenged the Medicaid provision that required all states with Medicaid programs to expand coverage to every individual in the state below approximately $14,856 in annual income, or 133% of the federal poverty level.[39] Under the ACA, if a state failed to expand its Medicaid program, it would lose the federal funds used to finance its Medicaid program.[40] The states complained that the expansion policy was coercive, effectively requiring them to implement an unaffordable policy. Parties with an interest in the outcome of the case, ranging from the health insurance industry to members of Congress, filed briefs for and against the ACA.

> NFPRHA and 59 other organizations joined an amicus brief authored by the National Women's Law Center in support of the ACA and its potential to significantly improve women's health.[41]

As the parties to this suit were preparing for the court review in March, several religiously affiliated organizations began filing suits in opposition to the contraceptive coverage requirement in the ACA. Most of the contraceptive coverage-related suits challenged the ACA on First Amendment/religious freedom grounds, an issue not taken up by the Supreme Court.[42]

On March 26, 2012, the US Supreme Court began its historic review of the ACA. Hundreds of supporters and opponents of the health reform law gathered outside, underscoring the significance of the decision before the nine justices. On the first day, the court heard arguments on a procedural issue involving whether the individual mandate was a tax penalty or not, the decision on which could have required the court to defer all other constitutional questions. The court ultimately decided the procedural question in a way that allowed the justices to

38 National Federation of Independent Businesses v. Sebelius, 567 U.S., 132 S.Ct. 2566 WL 24278180 (2012).

39 2012 Federal Poverty Level numbers.

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

41 Brief *amici curiae* of the National Women's Law Center et. al., filed, No. 11-398 (2011).

42 See the "Women's Preventive Health Services Begin Amidst Challenges to Contraceptive Coverage" section on page 18 for more information.

adjudicate the ACA on the merits. On the second day, the court heard arguments on the individual mandate, largely considered the main constitutional question raised by opponents of the law.

NFPRHA President & CEO Clare Coleman joined health reform supporters on the second day of oral arguments in discussing the ACA and the court case on radio programs that aired in Madison, WI; Chicago, IL; and Washington, DC. In her interviews, Clare outlined how the ACA was important to the lives of millions of poor and low-income women and men, and the role of the law in expanding access to family planning services.

On the third and final day of oral arguments, the court considered whether the law could survive if the individual mandate was ruled unconstitutional. The second half of the day was dedicated to arguments over the constitutionality of the Medicaid expansion.

All eyes were focused on Justice Anthony Kennedy, largely considered the "swing voter," in the hopes of getting a sense of how he might rule based on his interactions with counsel. Supporters of the ACA, including the White House, approached the law's Supreme Court review with a healthy amount of confidence. After three days and six hours of oral arguments, legal observers were skeptical about the law's survival at the close of oral arguments, and champions of health reform were deeply worried. The justices' questions to the arguing attorneys led many in the media to believe that the ACA was in jeopardy, and the law's supporters waited with nervous anticipation for the ruling.

Supreme Court Upholds ACA, Rules Medicaid Expansion Optional

On June 28, 2012, the Supreme Court affirmed the constitutionality of the ACA.[43] Excitement over the decision was followed by confusion and frustration when the court announced that it agreed with the states opposing the law that the ACA's Medicaid expansion was "coercive."[44] In agreeing with the states, the court allowed the Medicaid expansion provision to advance but removed the government's enforcement mechanism – the ability to take away states' existing Medicaid funds for noncompliance.[45] In other words, states were given the *option* to expand their full-benefit Medicaid programs to individuals earning up to 133% of the federal poverty level (FPL; $14,856 per year for an individual in 2012).[46]

The Supreme Court decision knocked down one barrier while erecting another for the ACA. NFPRHA, along with other advocacy organizations, sprang into action to encourage states to move forward with the Medicaid expansion as it was intended in the law. NFPRHA assembled a Supreme Court response toolkit that included a variety of resources to help its members navigate the decision and its impact on the publicly funded family planning network. The toolkit was designed to help NFPRHA members encourage the uptake of the Medicaid provision in their individual states.

Although not fully the desired outcome, the Supreme Court decision validated the work that NFPRHA and others had done to advance health reform.

Optional Medicaid Expansion Creates Challenges, Uncertainty for States

At the start of 2012, public health advocates and state legislators were clamoring for guidance on how to implement the ACA's Medicaid expansion, originally designed to add 16-17 million individuals to the program. Any policy decisions at the federal level for the Medicaid expansion were then complicated by the Supreme Court decision giving states the option to expand their programs.

The Supreme Court decision on Medicaid sent shockwaves through the advocacy community, which immediately looked to HHS leaders for additional guidance. The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) estimated that 6 million fewer people would be covered by the Medicaid program following the court's decision, with 3 million of those individuals expected to now obtain health insurance through the health care exchanges.[47,48] Unfortunately, the ACA was written in a way

43 National Federation of Independent Businesses v. Sebelius, 567 U.S., 132 S.Ct. 2566 WL 24278180 (2012).

44 *Ibid*.

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

46 For more on state decisions on the Medicaid expansion, see "Publicly Funded Family Planning: A Programmatic Look" beginning on page 22.

47 In March 2012, CBO/JCT had estimated that by 2022, the ACA would increase Medicaid enrollment by 17 million and enroll 22 million in the exchanges, leaving 27 million uninsured. Following the Supreme Court's decision, CBO/JCT changed their 2022 estimates to 11 million newly enrolled in Medicaid and 25 million in the exchanges, leaving 30 million uninsured. Congressional Budget Office and staff of the Joint Committee on Taxation (JCT), *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*, July 2012, accessed August 27, 2012, http://www.cbo.gov/publication/43472.

48 The CBO/JCT's revised estimates, however, assume that states will be able to partially expand their Medicaid programs while still receiving the fully enhanced federal medical assistance percentage (FMAP), an issue which has not yet been decided. Therefore, the estimates of how many individuals will no longer be eligible for the Medicaid expansion could be low.

that prevents individuals with incomes under 100% of the federal poverty level ($11,170 in annual income in 2012) from receiving subsidies to purchase health insurance through the exchanges. This omission would likely put affordable coverage out of reach for at least half of the six million people no longer expected to be enrolled in Medicaid following the court's decision.[49] In a July 2012 letter to governors, HHS Secretary Kathleen Sebelius indicated that the agency would exempt low-income, uninsured individuals in states that do not expand their Medicaid eligibility from paying the ACA's penalty for failing to maintain health insurance.[50] The individual mandate penalties do not go into effect until 2015, however, so the details of how such an exemption would work may not be known for some time. Such an exemption would certainly be positive for the nation's low–income population. However, it does nothing to address the fact that individuals in states that choose not to expand Medicaid would likely be without insurance coverage.

As the end of 2012 neared, only a handful of the policy questions raised by the Supreme Court's ruling had been answered, and most of those answers were not issued as formal regulations, but through statements by Centers for Medicare & Medicaid Services (CMS) officials carried by the press or included in letters to governors. For example, in a July 13, 2012, letter to the Republican Governors Association (RGA), CMS Acting Administrator Marilyn Tavenner told the RGA that "there is no deadline for a state to tell [CMS] its plans on the Medicaid eligibility expansion."[51] Tavenner further elaborated that states could receive the extra funding the federal government is offering for Medicaid information technology costs even if they have not yet decided whether they intend to expand their Medicaid programs, and that states would not have to pay back those funds in the event they chose not to expand.[52] In early August, Cindy Mann, CMS Deputy Administrator and Director of CMS' Center for Medicaid and CHIP Services, speaking to the National Conference of State Legislatures, said that states that had adopted the expansion would be allowed to drop the expansion at a later time.[53]

In addition, the question of whether Medicaid family planning waivers will continue beyond December 31, 2013, remained unanswered at the end of 2012.[54]

HHS Issues FAQ Answering Some Key ACA Implementation Questions

One of the biggest questions posed by states was whether they could partially expand their Medicaid programs, yet still receive the ACA's enhanced federal medical assistance percentage (FMAP).[55] The RGA, among others, wanted the federal government to allow states to expand their Medicaid programs up to a level below 133% of the FPL (for example, to 100% of the FPL) and still receive the enhanced FMAP.[56] A number of analysts and advocates, however, speculated that such a partial expansion might not be legally permissible.[57]

In September 2012, Cindy Mann made statements on a conference call with CMS stakeholders indicating that the administration did not intend to allow states to partially expand their Medicaid programs under the ACA, at least while the federal government is paying 100% of the cost of the expansion. As reported by *Inside Health Policy*:

> "It seems that what the law provides for is that states expand their programs to cover all people up to 133[%] of the [FPL]," Mann said in response to a stakeholder's

49 Congressional Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*, July 2012.

50 US Department of Health and Human Services Secretary Kathleen Sebelius, letter to state governors, July 10, 2012, accessed August 27, 2012, http://capsules.kaiserhealthnews.org/wp-content/uploads/2012/07/Secretary-Sebelius-Letter-to-the-Governors-071012.pdf.

51 Centers for Medicare & Medicaid Services Acting Administrator Marilyn Tavenner, letter to the Republican Governors Association, July 13, 2012, accessed August 27, 2012, http://familiesusa2.org/assets/pdfs/Tavenner-July-2012.pdf.

52 *Ibid*.

53 Kaiser Health News, "Medicaid Official Outlines State Flexibility in Health Law's Medicaid Expansion," August 7, 2012, accessed January 28, 2013, http://www.kaiserhealthnews.org/daily-reports/2012/august/07/health-law-implementation.aspx.

54 For more on the continuation of Medicaid family planning waivers, see "Publicly Funded Family Planning: A Programmatic Look" beginning on page 22.

55 The enhanced FMAP means that the federal government would pay 100% of the costs of the expansion population from 2014 to 2016, reducing down to a final match rate of 90% in 2020 and thereafter.

56 Governor Bob McDonnell, letter to US Department of Health and Human Services Secretary Kathleen Sebelius on behalf of the Republican Governors Association, July 23, 2012, accessed August 27, 2012, http://nevadajournal.com/assets/uploads/2012/07/rga-letter-to-sebelius.pdf.

57 Congressional Research Service, "Selected Issues Related to the Effect of *NFIB v. Sebelius* on the Medicaid Expansion Requirements in Section 2001 of the Affordable Care Act." *See also* Sara Rosenbaum and Timothy Westmoreland, "CBO's Updated Affordable Care Act Estimates: Resting On Shaky Assumptions?," *HealthAffairsblog*, July 31, 2012, http://healthaffairs.org/blog/2012/07/31/cbos-updated-affordable-care-act-estimates-resting-on-shaky-assumptions/.

> query. CMS has not issued guidance on states' ability to phase-in to that level, she said. Mann further gave no indication that CMS planned to offer more information, instead suggesting that the agency believes it has already answered such queries. CMS has said that a state can come in when it chooses, and "at least in the short term" this would address questions about a phase in, Mann said.[58]

The question was answered – in more concrete terms – in a December 10, 2012, letter and related document sent to governors from Secretary Sebelius. The 17-page document, entitled "Frequently Asked Questions on Exchanges, Market Reforms and Medicaid," answered a number of questions posed by states on a variety of ACA implementation-related issues following the Supreme Court's ruling, including the exchanges; market reforms; multi-state insurance plans; pre-existing condition insurance plans and other high-risk pools; consumer outreach, eligibility, and enrollment; and Medicaid.[59]

The frequently asked questions (FAQ) document explained that states would not be allowed to partially expand their Medicaid programs and still receive the ACA's enhanced matching rate, at least in the next few years. Regarding partial expansion, HHS explained, "Congress directed that the enhanced matching rate be used to expand coverage to 133% of FPL. The law does not provide for a phased-in or partial expansion. As such, we will not consider partial expansions for populations eligible for the 100 percent matching rate in 2014 through 2016."[60] The document goes on to say that states can seek a partial expansion via a demonstration project, but that services provided under such a project would only receive the state's regular FMAP.[61] However, the FAQ leaves the door open to the possibility that, beginning in 2017, states could be granted a waiver to partially expand their Medicaid programs and still receive the enhanced matching rate.

Additionally, the FAQ stated that no further deadline extensions would be offered for states to decide whether or not to establish an exchange. Consequently, by the end of 2012, a total of 25 states had defaulted to a federally facilitated exchange (FFE).[62] In the initial years of the exchanges, the FFE will be entirely run by the federal government, although states do have the ability to apply to run their own exchanges at any time. States still had until February 15, 2013, to apply for a state-federal partnership exchange.[63] As of year's end, 18 states plus the District of Columbia had declared they would establish a state-based exchange, and seven states were planning for a state-federal partnership exchange. Under the partnership model, the state and the federal government would divide some of the administration and operational functions of the exchange.

In 2012, NFPRHA submitted comments to CMS requesting policies be established that would allow increased access to family planning providers through the various exchange models.[64] NFPRHA's comments stressed the importance of protecting family planning providers from discrimination and encouraged FFE administrators to explicitly consult with health centers that deliver free or reduced-cost family planning services.

The FAQ also addressed how HHS hopes to reduce churn – the cycling of individuals between public and private insurance – by certifying Medicaid "bridge plans" as qualified health plans (QHPs). These plans would allow individuals transitioning between Medicaid/CHIP and commercial health insurance to maintain provider networks, providers, and the same insurer. Bridge plans would be required to meet all essential health benefit requirements.

The FAQ also indicated a change in the administration's position on the issue of a blended FMAP rate for Medicaid. Previously, the administration had signaled support for a blended FMAP rate, which would replace the various matching rates at which the federal government reimburses states for their costs with a single, blended rate for each state. The FAQ stated that HHS no longer supports moving to a blended rate, and that the Supreme Court decision on the Medicaid expansion made the higher matching rates available in the ACA for those newly eligible for Medicaid even more important to incentivize states to expand Medicaid coverage.

58 Amy Lotven, "CMS Officials Offer Hints on DSH, Medicaid Phase-In Policies," *Inside Health Policy*, September 13, 2012.

59 Centers for Medicare & Medicaid Services, *Frequently Asked Questions on Exchanges, Market Reforms and Medicaid*, Department of Health and Human Services, December 10, 2012, accessed December 2012, http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf.

60 *Ibid*.

61 *Ibid*.

62 The Advisory Board Company, *Decision Day: Which States Are Going with Insurance Exchanges and Does it Matter?*, December 14, 2012, accessed January 28, 2013, http://www.advisory.com/Daily-Briefing/2012/12/14/Decision-day-which-states-are-going-with-exchanges.

63 Centers for Medicare & Medicaid Services, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid*, December 10, 2012.

64 "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers." *Federal Register 77*:59 (March 27, 2012) p. 18421.

CMS Implements ACA's Medicaid Enrollment Provisions

Early in 2012, CMS issued a (mostly) final regulation implementing the Medicaid eligibility and enrollment provisions in the ACA.[65] The rule is intended to extend and simplify Medicaid eligibility and incentivize states to facilitate the expansion of full-benefit Medicaid eligibility. As originally written, the interim final rule on Medicaid eligibility could have inadvertently penalized individuals enrolled in and eligible for limited-benefit programs under Medicaid, including family planning waivers and state plan amendments. The final rule appeared to address the concerns NFPRHA raised in its comments.

CMS also issued guidance that impacted the structure of the Medicaid system in preparation for 2014. CMS published two rules applicable to Section 1115 Medicaid demonstration waivers and ACA state innovation waivers to increase transparency and public input in the waiver-making process.[66] The ACA requires HHS to issue regulations to ensure the public has "adequate opportunities to provide meaningful input into the development of State demonstration projects, as well as in the federal review and approval of State demonstration applications and renewals."[67] Both rules allow for a greater amount of public input in the waiver application process and encourage more participation from interested parties in the structure of the waivers. While such transparency could benefit family planning waiver programs because it would allow beneficiaries to weigh in with their states and CMS on how family planning services are needed in their individual communities, it could also inadvertently invite greater anti-family planning activism.

HHS issued one additional rule regarding Medicaid payment policy that placed family planning and other women's health providers at a disadvantage. On May 11, 2012, CMS published a proposed rule implementing a policy in the ACA that would reimburse primary care providers participating in Medicaid at increased rates.[68] Both the proposed and final rules enabled clinicians who practice family medicine, general internal medicine, and pediatric medicine to receive enhanced Medicaid reimbursement for the provision of preventive and primary care services. Under the ACA, states can increase reimbursement rates for primary care services at rates not less than the 2009 Medicare physician fee schedule for years 2013 and 2014.[69] Moreover, the federal government will pay 100% of the payment increase for states that increase payments above the Medicare rate.[70] Unfortunately, the enhanced payment does not apply to obstetricians and gynecologists or certified nurse midwives. Additionally, the definition of primary care does not extend to family planning services.

NFPRHA began conversations with other women's health providers on how best to fix the disparity in treatment in the 113th Congress which starts in 2013.

HHS Implements State Insurance Exchanges and Essential Health Benefits Packages

Recognizing that the state insurance exchanges and essential health benefits packages (EHB) could have the most significant impact on the public, HHS issued guidance that tested the administration's thinking on these issues without finalizing them. HHS published a series of documents ranging from formal regulations in early 2012 to bulletins and blueprints later in the year, which allowed public health advocates and state legislators alike to weigh in on exchanges and the EHBs.

In late 2011, HHS published an interim final rule guiding states on how to establish state-based exchanges. The interim final rule was of particular importance to the family planning network because it detailed how to structure the essential community providers (ECP) provision in the ACA. The ECP provision requires all health plans to include safety-net providers in its coverage network and was a significant achievement for family planning health centers who may have otherwise struggled to get into networks without the policy protection.[71]

65 "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010," *Federal Register* 77:52 (March 23, 2012).

66 "Medicaid Program; Review and Approval Process for Section 1115 Demonstrations;" "Application, Review, and Reporting Process for Waivers for State Innovation," *Federal Register* 77:38, (February 27, 2012).

67 *Ibid*.

68 "Medicaid payment for primary care services and charges for vaccine administration in the Vaccine for Children (VFC) program," *Federal Register* 77:27671 (May 11, 2012).

69 *Ibid*.

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

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

NFPRHA commented on the interim final rule asking for stronger protections for family planning and women's health providers, including the requirement that all health plans contract with "any willing safety-net provider." NFPRHA also asked for the least burdensome implementation of what became known as the Nelson Amendment, a policy requiring – among other things – that individuals with plans that cover abortion submit two separate premium payments.

In the spring of 2012, HHS published a combined final and interim final rule on state-based exchanges that included several policy changes important for the family planning network.[72] The final rule did not require that contracts be extended to any willing provider, but did require health plans to include a "sufficient choice of providers" and strengthened the language to require a "baseline" for all health plans to "ensure all services will be available without unreasonable delay" to plan enrollees.[73] The final rule also protected family planning providers by prohibiting health plans from excluding certain ECPs from participation in their health plan network or in their payment rates. The rule skirted the Nelson question and simply restated the statutory language requiring that individuals with insurance in exchange plans that cover abortion submit two payments for that coverage.

In response to concerns from the National Governors Association and because many states had been waiting for the outcome of the election before making ACA-related decisions, HHS extended the deadline for states to submit plans to run state-based exchanges twice in the late fall of 2012. The final deadline for submission was December 16, 2012.[74]

Additionally, HHS published a federal bulletin describing the regulatory approach it planned to propose in defining the EHB required under the ACA.[75] Family planning and women's health advocates had great concerns about whether and how the EHB would cover sexual and reproductive health services. Unfortunately, the bulletin failed to answer that question and more significantly left the decision for states to determine.

Under the ACA, the EHB are the set of services health plans participating in state-based exchanges are required to cover. The ACA outlined 10 coverage categories that must be included in the EHB package and gave the HHS Secretary the authority to further define these benefits.[76] Although the ACA explicitly granted the HHS Secretary the authority to determine the EHB, the bulletin proposed handing that decision over to the states. State policymakers would have the responsibility of choosing a plan to serve as the EHB for each individual state.

Fearing that state legislators hostile to sexual and reproductive health would choose plans that fail to cover important family planning services, NFPRHA submitted comments that expressed concern with the excessive amount of flexibility granted to states. NFPRHA's comments urged HHS to identify a more comprehensive health plan or set of benefits that would define the EHB and serve as a national "floor" for states. NFPRHA also encouraged HHS to require states to seek out advice and counsel from safety-net providers including family planning agencies in their selection of the EHB.

HHS issued a proposed rule on the EHB package late in the year essentially reiterating what was proposed in the federal bulletin.[77] The proposed rule allows states to enforce stricter requirements on the ability of health plans to substitute benefits but in NFPRHA's estimation still provided states with too much flexibility in their EHB selections. One notable addition to the proposed rule was the application of the abortion separation requirement (the Nelson Amendment) to all individual and small group health plans.

72 "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers," *Federal Register 77*:59 (March 27, 2012).

73 *Ibid*.

74 Centers for Medicare & Medicaid Services, *Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges – Frequently Asked Questions*, May 16, 2012, accessed January 28, 2013.

75 US Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin*, December 16, 2011, http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

76 *Ibid*.

77 "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation," *Federal Register 77*:227, (November 26, 2012).

NFPRHA submitted comments to the EHB proposed rule echoing many of the arguments presented in response to the bulletin. The comments reiterated the need for the Secretary to establish a national standard for the package of benefits and services that millions of people stand to gain under the ACA. NFPRHA argued that a national floor was particularly important in the context of sexual and reproductive health services which are frequently entangled in ideological and political battles. NFPRHA also urged HHS to repeal the application of the Nelson provision to all small group and individual health plans. NFPRHA, along with many organizations, outlined the legal and policy problems that resulted from expanding the Nelson provision's reach and strongly encouraged HHS to remove the policy in the final rule.

In addition to the EHB proposed rule, HHS also issued guidance on several of the popular consumer protections provisions in the ACA.[78] A proposed rule clarified reforms designed to ensure that health insurance is available to consumers regardless of their health status or demographic factors that have traditionally acted as barriers to coverage. The proposed rule addressed four areas of importance to consumers including: health insurance premiums; insurance rating; guaranteed availability of coverage ("guaranteed issue"); and guaranteed renewability of coverage. The proposed rule also provided instructions to states on how to monitor insurance rate increases and enforce the consumer protections in the ACA. NFPRHA was pleased that the proposed rule applied the women's health preventive services coverage to all new ACA-sanctioned health plans, including the catastrophic coverage available only to individuals under age 30.

In an unexpected and disappointing policy decision, CMS announced that undocumented immigrants, protected from deportation under a new immigration policy, were ineligible for health insurance coverage authorized under the ACA.[79] The immigration policy, "Deferred Action for Childhood Arrivals" (DACA), allows a small number of young people to stay in the United States without fear of deportation if they take actions towards citizenship. Unfortunately, in what was viewed as a largely political decision in an election year, the administration issued a rule prohibiting those young people from accessing ACA benefits.

NFPRHA and several other organizations commented on the federal register notice and expressed strong disappointment in the administration's decision to exclude immigrant residents covered by the DACA policy from ACA participation. The comments urged HHS to reverse its discriminatory decision, noting that it would serve only to exacerbate health disparities already pervasive in immigrant communities.

Women's Preventive Health Services Begin Amidst Challenges to Contraceptive Coverage

The end of 2011 brought an unwelcomed surprise for women's health advocates. The women's preventive health benefits, which guaranteed that all women would have access to insurance coverage of all FDA-approved contraceptives, family planning counseling, and well-woman visits, were being threatened by religiously affiliated organizations with objections to contraception. The Obama administration came under extreme pressure to reverse its decision to require insurance coverage of contraception and, in turn, women's health groups mounted an intense campaign in defense of the coverage.

As NFPRHA reported in "Gridlock Nation," in August 2011, HHS had issued an interim final rule requiring that commercial insurance plans cover a number of women's preventive health services, including contraception, without patient co-pays.[80] The interim final rule included an exemption for religious organizations that primarily employ persons who share the religious tenets of the organization. Immediately, a group of religious advocacy organizations, led by the US Conference of Catholic Bishops (USCCB), wanted the exemption expanded to include all religiously affiliated organizations with moral objections to contraception.[81]

After several weeks of intense lobbying by a coalition of women's health groups and members of Congress, the White House announced in January 2012 that the final rule implementing the women's preventive health services benefit would not expand the religious exemption for contraception.

78 "Patient Protection and Affordable Care Act; Health insurance Market Rules, Rate Review," *Federal Register* 77:227, (November 26, 2012).

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

80 "Group Health Plans Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act," *Federal Register* 76:149 (August 3, 2011).

81 US Conference of Catholic Bishops, "USCCB Urges Rescission of HHS Contraceptive Mandate, Criticizes 'Inexplicably Narrow' Definition of Religious Freedom," news release, US Conference of Catholic Bishops, August 31, 2011, http://www.usccb.org/news/2011/11-168.cfm.

Mistakenly believing that the administration had overreached, anti-family planning members of Congress immediately introduced bills and held hearings in the hopes of scoring political points in an election year.

Responding to some in Congress who called on the White House to reverse its decision, NFPRHA equipped its members with information and resources that enabled them to promote public support of the contraceptive coverage benefit. NFPRHA made available a "Contraceptive Coverage Toolkit" that included talking points, a sample letter to the editor, and polling showing strong public support for contraceptive access.

Just three weeks after announcing that all women with commercial insurance would get contraceptive coverage, the White House issued an advance notice of proposed rulemaking (ANPRM) that was billed as a compromise for religiously affiliated organizations.[82] The forthcoming rule implementing the policy would require insurance companies to cover contraception for women who work for religious organizations that object to providing such coverage. Religious organizations would not be required to pay for contraceptive coverage, and neither would the women being covered. Under the final rule, the insurer would provide the coverage to women directly and without cost. The rule would also give religious organizations an additional year to comply with the law. At the time of this writing, the administration had not yet published a final rule on the accommodation.

Requiring insurers to cover a benefit not also required of employers provided a regulatory challenge for HHS' rule-makers. Requiring health insurance plans to pay for a specific health benefit because of an employer's religious objection is a new concept in the health care delivery system. The ANPRM asked stakeholders to weigh in on several questions to help the departments choose a path of implementation that did not infringe on the religious views of entities that do not want to cover or pay for their employees' contraception.

The proposed accommodation satisfied a number of groups that had opposed the contraceptive insurance coverage requirement, including the Catholic Hospital Association. However, the United States Conference of Catholic Bishops (USCCB) continued its opposition to the requirement and anti-family planning members of Congress stated their intent to overturn the requirement.

Senators Marco Rubio (R-FL) and Joe Manchin (D-WV) introduced a bill to expand the types of entities exempted from providing insurance coverage for contraception to their employees.[83] In addition to exempting any health care entity from providing the coverage, the bill would also allow individuals or entities who oppose contraception or sterilization to refuse to educate or counsel on these health issues, meaning they would not be required to inform their employees of alternate ways to access coverage of contraception.

Going to an even greater extreme, Senator Roy Blunt (R-MO) angered provider groups and women's health advocates alike when he offered an amendment to allow any employer or insurance company to refuse to offer, provide, or cover ***any*** essential health care service – including birth control coverage – if the employer or insurance company opposed the service on religious or moral grounds.[84]

NFPRHA joined with the Service Employees International Union, Planned Parenthood Federation of America, NARAL Pro-Choice America, and more than 50 other organizations in the Coalition to Protect Women's Health Care to ensure all women would maintain access to the contraceptive coverage requirement in the ACA. The coalition came together to demonstrate the breadth of organizations that support contraceptive coverage benefits and to work together to defeat the anti-family planning messages coming from a vocal few in Congress and religiously aligned organizations with a strong influence on policymakers.

In a tremendously tone-deaf display, on February 16, 2012, the House Oversight and Government Reform Committee held a hearing entitled, "Lines Crossed: Separation of Church and State. Has the Obama Administration Trampled on Freedom of Religion and Freedom of Conscience?"[85] Committee Chairman Darrel Issa (R-CA) had invited an all-male panel to testify on the importance of contraceptive coverage, creating a visual representation of an "out-of-touch" Congress that went viral and sparked outrage nationwide. Representatives Carolyn Maloney (D-NY)

82 "Certain Preventive Services Under the Affordable Care Act," *Federal Register 77*:55 (March 21, 2012).

83 Religious Freedom Restoration Act of 2012, S. 2092, 112th Cong. (2012).

84 Respect for Rights of Conscience Act of 2011, S. 1467, 112th Cong. (2011).

85 "Lines Crossed: Separation of Church and State. Has the Obama Administration Trampled on Freedom of Religion and Freedom of Conscience?: Hearing Before the Committee on Oversight and Government Reform of the House of Representatives," 112th Cong. p. 1 (2012), http://oversight.house.gov/wp-content/uploads/2012/06/02-16-12-Full-Committee-Hearing-Transcript.pdf.

and Del. Eleanor Holmes Norton (D-DC), both committee members, walked out of the hearing to protest the chair barring a Georgetown Law student named Sandra Fluke from testifying in support of contraception.[86] Several days later, Democrats allowed Fluke to deliver her testimony, rocketing her to star status in the national conversation about the newly termed "war on women."[87]

Following the House hearing, Republicans and Democrats seemed to gain a new awareness of the significance of women's health issues in the public discourse. As quickly as anti-family planning politicians flocked to the issue, they began retreating. Senators who originally stood with Senator Blunt when he introduced his amendment began backing away from it. On March 1, 2012, the Senate voted 51-48 to table the Blunt Amendment, effectively killing it.[88]

HHS also released a final rule regarding contraceptive coverage under student health plans.[89] Under the rule, student health plans would be required to cover contraception and several other preventive services without co-pays. Students at religiously affiliated schools with contraception objections would receive contraceptive coverage under the same process as employees of religiously affiliated organizations.

NFPRHA submitted comments to HHS requesting policies be established that would allow the greatest access to contraceptive coverage for women. NFPRHA urged HHS to ensure that any employer under the accommodation be required to provide their insurance plan beneficiaries with timely, clear, and accurate information about their contraceptive coverage and without any additional barriers.

The fury over contraceptive coverage continued through the summer as the August 1, 2012, start date for the coverage approached. The USCCB began a national campaign called the "Fortnight to Freedom."[90] The two-week campaign was described by the USCCB as a way to champion religious freedom leading up to Independence Day, but the media reported on the event as a campaign to roll back access to contraception.

NFPRHA encouraged its members to celebrate the August 1 date and educate their communities about the value of the women's preventive health services coverage. NFPRHA assembled a toolkit for its members that included a sample press statement, a sample letter to the editor, links to resources on its website that explained how the benefit was a historical achievement in health insurance coverage for millions of women, and links to other supportive organizations with resources and grassroots opportunities.

As the year wound down, several legal challenges to the contraceptive coverage requirement were moving through the courts. The list of complainants included institutions like the University of Notre Dame and the Archdioceses of New York. At the time of this writing, the majority of the challenges to the contraceptive coverage requirement had been dismissed on procedural grounds because the provisions affecting religious organizations had not yet taken effect. However, a few courts departed from that trend and granted complainants, including some privately run companies, preliminary injunctions against the coverage requirement.

86 Sunlen Miller, "Birth-Control Hearing was Like Stepping Into a Time Machine," *ABC News*, February 21, 2012, http://abcnews.go.com/blogs/politics/2012/02/birth-control-hearing-was-like-stepping-into-a-time-machine/, accessed January 30, 2013.

87 For more on the public debate around women's health, see the "Introduction" on page 5, the "Family Planning Services and Supplies" section on page 26 and the "Look Ahead" section on page 34.

88 Josiah Ryan and Sam Baker, "Senate Rejects Blunt amendment to limit birth-control mandate," *The Hill*, March 1, 2012, http://thehill.com/blogs/floor-action/senate/213615-senate-rejects-blunt-amendment-to-kill-birth-control-mandate, accessed March 3, 2012.

89 "Student Health Insurance Coverage," *Federal Register*, *77*:55 (March, 21, 2012).

90 "Fortnight for Freedom," US Conference of Catholic Bishops website, http://www.usccb.org/issues-and-action/religious-liberty/fortnight-for-freedom/, accessed January 30, 2013.

One of the legal challenges to the contraceptive coverage requirement may eventually be heard in the Supreme Court. Because of the direct impact on its membership, NFPRHA joined an amicus brief in *Frank O' Brien Jr. et al. vs. US Department of Health and Human Services* authored by the Center for Reproductive Rights in support of the federal government's position.[91] O'Brien Industrial Holdings, a for-profit mining company in Missouri, challenged the contraceptive coverage requirement on First Amendment grounds. The amicus argued that the contraceptive coverage requirement did not overburden a religiously affiliated organization's free exercise of religion. Moreover any burden caused by the federal contraception coverage requirement is supported by compelling reasons, including public health promotion and preventing unintended pregnancy. At the time of this writing, a decision was pending.

ACA Remains Law of the Land with Hurdles Ahead

2012 was a monumental year for the ACA. It survived legal and political challenges. Both the American public and opponents of the ACA have accepted it as the law of the land and understand that it will move forward. Post-election statements from Republican leaders in Congress suggested that while they may attempt to repeal the law's politically unpopular provisions, they may no longer attempt to repeal the entire law. In 2013, HHS, states, and health care providers are expected to work overtime to prepare for the implementation. While the law may experience more setbacks, it remains – as it was on the day it became law – a monumental achievement in public health.

91 Brief *amici curiae* of the Center for Reproductive Rights et. al., filed, No. 12-3357 (2012).

Publicly Funded Family Planning: A Programmatic Look

The Title X family planning program and Medicaid-funded family planning services underwent several important changes in 2012. The Office of Population Affairs (OPA) finalized its Title X guidelines revision with a release expected in 2013. OPA also reorganized its training centers, moving away from a regionally based system to a system of four national centers. Additionally, the Centers for Disease Control and Prevention (CDC) announced it planned to begin an evaluation of the effect of certain guidance documents on family planning health centers. As described in the last section, the Centers for Medicare & Medicaid Services (CMS) primarily focused on implementing new Affordable Care Act (ACA) provisions and assessing the implications of Medicaid expansion becoming optional for states, as a result of the June Supreme Court decision. The Department of Health and Human Services (HHS) finalized initial Medicaid quality measures, and in February, the Supreme Court ruled that it would not decide the issue of whether health care providers can sue a state to enforce federal Medicaid law, sending the case back to the lower courts. Throughout the year, NFPRHA continued to advocate for programmatic changes to ensure the widest possible access to sexual and reproductive health services for both providers and patients.

OPA Continues Title X Guidelines and FPAR Revision, Reorganizes Training Centers

Throughout 2012, NFPRHA continued to work with the OPA's expert work group, individuals organized to consult with the agency, on the Title X guidelines revision. The new guidelines were in the review process by the end of the year. NFPRHA played a key role during the revision, advocating for its members and for guidelines that reflect both evidence-based and best practices in family planning care.

Funding for the new training centers began September 1, 2012, and the agreement awards included: National Training Center for Coordination and Strategic Initiatives – Altarum Institute and Cicatelli Associates, Inc.; National Training Center for Management and Systems Improvement – JSI Research and Training Institute, Inc.; National Training Center for Family Planning Service Delivery – Cardea Services; and National Training Center for Quality Assurance, Quality Improvement and Evaluation – JSI Research and Training Institute, Inc.[92] NFPRHA's *Life After 40: The Family Planning Network* and *the ACA* project includes resources for trainings that will complement the efforts of the new national training centers, particularly regarding health care reform. The change to training, especially at a time of great challenge for Title X programs, has been questioned by many NFPRHA members – NFPRHA conveyed concerns and questions related to the shift to OPA throughout the year.

OPA also announced it would begin revising the Family Planning Annual Report (FPAR), again working with an expert work group on which NFPRHA sits. A new report would need Office of Management and Budget (OMB) approval and be in effect no earlier than 2015.

CDC Proposes Family Planning Evaluation Project

In April 2012, the CDC's Division of Reproductive Health, in collaboration with OPA, announced plans to conduct an evaluation of the utilization of and impact on provider and clinic-level attitudes and practices of three national guidance documents.[93] Intended to be a follow-up evaluation from the baseline data collected prior to the distribution of the US Medical Eligibility Criteria for Contraceptive Use (MEC), the evaluation would also establish baseline data prior to the release of the forthcoming US Selected Practice Recommendations for Contraceptive Use (SPR) and the forthcoming Guidelines for Providing Quality Family Planning Services (QFPS – an aspect of the anticipated revised Title X guidelines). After the OMB's approval of the project, the

92 "National Training Centers," Office of Population Affairs, accessed December 20, 2012, http://www.hhs.gov/opa/title-x-family-planning/training/national-training-centers/.

93 "Evaluation of U.S. Family Planning Guidelines–New–National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC), Proposed Data Collection and Request for Comments," Federal Register, 77:68 (April 9, 2012) p. 21101, http://www.gpo.gov/fdsys/pkg/FR-2012-04-09/html/2012-8448.htm.

CDC Division of Reproductive Health said it would seek Title X and non-Title X family planning provider participation. The evaluation was not launched in 2012.

ACA Implementation Brings Questions, Changes to Medicaid

After the Supreme Court's ruling on the ACA, family planning providers and patients faced a number of uncertainties regarding implementation of the ACA's Medicaid expansion.[94] Chief among these uncertainties was which states would choose to expand their Medicaid programs up to 133% of the federal poverty level (FPL).[95] As of the end of 2012, 14 states, plus the District of Columbia, had announced their intentions to implement the ACA's Medicaid expansion, with another 5 states leaning toward expansion.[96] Nine states had indicated they would not expand, with an additional 5 states leaning towards not expanding.[97] Seventeen states remained undecided or had made no public comment.[98]

Policies related to other key issues, including the minimum benefits to be offered in Medicaid expansion plans, how Medicaid and the ACA's health insurance exchanges will overlap, concerns over outreach and enrollment, and recognizing the ongoing importance of safety-net providers, remain outstanding. Although the administration offered some guidance in 2012 and states made some initial decisions, 2013 will likely prove to be another important year for Medicaid policy.

States Continue to Expand Medicaid Coverage of Family Planning Despite Uncertainty

The number of states which have expanded Medicaid coverage of family planning services grew in 2012, despite uncertainty about a number of issues related to the ACA. States used two mechanisms to expand family planning access under Medicaid: state plan amendments (SPAs), as authorized by the ACA, and Section 1115 demonstration waivers. By the end of 2012, a total of 31 states had sought and received approval from CMS to expand Medicaid coverage of family planning through either a waiver or a SPA. Twenty-two states expanded family planning access via a waiver, with Montana becoming the newest waiver state. Indiana and North Carolina secured family planning SPAs, bringing the total number of SPA states to nine at the end of 2012 (joining California, New Mexico, Oklahoma, Ohio, South Carolina, Virginia, and Wisconsin).

Despite the proven effectiveness of Medicaid family planning expansions and the ongoing need for safety-net services, there remains uncertainty about the future of Medicaid family planning waivers. Following the passage of the ACA, CMS began shortening the length of Medicaid family planning waiver applications and renewals. Instead of approving initial waiver applications and renewals for their traditional five- and three-year terms, respectively, CMS shortened the waiver timeframe so that all new or renewed waivers had scheduled end dates of December 31, 2013. In 2012, CMS began including language in waiver renewals directing states to prepare transition plans detailing how they plan to move waiver enrollees into more comprehensive coverage under the ACA. As of the end of 2012, this issue had not yet been resolved.

> NFPRHA and its members firmly believe that waivers will be needed past January 2014, especially now that the ACA's Medicaid expansion is effectively optional for states, and have routinely communicated that idea to CMS. NFPRHA elevated its concerns on this question and in the summer of 2012, representatives from NFPRHA, the Guttmacher Institute, and the National Women's Law Center met with CMS officials to discuss the importance of family planning services and providers in the Medicaid program. In that meeting and in subsequent conversations, CMS has seemed receptive to the rationales put forward by NFPRHA and its partners for extending family planning waivers beyond their current end dates, and NFPRHA continues to advocate for such an extension.

Even as new states expanded Medicaid access to family planning, other states worked to limit the kinds of providers that could participate in the program. Over the past two years, more than a dozen states have introduced or enacted measures to block abortion providers from receiving public funding, including funding for services such as family planning through Medicaid, and there is growing speculation that this issue will eventually make its way to the Supreme Court.

94 For more on the Supreme Court's decision, see "The Affordable Care Act" section beginning on page 12.

95 For more on the Medicaid expansion, see the "Supreme Court Upholds ACA, Rules Medicaid Expansion Optional," and "Medicaid Expansion Creates Challenges, Uncertainty for States," sections on page 13.

96 The Advisory Board Company, "After Election 2012: Where the States Stand," updated 12/21/12, accessed 1/3/13, http://dl.ebmcdn.net/~advisoryboard/infographics/Where-the-States-Stand27/story.html.

97 *Ibid.*

98 *Ibid.*

On October 23, 2012, the Seventh Circuit Court of Appeals upheld a lower court's ruling that Indiana violated federal regulations when it enacted a May 2011 law banning abortion providers from the state's Medicaid program.[99] In its decision, the Seventh Circuit wrote, "The defunding law excludes Planned Parenthood from Medicaid for a reason unrelated to its fitness to provide medical services, violating its patients' statutory right to obtain medical care from the qualified provider of their choice."[100] Indiana's law has been on hold since June 2011, when a federal judge granted Planned Parenthood of Indiana's request for a preliminary injunction to prevent Indiana from enforcing it. That initial ruling was based in part on a June 1, 2011, decision by CMS to deny Indiana's application to change its Medicaid program to exclude abortion providers. The Seventh Circuit ruling sent the case back to the district court to determine whether the original injunction blocking the law should be made permanent.[101]

In March 2012, Texas moved to implement a 2011 state law barring abortion providers, including Planned Parenthood affiliates, from participating in the state's Medicaid waiver program, called the Women's Health Program.[102] That same month, CMS announced it would not continue to fund the program because the Texas law violated federal "freedom of choice" provisions in Medicaid that allow Medicaid patients to seek services at the qualified provider of their choice.[103] Shortly after CMS' announcement, Texas declared it would fund the Women's Health Program with state-only funds, thus circumventing the federal freedom of choice requirement.[104] Planned Parenthood sued to block the state law, and on October 25, the Fifth Circuit Court of Appeals effectively ruled that Texas could implement its law.[105]

The Fifth Circuit ruling was not the end of the story, however; at the end of October, a state judge issued an injunction prohibiting Texas from barring Planned Parenthood's participation in the Women's Health Program.[106] Texas successfully appealed that injunction and began moving toward implementation of its law. On December 31, a district judge denied one last request by Planned Parenthood to prevent the state from implementing its law, ruling that Texas can exclude Planned Parenthood from participating in the Texas' state-dollars-only version of its Women's Health Program, which took effect January 1, 2013.[107]

HHS Finalizes Initial Medicaid Quality Measures

In 2012, HHS took a step toward increasing the quality of care provided to Medicaid recipients by issuing a final notice of an initial core set of quality measures for Medicaid-eligible adults. The measures were determined based on recommendations from the Agency for Healthcare Research and Quality and the public and finalized by HHS Secretary Kathleen Sebelius. Most important for family planning providers, the measures included items for maternal and reproductive health, as well as others regarding prevention and health promotion, family experiences of care, and care coordination.[108]

99 Charles Wilson, "Court bars Ind. defunding of Planned Parenthood," *The Boston Globe*, October 24, 2012, http://www.bostonglobe.com/news/nation/2012/10/23/court-blocks-indiana-defunding-planned-parenthood/jwvsfnYV9KORgiJdwSlXqM/story.html.

100 *Ibid*.

101 For more on abortion access, see the "Access to Abortion Care" section on page 30.

102 Andrea Grimes, "Goodbye, Texas Women's Health Program," *RH Reality Check*, March 13, 2012, http://www.rhrealitycheck.org/article/2012/03/13/goodbye-texas-womens-health-program.

103 *Ibid*.

104 Texas was scheduled to stop receiving federal funds for its Medicaid family planning waiver program on December 31, 2012. In December 2012, a federal judge refused Texas' attempt to force the federal government to continue providing the state with Medicaid funding for the Women's Health Program despite its exclusion of Planned Parenthood providers.

105 Andrea Grimes, "Appeals Court Refusal Will Leave 50,000 Women in Texas Without Care," *RH Reality Check*, October 26, 2012, http://www.rhrealitycheck.org/article/2012/10/26/not-done-appeals-court-refuses-to-reconsider-planned-parenthood-ruling-in-texas.

106 Jordan Smith, "Texas Women's Health Program Back in Court," *The Austin Chronicle*, October 27, 2012, http://www.austinchronicle.com/blogs/news/2012-10-27/texas-womens-health-program-back-in-court/.

107 Vivian Kuo, "Planned Parenthood loses bid to delay Texas funding law," *CNN*, January 1, 2013, http://www.cnn.com/2012/12/31/us/texas-planned-parenthood.

108 "Medicaid Program: Initial Core Set of Health Care Quality Measures for Medicaid Eligible Adults, Final Notice." *Federal Register* 77:2 (January 4, 2012).

Supreme Court Punts Decision on Whether Providers Can Sue to Enforce Federal Medicaid Law

In February 2012, the Supreme Court ruled that it would not decide the issue of whether health care providers can sue a state to enforce federal Medicaid law, instead sending the case back to the lower courts.[109] *Douglas v. Independent Living Center of Southern California* dates back to 2008 and 2009, when the California legislature attempted to severely limit the rates the state would pay Medicaid-participating providers. Some of the affected providers and beneficiaries filed suit to block the cuts from taking effect. The state of California argued that the providers did not have the right to sue to enforce Medicaid law. The Ninth Circuit Court of Appeals upheld established Medicaid law in its ruling that California could not reduce Medicaid payment rates for purely budgetary reasons and without considering the impact that reductions would have on the ability of Medicaid recipients to access quality care. The case was appealed to the Supreme Court. In May 2011, the United States filed a brief in the case agreeing with California, arguing that only CMS could challenge the state cuts, as opposed to the private citizens affected by them.

In August 2011, the National Health Law Program and the AARP Foundation Litigation filed an amicus brief with the Supreme Court on behalf of 20 organizations, including NFPRHA, urging the Court to uphold the rights of Medicaid providers and patients to sue.[110]

The Supreme Court's February 22, 2012, decision sent the case back to the Ninth Circuit to decide if "changed circumstances" – CMS approved California's proposed Medicaid cuts after oral arguments in the case were heard in October 2011 – impacted the plaintiffs' case.[111] Justice Stephen Breyer, writing for the majority, wrote that while CMS' approval of the cuts did not render the case moot, it might require the plaintiffs to use a different process to challenge the cuts.[112] The decision also set aside the Ninth Circuit's original ruling to block California's Medicaid cuts from taking effect. In December, the Ninth Circuit ruled that California could move forward with its Medicaid cuts, paving the way for the state to implement cuts to provider rates by up to 10%.[113]

109 Douglas v. Independent Living Center of Southern California, No. 09-958, February 22, 2012, http://www.supremecourt.gov/opinions/11pdf/09-958.pdf.

110 A copy of the brief is available at http://www.healthlaw.org/images/stories/nhelpinthenews/2011_08_05_ILC_Amicus_Filing_Press%20Release.pdf.

111 Douglas v. Independent Living Center of Southern California, No. 09-958, February 22, 2012, http://www.supremecourt.gov/opinions/11pdf/09-958.pdf.

112 *Ibid.*

113 *California Healthline*, "Providers Prepare for Long Fight Against 10% Medi-Cal Rate Cut," January 18, 2013, http://www.californiahealthline.org/articles/2013/1/18/providers-prepare-for-long-fight-against-10-medi-cal-rate-cut.aspx.

Family Planning Services and Supplies

2012 saw an escalation of rancor over sexual and reproductive health issues into the national conversation. The controversy over the Susan G. Komen Foundation's announcement that it would cut off funding to Planned Parenthood affiliates for breast cancer screenings caused a severe public backlash that underscored the country's staunch support for access to family planning services and supplies and its disapproval of political efforts to limit them. Despite the Komen controversy, anti-family planning advocates continued to attack the Affordable Care Act's (ACA) contraceptive coverage requirement in the media, in the courts, and in Congress, even after the Obama administration went to great lengths to accommodate religious entities. The contraceptive coverage requirement, which went into effect August 1, 2012, as part of the women's health preventive benefits package, was a victory for women across the country.[114] Throughout the year, however, the Obama administration weathered strong backlash from women's health advocates, including NFPRHA, for blocking the Food and Drug Administration's (FDA) recommendation to make emergency contraception available over-the-counter for women and men of all ages. Additionally, federal support for Electronic Health Record (EHR) technology continued with the release of meaningful use rules and the introduction of legislation to allow safety-net providers to be eligible for EHR incentives. Republicans in Congress continued to attack the 340B Drug Pricing Program, raising concerns about oversight of the program and purchasing practices. Government agencies issued a number of guidelines and recommendations on sexually transmitted disease (STD) testing and treatment, as well as contraceptive methods, including updated guidelines on Pap testing frequency and a warning to medical providers about the potential spread of a drug-resistant form of gonorrhea.

Birth Control, Breast Cancer Screenings in National Spotlight

Family planning services and supplies, like contraceptive methods and simple breast cancer screenings for low-income women, faced highly public and controversial political attacks throughout 2012. Contrary to what many opponents of family planning policies intended, these basic services became national symbols of the private and personal health care decisions that women and men across the country make on a daily basis. As the nation saw these important services threatened, support for preserving reproductive and sexual health care access increased in an unprecedented way.

On January 31, 2012, it was reported that the Susan J. Komen for the Cure Foundation was cutting its grant funding to Planned Parenthood affiliates for breast cancer screening.[115] Komen claimed that under newly created guidelines, it was prohibited from giving money to any organization under investigation by local, state, or federal authorities. At the time, Planned Parenthood was the subject of investigations by several Republican members of Congress for allegedly using federal funding to provide abortions. When Komen made its announcement, nothing had materialized from these "investigations," which are regularly initiated by anti-choice legislators. The decision sparked outrage in Congress and across the country. Millions condemned the decision as caving into political pressure, and social media networks were inundated with calls for the Komen Foundation to reverse its decision. On February 3, after significant public backlash, the Komen Foundation announced that it would continue to provide grants to Planned Parenthood for breast cancer screenings and education.[116] Komen Foundation founder and then-CEO Nancy Brinker announced that the foundation would amend its grant-making criteria to ensure that disqualifying investigations were "criminal and conclusive" in nature. The Komen Foundation controversy set the tone for the year by demonstrating the capacity of the women's and reproductive health communities to galvanize public support that led to change.

114 For more on the women's health preventive benefits and contraceptive coverage requirement, see the "Women's Preventive Health Services Begin Amidst Challenges to Contraceptive Coverage" section on page 18.

115 Staff Report, "Komen foundation ends grants to Planned Parenthood affiliates," *Times Herald-Record*, February 1, 2012, accessed November 2012, http://www.recordonline.com/apps/pbcs.dll/article?AID=/20120201/NEWS/120209980.

116 Staff Report, "Susan G. Komen reverses Planned Parenthood funding move," *Houston Business Journal*, February 2012, accessed November 2012, http://www.bizjournals.com/houston/news/2012/02/03/susan-g-komen-reverses-planned.html.

In January, as public awareness of attacks on family planning rose, NFPRHA wrote President Obama to urge him to reverse the unprecedented decision by US Health and Human Services (HHS) Secretary Kathleen Sebelius to block the Food and Drug Administration's (FDA) recommendation to allow emergency contraception (EC) to be sold over the counter to women and men of all ages. In February, the Center for Reproductive Rights (CRR), a coalition partner of NFPRHA's, filed to have a federal judge reopen its lawsuit against the FDA over access to Plan B One-Step emergency contraception.[117] CRR's filing asked that the FDA be ordered to make all levonorgestrel-based emergency contraceptives – including the single-dose Plan B One-Step and the two-dose generic brands – available over-the-counter (OTC) within 30 days without any age restriction. CRR also asked that Secretary Sebelius be added as a defendant in the case. The case is still pending.[118]

In December, to mark the one year anniversary of the administration's decision to block access to EC over the counter for people of all ages, NFPRHA signed onto a letter asking HHS to reverse its decision and emphasizing that removing the age requirement for emergency contraception is a step toward ensuring greater access to the full range of high-quality family planning services and supplies.

Advances Continue in Health Information Technology

On August 23, 2012, the federal Office of the National Coordinator for Health IT (ONC) released the final rules for "stage 2" meaningful use of EHRs. In a blog post for HHS, the National Coordinator, Farzad Mostashari, said the rules were designed to create more effective interoperability between providers without overly burdensome regulations.[119] The rules were co-written and issued with the Centers for Medicare & Medicaid Services (CMS) as part of the federal incentive program for eligible providers to adopt EHR. The stage 2 rules focus on improving quality of care, whereas stage 1 rules focused on early EHR implementation and data collection.

In September, then-Senator John Kerry (D-MA) introduced S. 3539, the "Medicaid Information Technology to Enhance Community Health Act of 2012" (the MITECH Act).[120] This bill would allow providers who work in "Qualified Safety Net Clinics" (QSNCs) – defined in the bill as health centers in which 30% of the patients are "needy individuals" – to be eligible to receive EHR incentives from CMS. Under current law, providers – other than those working in federally qualified health centers (FQHCs) or rural health centers – must meet a 30% Medicaid patient threshold to qualify for CMS' EHR incentives. CMS defines "needy individuals" as patients receiving Medicaid or CHIP benefits, or patients who receive uncompensated or reduced-cost care. The MITECH Act would also allow physician assistants who lead a QSNC to qualify for the EHR incentives.

Furthermore, the MITECH Act would support increased adoption of EHR in the safety net, including the publicly funded family planning network, and would assist in closing the technological divide that exists in today's health care system. By expanding the Medicaid EHR incentive program, providers who serve millions of patients in the family planning safety net could offer more coordinated care and support improved health outcomes. The MITECH Act was introduced and was referred to the Senate Finance Committee. NFPRHA will continue working with its coalition partners to advance the bill in the 113th Congress.[121]

340B Drug Pricing Program Scrutinized in Congress

Throughout 2012, several conservative members of Congress called into question the role of the 340B Drug Pricing Program in the public health safety net. For decades, the 340B program has enabled Title X health centers and other qualifying entities to provide drugs to low-income patients at a significant discount. In March, Senators Michael Enzi (R-AZ), Orrin Hatch (R-UT), Chuck Grassley (R-IA), and Representative Joseph Pitts (R-PA), sent letters of inquiry to the Pharmaceutical Manufacturers Association of America, Biotechnology Industry Organization,

117 Center for Reproductive Rights, "Center for Reproductive Rights Reopens Lawsuit Against FDA Restrictions on Emergency Contraception," news release, February 8, 2012, http://reproductiverights.org/en/press-room/center-for-reproductive-rights-reopens-lawsuit-against-fda-restrictions-on-emergency-cont.

118 For more on the women's health preventive benefits and contraceptive coverage requirement, see the "Women's Preventive Health Services Begin Amidst Challenges to Contraceptive Coverage" section on page 18.

119 Dr. Farzad Mostashari, "Meaningful Use Stage 2: A Giant Leap in Data Exchange," *Health IT Buzz (blog)*, US Department of Health and Human Services, August 28, 2012, http://www.healthit.gov/buzz-blog/meaningful-use/meaningful-use-stage-2/.

120 Medicaid Information Technology to Enhance Community Health Act of 2012, S. 3539, 112th Cong. (2012), http://www.gpo.gov/fdsys/pkg/BILLS-112s3539is/xml/BILLS-112s3539is.xml.

121 *Ibid.*

Apexus Inc. and the Safety Net Hospitals for Pharmaceutical Access – all stakeholders in the 340B prescription drug discount program.[122] Although varied in their specific requests for information, each letter raised concerns about alleged inadequate oversight of the 340B program, including possible drug diversion and improper purchasing practices.

Senator Hatch also introduced a discussion draft of legislation to exempt drug manufacturers of certain drugs presumed to be in short supply from paying Medicaid rebates and 340B discounts on products for seven years.[123] The exemptions would apply to generic injectable products and would begin on or after January 1, 2013, and sunset on January 1, 2020.

In July, Representative Pitts, in his capacity as House Energy & Commerce Health Subcommittee Chair, along with Subcommittee member Rep. Bill Cassidy (R-LA), urged Health Resources and Services Administration (HRSA) Director Mary Wakefield to issue more specific guidance on the definition of a 340B patient. In a July 18 letter to Dr. Wakefield, the members of Congress expressed their concerns with the growth of the 340B program and stated that they have information that shows the program has deviated from its original intent.[124] Congressional Republicans were steadily building a case for stronger oversight and reduced access to the 340B program.

In November, Rep. Bill Cassidy prepared legislation that would exempt generic sterile injectables with four or fewer manufacturers from 340B discounts and Medicaid rebates.[125] The draft bill, entitled the "Patient Access to Drugs in Shortage Act," was similar to draft legislation being circulated in the Senate by Senator Hatch. Both bills were promoted as ways to reduce drug shortage problems, such as for cancer drugs and anesthetics, but there is little evidence linking the 340B program to actual drug shortages. Cassidy's bill was introduced and referred to committee but no further action was taken.

Government Agencies Issue Guidelines and Recommendations on STD Testing and Treatment, Contraceptive Methods

In March, the United States Preventative Services Task Force (USPSTF) posted its recommendation on screening for cervical cancer, which consisted of five recommendations.[126] The USPSTF recommended screening for cervical cancer in women age 21 to 65 years with cytology (Pap smear) every 3 years or, for women age 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years. The USPSTF also recommended against the following practices: screening for cervical cancer in women younger than age 21 years and in women older than age 65 who have had adequate prior screening and are not otherwise at high risk for cervical cancer; screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and who do not have a history of a high-grade precancerous lesion (cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer; and screening for cervical cancer with HPV testing, alone or in combination with cytology, in women younger than 30 years of age. In November, the USPSTF recommended more research on cervical cancer screening using HPV tests in its annual report to Congress. The Task Force acknowledged making gains in curbing the incidence and mortality of cervical cancer. However, the Task Force believes more research is required to understand the risks and rewards of recommending different screening approaches using new technologies.[127]

In May, the US Centers for Disease Control and Prevention (CDC) released a report which found that evidence-based education and access to a broad range of low or no-cost, highly effective contraceptive methods are critical to efforts to reduce teen pregnancy.[128] The report, published in the May 4 *Morbidity*

122 Office of Senator Chuck Grassley (R-IA), "Grassley, Enzi, Hatch, Pitts Seek Details of Discount Drug Program," news release, March 5, 2012, http://www.grassley.senate.gov/news/Article.cfm?customel_dataPageID_1502=39441.

123 "Pharmacy Flash," 340B Prime Vendor Program website, managed by Apexus, May 2012, accessed 1/28/13, https://docs.340bpvp.com/documents/public/news/flash/flash_1205.html#GovernmentPolicy4.

124 Representative Joseph R. Pitts (R-PA) and Rep. Bill Cassidy, M.D., (R-LA), letter to Health Resources and Services Administrator Mary K. Wakefield, BSN, MS, PhD, July 18, 2012, accessed November 2012, http://pitts.house.gov/sites/pitts.house.gov/files/documents/071812%20Mary%20K%20%20Wakefield%20340b%20Drug%20Pricing%20Program%20Ltr.pdf.

125 Office of Representative Bill Cassidy MD (R-LA), "Cassidy Proposes Drug Shortage Solutions," news release, November 29, 2012, http://cassidy.house.gov/press-release/cassidy-proposes-drug-shortage-solutions.

126 US Preventive Services Task Force, *Screening for Cervical Cancer: U.S. Preventive Services Task Force Recommendation Statement*, March 2012, accessed December 2012, http://www.uspreventiveservicestaskforce.org/uspstf11/cervcancer/cervcancerrs.htm.

127 U.S. Preventive Services Task Force (USPSTF or Task Force), *Second Annual Report to Congress on High-Priority Evidence Gaps for Clinical Preventive Services*, November 2012, accessed January 2013, http://www.uspreventiveservicestaskforce.org/annlrpt2/index.html.

128 Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report: Sexual Experience and Contraceptive Use Among Female Teens — United States, 1995, 2002, and 2006–2010*, May 4, 2012, accessed December 2012, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6117a1.htm?s_cid=mm6117a1_w.

and Mortality Weekly Report found both a reduction in the United States' teen birth rate since 1990 and an increase in the use of highly effective contraceptive methods since 1995.[129]

> Following release of the data, NFPRHA President & CEO Clare Coleman made a public statement noting, "Evidence-based sexual and reproductive health education, as well as open and honest communication between parents and teens about matters of sexual health, is essential to winning the battle against teen pregnancy. Equally important in this fight, however, is ensuring that teens have access to highly effective contraceptive methods and safe, trusted, confidential health care providers such as those funded by the Title X national family planning program."

In June, the CDC revised its recommendations for the use of hormonal contraception among women at high risk for HIV infection or who are already infected.[130] These recommendations were initially published in the *US Medical Eligibility Criteria for Contraceptive Use*. A clarification also added acknowledging that there has been inconclusive evidence about the association of progestin-only injectable method use and HIV acquisition. The clarification noted the importance of condom use, and other HIV preventive measures, as well as the need for further research on these issues.

Also in June, the World Health Organization (WHO) issued a warning to medical providers about the potential spread of a drug-resistant form of gonorrhea.[131] This warning came shortly after an editorial published in the February 2012 *New England Journal of Medicine* highlighted the rising rate of drug-resistant gonorrhea.[132] Resistance to the only remaining class of drugs to treat gonorrhea grew from 0.1% to 1.7% between 2006 and mid-2011. Scientists at the WHO predicted that in a few years, the bacterium would likely stop responding to the drugs all together. The WHO planned to issue a "global action plan," designed to encourage more research in finding a cure. The WHO also hoped that medical providers around the world will be vigilant in testing for the disease.

In August, the CDC released updated guidelines for the treatment of gonorrhea, no longer recommending use of the cephalosporin cefixime as a first-line regimen for treating the disease.[133] In years prior, providers were using combination therapy to treat gonorrhea: either cefixime or the injectable cephalosporin ceftriaxone, plus a second antibiotic. CDC now advises only the use of ceftriaxone, along with one of two other oral antibiotics, azithromycin or doxycycline. The change left only one cephalosporin proven effective for treating gonorrhea. The CDC revised these guidelines in response to evidence of gonorrhea's rising resistance to antimicrobials.

> In December 2012, NFPRHA signed a coalition letter urging the USPSTF to adopt a draft recommendation in strong support of routine HIV testing for all adolescents and adults ages 15 through 65, pregnant women, and others at increased risk for HIV. This recommendation would be a substantial change from previous recommendations which included testing only for people who are at risk for HIV and pregnant women.

129 For more on the funding of sexuality education and other programs in 2012, see the "Publicly Funded Family Planning: Budget and Appropriations," section on page 6.

130 Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report: Update to CDC's U.S. Medical Eligibility Criteria for Contraceptive Use, 2010: Revised Recommendations for the Use of Hormonal Contraception Among Women at High Risk for HIV Infection or Infected with HIV*, June 22, 2012, accessed December 2012, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6124a4.htm?s_cid=mm6124a4_e%0d%0a.

131 World Health Organization, *WHO: Urgent action needed to prevent the spread of untreatable gonorrhea*, June 6, 2012, accessed December 7, 2012, http://www.who.int/mediacentre/news/notes/2012/gonorrhoea_20120606/en/index.html.

132 Gail A. Bolan, M.D., P. Frederick Sparling, M.D., and Judith N. Wasserheit, M.D., M.P.H., "The Emerging Threat of Untreatable Gonococcal Infection," *New England Journal of Medicine* (February 2012): 366:485-487, http://www.nejm.org/doi/full/10.1056/NEJMp1112456.

133 Centers for Disease Control and Prevention, "CDC No Longer Recommends Oral Drug for Gonorrhea Treatment: Change is critical to preserve last effective treatment option," news release, August 9, 2012, http://www.cdc.gov/nchhstp/Newsroom/2012/GCTx-Guidelines-PressRelease.html.

Access to Abortion Care

Efforts to limit access to abortion care persisted in 2012. Anti-abortion bills from previous congressional sessions were re-introduced and several new bills emerged as some legislators saw the Affordable Care Act (ACA) as an expansion of access to abortion services. Despite the fact that abortion is safe and legal, and a majority of Americans support access to the service, several members of Congress introduced legislation that interferes with a woman's relationship with her provider in making a decision about abortion. In 2012, many of these efforts were ineffective, thanks to a heightened national awareness of efforts to politicize reproductive health and a new makeup of the Senate.

ACA Implementation Rules Overly Burdensome to Plans Offering Abortion

Insurance coverage of abortion continued to be an issue during implementation of the ACA. In March 2012, the US Department of Health and Human Services (HHS) published a combined final and interim final rule guiding states on how to establish state-based exchanges.[134] The rule finalized the abortion separation requirements as laid out in an amendment to the ACA from Senator Ben Nelson (D-NE). The rule restates the statutory language requiring that individuals with insurance through any exchange plan that covers abortion must submit two payments, one for abortion coverage and one for everything else. In addition, under the rule, qualified health plans are required to submit a plan and methodology for compliance with the provision and must submit an annual assurance statement to the state's insurance commissioner. These rules create significant administrative burdens on insurance plans that choose to cover abortion and serve as a disincentive to offer abortion coverage.

Members of Congress Continue to Offer Bills Limiting Abortion Access

In January 2012, Representative Trent Franks (R-AZ) introduced H.R. 3803, which would have banned abortions in the District of Columbia after 20 weeks unless the procedure was necessary to save the life of the woman. The "District of Columbia Pain-Capable Unborn Child Protection Act" was modeled after similar legislation passed in Georgia, Nebraska, Kansas, Idaho, Oklahoma, and Alabama, and garnered more than 200 sponsors.[135] The bill did not include a viability standard, or exceptions for the health or well-being of the pregnant woman (as required by *Roe v. Wade*).[136] In May, a House Judiciary subcommittee held a hearing on the bill, but there was no subsequent full committee hearing. Senator Mike Lee (R-UT) introduced a companion bill, S. 2109, but there were no hearings scheduled.[137]

Congress dealt again with the "Child Interstate Abortion Notification Act" (CIANA), H.R. 2299, a bill that has been introduced in different forms for nearly 15 years.[138] The bill was introduced by Representative Ileana Ros-Lehtinen (R-FL) in June 2011, and had a hearing in the House Judiciary Subcommittee on the Constitution, in March 2012. The bill, which had 172 co-sponsors, would have prohibited a trusted adult from accompanying a minor across a state line to obtain an abortion. The bill would have also imposed a fine and/or a prison term of up to one year on a physician convicted of performing an abortion on an out-of-state minor in violation of parental notification requirements of the state in which she lives. The bill was approved by the Constitution Subcommittee and was also passed by the full Judiciary Committee, but it did not receive a vote on the House floor.[139] A companion bill, S. 1241, was introduced by Senator Mark Rubio (R-FL), but no committee action was taken on the bill in the Senate.

134 "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, Final Rule, Interim Final Rule," *Federal Register* 77:59 (March 27, 2012) p.18310.

135 Erik Eckholm, "Several States Forbid Abortion After 20 Weeks," *New York Times*, June 26, 2011, accessed November 2012, http://www.nytimes.com/2011/06/27/us/27abortion.html?_r=0.

136 National Women's Law Center, *The D.C. Abortion Ban Would Impose an Unconstitutional Abortion Ban on Women Who Have no Representation in Congress*, accessed November 2012, http://www.nwlc.org/sites/default/files/pdfs/final_dc_20_week_abortion_ban_051812.pdf.

137 Office of Senator Mike Lee, "Lee Introduces Pain-Capable Abortion Restriction in DC," news release, February 15, 2012, http://www.lee.senate.gov/public/index.cfm/press-releases?ID=0270c814-b4c6-4730-b0fc-14032559c087.

138 NARAL Pro-Choice America, "House Obsession with Attacking Choice to Continue This Week," news release, March 5, 2012, http://www.prochoiceamerica.org/media/press-releases/2012/pr03052012_ciana.html.

139 Office of Congresswoman Ileana Ros-Lehtinen, "With CIANA approved in Judiciary Committee, Ros-Lehtinen Hopeful it Will Soon be Brought to House Floor for Vote," news release, March 27, 2012, http://ros-lehtinen.house.gov/press-release/ciana-approved-judiciary-committee-ros-lehtinen-hopeful-it-will-soon-be-brought-house.

In March, Representative Todd Rokita (R-IN) introduced H.R. 4160, the "State Health Flexibility Act." This bill would have banned states from using their own money to assist low-income women in paying for abortion care outside of the current Medicaid exceptions for rape, incest, and life endangerment.[140] At the time of the bill's introduction, seventeen states used their own funds to pay for low-income women to obtain abortion care beyond the federal restrictions.

In May, Representative Steve King (R-IA) introduced H.R. 5371, a bill that would have prohibited any provider who uses telemedicine to administer medication abortions from receiving federal money designated to support the practice of telemedicine – even when the funds are not used for medication abortion services.[141] Rep. King successfully attached similar language to H.R. 2112, the "Agriculture, Rural Development, Food and Drug Administration and Related Agencies Appropriations Act of 2012," but this language was not included in the Senate bill. Had it been enacted, this amendment would have had serious ramifications on abortion access in rural, frontier, and other underserved communities which may rely on telemedicine services.

While anti-abortion legislation has been common since the passage of *Roe v. Wade*, 2012 saw a new type of bill introduced – a sex-selection abortion bill. Although the states had introduced and even passed similar bills, Congress had yet to deal with this issue. H.R. 3541, the "Prenatal Non-Discrimination Act" (PRENDA) was introduced by Representative Trent Franks (R-AZ); it would have made it a crime for a provider to perform an abortion if he or she did so knowing that the woman was seeking to terminate her pregnancy based on the sex of the fetus. In a version introduced earlier in the year, the bill would have also banned abortions based on the race of the fetus.[142] After several hearings in subcommittee and full committee, the bill was brought up for a vote on the House floor on May 31, 2012, and failed under a suspension of the rules.[143] A bill that is voted upon during a suspension of the rules needs a two-thirds majority of those present and voting in order to pass, as opposed to a simple majority. A Senate version of the bill, S. 3290, was introduced by Senator David Vitter (R-LA). No action was taken in the Senate.

Although President Obama did not release a Statement of Administrative Policy regarding PRENDA, the White House did release a comment stating that the bill "would subject doctors to criminal prosecution if they fail to determine the motivations" of a woman seeking an abortion.[144] Jamie Smith, the White House Deputy Press Secretary, said that the administration opposes all gender discrimination and the government should not interfere with individual medical decisions.[145]

Abortion Restrictions Attached to Other Legislation

During the House Appropriations Committee markup of the fiscal year (FY) 2013 Financial Services and General Government appropriations bill, members on both sides of the aisle offered amendments that could have affected women's access to abortion. Representative Alan Nunnelee (R-MS) offered an amendment to prohibit insurance coverage for abortion care for women who are covered under a multi-state insurance plan in any insurance exchange created by the ACA.[146] It would have also extended the current ban on abortion coverage in any federal employee's health plan. Despite arguments that the prohibitions would limit access to comprehensive health insurance coverage and services for women, Rep. Nunnelee's amendment passed along party lines, 28-20. The bill passed out of committee, but did not receive a full House vote. As in previous years, the Financial Services Appropriations bill included language that would bar the District of Columbia from using its own funds to provide abortion services to low-income women. Representative Barbara Lee (D-CA) offered an amendment to strike this language from the bill. The amendment failed 21-26, with Representative Rodney Frelinghuysen (R-NJ) voting with the minority.

During the hearing on the FY 2013 Homeland Security Appropriations bill (H.R. 5855) in May, Representative Robert Aderholt (D-AL) introduced an amendment to bar any Department of Homeland Security (DHS) funds from being used for abortion care, except in the cases of life endangerment

140 Office of U.S. Representative Todd Rokita, "ICYMI: Representative Rokita's State Health Flexibility Act, H.R. 4160, Gets National Attention," news release, March 13, 2012, http://rokita.house.gov/editorial/icymi-rokita's-state-health-flexibility-act-hr-4160-gets-national-attention.

141 "Bill Would Block Grants for Using Telehealth to Prescribe Abortion Drug," *iHealthBeat*, May 14, 2012, http://www.ihealthbeat.org/articles/2012/5/14/bill-would-block-grants-for-using-telehealth-to-prescribe-abortion-drug.aspx.

142 "Miriam Yeung, Executive Director, Testifies for the Pro-Choice Movement as Congressional Hearing on HR 3541 (PRENDA)," National Asian Pacific American Women's Forum website, December 6, 2011, accessed November 4, 2012, http://napawf.org/2011/12/6046/.

143 "H.R. 3541 (112th): Prenatal Nondiscrimination Act (PRENDA) of 2012," govtrack.us, accessed December 2012, http://www.govtrack.us/congress/bills/112/hr3541.

144 "Legislation Abortion Gender Selection and Abortion – Today's Q for O's WH – 5/30/2012," *ABC News*, May 30, 2012, http://abcnews.go.com/blogs/politics/2012/05/legislation-about-gender-selection-and-abortion-todays-q-for-os-wh-5302012/.

145 *Ibid.*

146 Erik Wasson, "House panel votes to limit abortion under Obama's healthcare law," *On The Money, The Hill's Finance & Economy Blog*, June 20, 2012, http://thehill.com/blogs/on-the-money/appropriations/233793-house-panel-votes-to-limit-abortion-under-obama-healthcare-reform.

or rape.[147] Representative Jim Moran (D-VA) subsequently introduced language to add incest as an exception. The amendment passed out of the House along party lines.[148] However, the DHS budget bill was not considered by the Senate in the 112th Congress. If the bill, along with the amendment, had passed the Senate, it would have primarily affected abortion access for Immigration and Customs Enforcement (ICE) detainees.

Members of Congress Introduce Refusal Rights Measures

Several bills were introduced to preserve or strengthen a provider's right to refuse to perform or assist with any service to which he or she objects. Some of the bills introduced in 2012 also sought to allow insurance plans and employers to decide not to cover certain health care services if the company objected to the treatment, drug, etc. The most notable of these bills was Senator Roy Blunt's (R-MO) amendment to the Senate's Surface Transportation Bill (S.Amdt. 1520 to S. 1813). This amendment would have allowed any entity or individual to deny his or her employees any type of health care service or device for any religious or moral reason.[149] The Senate voted to table the amendment on March 1, 2012.[150] Sen. Blunt's amendment was based on a bill that he had originally introduced as a stand-alone measure, S. 1467, the "Respect for Rights of Conscience Act."[151] It was first introduced in the House as H.R. 1179, by Representative Jeff Fortenberry (R-NE). The legislation did not move forward in either chamber. S. 2092, the "Religious Freedom Restoration Act of 2012," introduced by Senators Marco Rubio (R-FL) and Joe Manchin (D-WV), proposed extending individual provider refusal rights to insurance companies.[152] It was introduced in the House as H.R. 3897 by Representative Steve Chabot (R-OH) but was not brought up for a hearing in either chamber. State legislatures began introducing broader refusal rights legislation just as private companies were suing the administration over the contraceptive coverage requirement.[153] The national and local discussion of refusals of medical care and coverage – including birth control – made refusal clauses a high-profile part of the women's health care debate.

Although refusal clauses have traditionally focused on protecting individuals who do not want to participate in a health service, the bills introduced in 2012 would have also permitted insurance plans and employers to deny to provide coverage or any service, including abortion and contraception, that they did not agree with on religious or moral grounds. Under these proposals, any employer (including private, for-profit entities) or insurance plan could simply assert a moral objection and then would not have to cover any of the services to which they objected. Although these bills and amendments were designed to limit reproductive health services, they could have created loopholes in general for insurance coverage requirements.

Legislation Supports Providers, Widens Abortion Access

Amid efforts to limit abortion access on the federal level, legislation to protect abortion providers and patients seeking care was also introduced in 2012. In May, Representative Robert Dold (R-IL), introduced H.R. 5650, the "Protecting Women's Access to Health Care Act," which would prohibit discrimination against a hospital, health care center, or other provider who performed abortion services that were paid for using separate, non-Title X funds.[154] Recognizing that the legislation was unlikely to garner support for passage in the Republican-controlled House, Rep. Dold stated that he introduced the legislation in an effort to find common ground on the issue of health care access for women.[155]

Senator Jeanne Shaheen (D-NH) introduced an amendment to the 2013 National Defense Authorization Act (NDAA) that

147 "H.R. 5855 (112th): Department of Homeland Security Appropriations Act, 2013," govtrack.us, accessed February 2013, http://www.govtrack.us/congress/bills/112/hr5855.

148 Office of Representative Robert Aderholt (AL-R), "Appropriations Committee Approves Fiscal Year 2013 Homeland Security Appropriations Bill," news release, May 16, 2012, http://aderholt.house.gov/index.cfm?sectionid=20&itemid=1373.

149 National Women's Law Center, *The Blunt Amendment Takes Away Access to Critical Health Insurance Coverage for Millions of Americans*, accessed December 2012, http://www.nwlc.org/resource/blunt-amendment-takes-away-access-critical-health-insurance-coverage-millions-americans.

150 Jennifer Haberkorn and Kate Nocera, "Blunt Amendment defeated in Senate," *Politico*, March 1, 2012, http://www.politico.com/news/stories/0312/73497.html.

151 Anna Benyo, "How Often Do We Have to Do This? Another Attempt to Take Away Contraception?," *Womenstake* (blog), April 30, 2012, http://www.nwlc.org/our-blog/how-often-do-we-have-do-another-attempt-take-away-contraception.

152 "S.2043 – Religious Freedom Restoration Act of 2012," OpenCongress.org, accessed December 2012, http://www.opencongress.org/bill/112-s2043/show.

153 Brigitte Amiri, "More Challenges to the Contraception Rule, More Misguided Arguments," *ACLU Blog of Rights* (blog), November 15, 2012, http://www.aclu.org/blog/religion-belief-reproductive-freedom-womens-rights/more-challenges-contraception-rule-more.

154 Elise Viebeck, "House Republican floats bill to protect Planned Parenthood," *The Hill,* May 9, 2012, http://thehill.com/blogs/healthwatch/abortion/226351-gop-member-floats-bill-to-protect-planned-parenthood-funds.

155 For more information about Dold's bill, see the "House Title X Advocates Fight Back" section on page 9.

would allow military women and military dependents to receive insurance coverage of abortion in the circumstances of rape or incest.[156] The amendment, which gives women in the military and military dependents the same coverage for abortion as other federal programs, passed the Senate Armed Services Committee in a bipartisan vote in May and on the Senate floor in December.[157] The Shaheen Amendment was preserved in a House – Senate conference and was included in the NDAA, signed by President Obama on January 2, 2013.[158,159] The Shaheen Amendment is an important first step towards improved reproductive health coverage, not only for women in the military, but for all women who rely on the government for their health care.

States Continue to Advance Anti-Abortion Bills

As in 2011, 2012 brought a surge of anti-reproductive health bills in the states. There were nearly 40 laws passed in states in 2012 to restrict access to abortion, with dozens more introduced that did not pass.[160]

In several states, including Ohio, Tennessee, and Mississippi, legislatures passed "Targeted Regulation of Abortion Providers" or TRAP laws.[161] These laws place burdensome requirements on health centers that provide abortion, including unnecessary facility requirements or new licensing requirements.[162] Some laws also place hospital admitting requirements on the providers working in these centers, which is problematic. Because of these onerous laws, centers have had to close in some states, leaving some underserved communities with even fewer health care options.

2012 also saw new abortion bans, including bills prohibiting abortion at 18-20 weeks in Arizona, Georgia, and Louisiana.[163] Several states also passed mandatory counseling and waiting period laws. These laws require a woman to receive counseling and wait an average of 24 hours before obtaining an abortion. Some states enacted mandatory waiting periods, of which several, like the one passed in Virginia, require women to also obtain an ultrasound before having an abortion.[164] The Virginia law, which initially required the ultrasound to be done transvaginally, garnered national attention and became a springboard for a larger discussion on how these intrusive laws can jeopardize a woman's access to care.

Beyond legislative actions, anti-abortion measures also appeared on state ballots. A parental notification measure in Montana and a constitutional amendment measure in Florida, which would have taken away a woman's right to privacy and restricted insurance coverage for abortion, were both defeated.[165] Anti-abortion ballot measures persist but outcomes in 2012 proved that educating and sharing patients' stories can help the public understand the significance of access to abortion services.

In 2012, states, including Arizona, Texas, and Wisconsin, restricted family planning providers that perform abortion services from receiving federal and/or state family planning funding.[166] Texas' actions resulted in federal government intervention, cutting off all Medicaid family planning funding to the state. Some providers have chosen to apply directly to the federal government for family planning funding without having to rely on the state to keep their health centers open.[167]

156 Office of Senator Jeanne Shaheen, "Shaheen Amendment Included in Defense Bill, Would Ensure Equity For Servicewomen in Reproductive Health," news release, May 24, 2012, http://www.shaheen.senate.gov/news/press/release/?id=51caf2d4-9fe0-4cc6-b8fa-6f3e094a197e.

157 *Ibid*.

158 Office of Senator Jeanne Shaheen, "Shaheen Amendment Passed by Congress," news release, December 21, 2013, http://www.shaheen.senate.gov/news/press/release/?id=aad21395-816e-43c2-bd8a-6f21d98d03bf.

159 Office of Senator Jeanne Shaheen, "Shaheen Amendment Signed Into Law," news release, January 3, 2013, http://www.shaheen.senate.gov/news/press/release/?id=014ebb9a-85fc-4bf8-8894-7c5df8d863c4.

160 Guttmacher Institute, *State Legislation Enacted in 2012 Related to Reproductive Health*, accessed November 2012, http://www.guttmacher.org/statecenter/updates/2012newlaws.pdf.

161 *Ibid*.

162 National Abortion Federation, *The TRAP: Targeted Regulation of Abortion Providers*, accessed November 2012, http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/trap_laws.pdf.

163 Guttmacher Institute, *State Legislation Enacted in 2012 Related to Reproductive Health*, accessed November 2012.

164 National Abortion Federation, *The TRAP: Targeted Regulation of Abortion Providers*, accessed November 2012.

165 Gavin Aronsen, "How 2012's Biggest Ballot Measures Played Out," *Mother Jones*, November 7, 2012, http://www.motherjones.com/mojo/2012/11/ballot-measures-2012-results.

166 Guttmacher Institute, *State Family Planning Funding Restrictions*, accessed November 2012, http://www.guttmacher.org/statecenter/spibs/spib_SFPFR.pdf.

167 Jordan Smith, "Family Planning Clinics to Seek Federal Funds on Own," *Austin Chronicle*, November 19, 2012, http://www.austinchronicle.com/blogs/news/2012-11-19/family-planning-clinics-to-seek-federal-funds-on-own/.

A Look Ahead

Sexual and reproductive health advocates can approach the 113th Congress with significantly greater political leverage and strong evidence from 2012 that anti-family planning and anti-choice policies are not favored by the public. Republicans have begun an internal debate on the merits of continuing to campaign against contraception, and while Title X may again come under attack in the Republican-controlled House of Representatives, it should be with less anticipation of success than in years past. The 2012 elections made one very important point – it is both bad policy and bad politics to oppose access to sexual and reproductive health care.

Despite the momentum on the side of sexual and reproductive health, policymakers' efforts to improve the nation's fiscal health threaten to consume all of the legislative attention in Washington. Republicans and Democrats entered into the 113th Congress with the same hardened positions on taxes and spending that existed at the start of 2012. However, with the presidential election behind them, legislators seem to realize the need to find a solution to the big economic issues that added to the nation's growing debt, at least temporarily.

Family planning providers and public health programs will again face the threat of cuts. Although federal budget discussions include almost no consideration of the Title X-supported systems, the impact of the final decisions on family planning access could be substantial.

As family planning providers prepare to receive less federal funding, most will be working to get ready for the start of the Affordable Care Act (ACA) coverage expansions on January 1, 2014. Over the next year, the federal government, states, and health care providers will be establishing the structures required to assist millions of Americans in gaining insurance coverage and accessing health care services.

The US Department of Health and Human Services (HHS) is expected to move additional resources to help states implement the ACA, against the backdrop of a national debate about the role of the federal government in the lives of Americans. Negotiations between the administration and states on key health reform policies, including the Medicaid expansion, will presumably result in compromises that directly impact low-income populations. Unlike the year-long policy stalemate in 2012, 2013 is projected to be filled with big policy decisions that will have repercussions for the future of health care and family planning service delivery.

In 2013, NFPRHA will make every effort to capitalize on the political gains made for sexual and reproductive health issues in 2012. NFPRHA will continue providing policymakers with the resources they may need to strengthen their arguments with their colleagues and constituents.

After enduring years of misguided attacks, 2013 represents a turning point in the policy and politics of sexual and reproductive health and NFPRHA, working with its members, plans to seize the moment.

About NFPRHA

The National Family Planning & Reproductive Health Association (NFPRHA) represents the broad spectrum of family planning administrators and clinicians serving the nation's low-income and uninsured.

NFPRHA serves its members by providing advocacy, education and training to those in the family planning and reproductive health care fields. As health care reform is phased in over the next several years, NFPRHA will focus on:

- Strengthening the Title X program now and anticipating its future;
- Making Medicaid a priority and preparing family planning providers to care for a large newly insured population in danger of slipping through the cracks; and
- Tackling issues that affect the future of service delivery, including preparing the family planning infrastructure for the systemic changes initiated by health reform.

For over 40 years, NFPRHA members have shared a commitment to providing high-quality, federally funded family planning care - making them a critical component of the nation's public health safety net. Every day NFPRHA members help people act responsibly, stay healthy and plan for strong families.

NFPRHA's 2012 federal legislative report was made possible with the generous support of the Robert Sterling Clark Foundation. Under the direction of President & CEO Clare Coleman, this report was written by Lauren Levenstein, Julie Lewis, Nicolette Paterson, Hallie Stevens, Robin Summers, Dana Thomas, Jessica Thomas, and Annie Walden-Newman. The report was edited by Coleman, Jeffrey Eaton, Levenstein, Summers, and Dana Thomas.

National
Family Planning
& Reproductive Health Association

www.nationalfamilyplanning.org

National
Family Planning
& Reproductive Health Association

1627 K Street, NW, 12th Floor
Washington, D.C. 20006
Phone: (202) 293-3114
E-mail: info@nfprha.org
www.nationalfamilyplanning.org