

# FAMILY PLANNING IN PERIL



FEDERAL LEGISLATIVE AND REGULATORY ACTION ON  
FAMILY PLANNING AND REPRODUCTIVE HEALTH IN 2017-2018

National  
**Family Planning**  
& Reproductive Health Association



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MARCH 2019

National  
**Family Planning**  
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# Executive Summary

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For nearly 50 years, the Title X (ten) family planning program, the nation's only dedicated source of federal funding to support affordable, high-quality family planning and sexual health care, has provided lifesaving health services to millions of poor and low-income women, men, and adolescents across the country. Title X is at the foundation of the health care safety net in big cities and small towns, even though the program and its successes remain largely unknown across the country.

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The commonly shared brand or identifier that links Title X-funded health centers – from large and small private non-profit health centers to state, local, and county health units – is not a shared logo or color scheme; it is the shared mission and the integrity with which health centers are dedicated to providing comprehensive, voluntary, unbiased medical care and counseling for our nation's poor and low-income women, men, and teens.

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Unfortunately, as partisanship has intensified in Washington and family planning has been politicized, Title X's strength in communities has, in some ways, become its weakness in the policy arena. Opponents in Congress and the administration are seizing every opportunity to undermine not only Title X, but the entire family planning safety net, including the other federal programs that support family planning coverage and access for our nation's most vulnerable people.

In this report, *Family Planning in Peril*, the National Family Planning & Reproductive Health Association (NFPRHA) provides a two-year snapshot beginning in 2017 of federal legislative and administrative action taken on these key issues. NFPRHA intends for the 2017-2018 report to fuel collaboration among policymakers and advocates so that together we can drive legislative and programmatic changes that improve access to the high-quality family planning and sexual health care that poor and low-income people deserve.

*NFPRHA is a non-partisan membership association that advances and elevates the importance of family planning in the nation's health care system and promotes and supports the work of family planning providers and administrators, especially in the safety net. Representing more than 850 organizations and individuals that operate or fund more than 3,500 health centers in the United States, NFPRHA conducts and participates in research; provides educational subject matter expertise to policymakers, health care providers, and the public; and offers its members varying levels of capacity-building support aimed at maximizing their effectiveness and financial sustainability as providers of essential health care.*

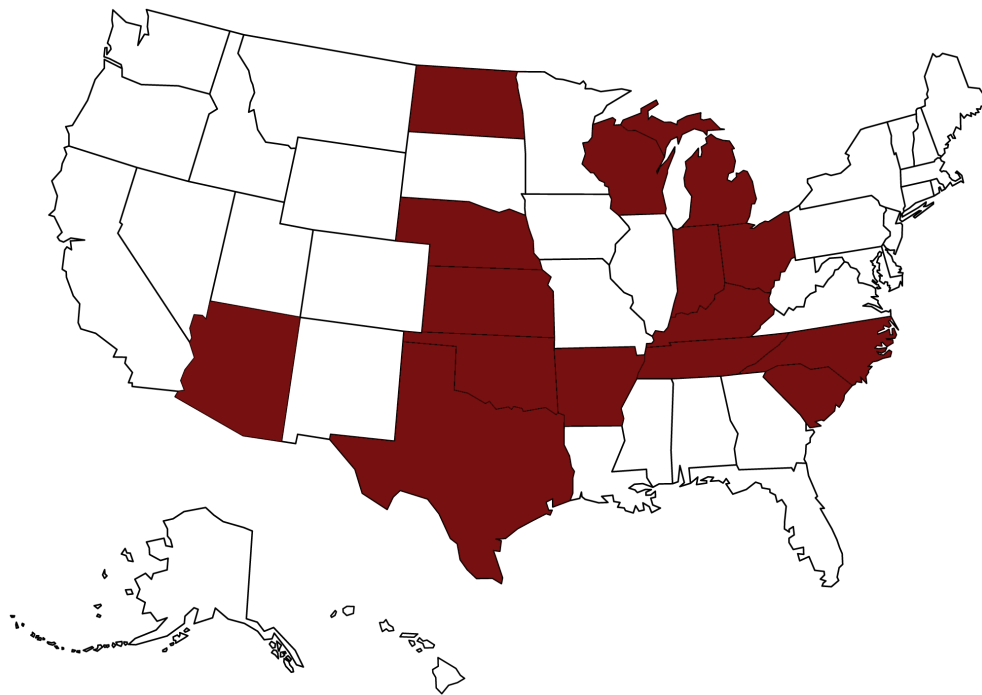
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# Section 1: The Title X Family Planning Program

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## ***2016 Title X Provider Nondiscrimination Regulation***

Leading into 2017, one of the final achievements of the Obama administration was to update the Title X family planning program’s regulations to reinforce and clarify that highly qualified family planning providers could not be prohibited from participating in Title X “for reasons unrelated to its ability to provide services effectively.” The Obama-era regulation, “Compliance with Title X Requirements by Project Recipients in Selecting Subrecipients<sup>i</sup>,” served as a direct response to efforts by anti-family planning state governments that were increasingly barring abortion providers from participating in Title X through outright bans or by setting a prioritization scheme for funding that would indirectly prohibit their access.



*Since 2011, 15 states have barred or de-prioritized certain providers of subsidized family planning care: Arizona, Arkansas, Indiana, Kansas, Kentucky, Michigan, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, Tennessee, Texas, and Wisconsin.*

The new Republican congressional majority made clear in its first weeks that it would use the authority granted by *the Congressional Review Act (CRA)* to disapprove and invalidate regulations issued at the end of the Obama administration, including the Title X regulation prohibiting provider discrimination.

Prior to 2017, Congress had only successfully exercised its' CRA authority once, in 2001, to disapprove an Occupational Safety and Health Administration regulation on ergonomics; in the 115<sup>th</sup> Congress, the CRA was used to disapprove 16 regulations.

The **Congressional Review Act (CRA)** gives Congress the authority to review and disapprove new federal regulations within 60 legislative days of the promulgation of the rule. CRA resolutions only require a simple majority in both chambers. Once a CRA disapproval resolution is successfully passed and signed by the president, the disapproved regulation is no longer in effect, and the executive branch is permanently prohibited from issuing a regulation that is "substantially similar."

CRA RESOLUTIONS BEFORE 2017	115 <sup>TH</sup> CONGRESS
1	16

On February 16, 2017, in a 230-188 vote<sup>ii</sup>, the House of Representatives passed a CRA disapproval resolution (H. J. Res. 43) seeking to block the Title X regulation<sup>iii</sup>. After House passage, there was speculation that Senate leadership did not have sufficient votes for passage; however, the Senate brought its resolution to the floor and voted 50-50 to pass H.J. Res 43 on March 30, 2017. Vice President Mike Pence, in his role as President of the Senate, broke the tie, leading to a final vote of 51-50<sup>iv</sup>. President Trump signed H.J. Res. 43 on April 13, 2017, overturning the Title X provider nondiscrimination regulation, and prohibiting "substantially similar" regulations from being issued in the future.



## ***The White House Budget Process: A Signal for Its Family Planning Agenda***

In May 2018, in what was at first a surprise to many family planning supporters given a truncated budget that proposed decimating health funding a few months prior, the president provided his first full budget request for fiscal year (FY) 2018 that recommended level funding for Title X. However, the request, which serves as an important signal for the administration's priorities, also included proposals to bar Planned Parenthood from discretionary funding programs and to reshape the Medicaid program.<sup>v</sup> The subsequent proposal for FY 2019 was remarkably similar and as potentially damaging as the FY 2018 proposal, reinforcing the administration's opposition to the nation's existing family planning safety net.

### ***Title X Program Grant Shortenings***

Without warning, the Office of Population Affairs (OPA) announced in July 2017 that it would shorten all Title X grants across the network; funding for grantees with April 1 start dates would end as of March 31, 2018, and grantees with July 1 start dates would end as of June 30, 2018. This announcement came despite grant awards that indicated project periods of three years for all grants.<sup>vi</sup> The grant shortening put substantial burden on grantees who had just competed in 2017 and on OPA and grants management career staff, who had to evaluate applications for the entire country in one year rather than just one-third of the program, as had been the practice. However, the early close of the grant period created an opportunity for OPA to re-compete and potentially re-shape the entire Title X service delivery network and impose new requirements in the funding announcement for 2018 grants. At the same time, OPA cancelled both the Guttmacher Institute's multi-decade research cooperative agreement and the University of California, San Francisco's patient-reported outcomes measures research.

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Shortly after the research cancellations, OPA forecasted new research priorities for the nation's family planning program, including **investigating barriers to discontinuing reversible contraceptive methods**, with a particular focus on long-acting reversible contraception (LARCs); and options to **improve the fertility of couples trying to conceive via vaginal intercourse**.<sup>vii</sup>

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### ***2018 Title X Service Delivery Funding Opportunity Announcement***

On February 23, 2018, the Trump administration took its next significant action to reshape the Title X network following its shortening of the program's service delivery grants the previous summer. OPA issued the FY 2018 funding opportunity announcement (FOA) for the program's service delivery grants after months of delay. The FOA, which outlined the competition criteria for grant awards beginning September 1, 2018, de-emphasized contraceptive care, delinked Title X requirements from the nationally recognized clinical standards on family planning, and shifted the program from emphasizing clinical care to activities concentrating on behavior change.

In response, NFPRHA, represented by the American Civil Liberties Union (ACLU), filed a lawsuit on May 2, 2018, to bar the US Department of Health and Human Services (HHS) from using the FY 2018 Title X FOA to award Title X service grants, on the grounds that the FOA impermissibly added new criteria that conflict with Title X's governing law. Planned Parenthood of Wisconsin, Planned Parenthood of Greater Ohio, and Planned Parenthood Association of Utah filed a separate legal challenge to the FOA on similar grounds the same day.

DC District Court Judge Trevor McFadden ruled against NFPRHA and the three Planned Parenthood affiliates, citing that NFPRHA's substantive claims were not reviewable because the administration's FOA would not be considered final agency action subject to the Administrative Procedures Act (APA).<sup>1</sup> Later that month, NFPRHA and the other plaintiffs filed an unsuccessful appeal with the United States Court of Appeals for the District of Columbia to block the administration from issuing grants while the overall case was still under review by the courts. HHS began issuing seven-month awards in late August 2018. The efforts to reshape the Title X network using the FY 2018 FOA were largely unsuccessful – every existing grantee that applied received funding and the only changes were the addition of 12 new grantees, some of whom had participated in Title X previously as providers.

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### ***Proposed Title X Regulation***

From the earliest days of 2017, rumors swirled that the Trump administration was planning major changes to the regulations governing the Title X program. Those rumors were finally realized in May 2018, when the administration announced it would release a new rule to restrict actions related to abortion in Title X. The draft version of the proposed rule was posted to OPA's website on May 22. It was an unusual move to make a draft proposal public prior to being officially released for notice and public comment. Indeed, the draft was characterized on the OPA website as the "HHS-approved document [that] is being submitted to the Office of the Federal Register (OFR) for publication and has not yet been placed on public display or published in the *Federal Register*."

The administration officially released its notice of proposed rulemaking (NPRM) for Title X—with some minor changes from the draft version—on May 29, with the NPRM formally published in the *Federal Register* on June 1. The proposed rule, "[Compliance with Statutory Program Integrity Requirements](#)," would dramatically reshape the Title X program. The

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<sup>1</sup> At the time of publication, the case is still under review by the appellate court.

NPRM not only reintroduced the majority of a Reagan-era Title X rule, known as the “domestic gag” rule, but it expanded those provisions and introduced numerous new and harmful requirements and restrictions.

Collectively, the provisions of the NPRM would undermine the high-quality standards of care in Title X and discourage and prevent highly qualified, trusted family planning providers from participating in the Title X program. Although the rule in many ways was designed to target abortion-related activities and entities that provide abortion care, it was not limited to such activities and/or providers, and would have far-reaching implications for all Title X-funded entities, the services they provide, and the ability of patients to seek and receive high-quality, confidential family planning and sexual health care.

***Key harmful [changes](#) proposed in the NPRM included:***

- weakening (or eliminating entirely) the requirement that Title X projects offer a broad range of contraceptive methods;
- eliminating Title X’s longstanding legal and ethical requirement for nondirective options counseling, including all referrals upon a patient’s request;
- directing Title X-funded entities to withhold full and accurate medical information from patients;
- leaving unclear whether providers could mention abortion in pregnancy counseling in any manner and ignoring non-physician providers;
- changing the criteria for awarding Title X grants and allowing HHS to disqualify applicants if the agency decides the applicant hasn’t sufficiently described how it will satisfy every part of the regulation;
- threatening patient confidentiality, particularly for minors, in ways that could cause many patients to avoid seeking care in Title X settings;
- requiring physical separation between Title X activities and a variety of activities outside Title X and paid for with non-Title X funds;
- and explicitly enabling and possibly requiring Title X-funded entities to provide free or low-cost contraceptive services to women, regardless of income, whose employers provide insurance coverage but object, contrary to the ACA, to that coverage including contraception.

According to the Trump administration, more than 500,000 comments were submitted during the public comment period, which ran from June 1 to July 31, 2018. The comments included letters of opposition from [NFPRHA](#), other family planning and sexual health organizations, many members of Congress, and several governors and state attorneys general.<sup>2</sup>

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2 A final version of the rule was unofficially posted on the OPA website on February 22, 2019. The

## Appropriations for Title X

Running concurrently to the Trump administration's actions on Title X, the Republican majority also sought to leave its mark on the program. The House's FY 2018 bill eliminated all funding for Title X and included a rider barring funds from going to Planned Parenthood.<sup>viii</sup> The bill was the sixth time in eight years that the House proposed defunding Title X.<sup>3</sup> In contrast, the Senate bill provided level funding (\$286.5 million) for Title X and included no new riders.<sup>ix</sup> Congress ultimately passed five continuing resolutions (CRs) before reaching an agreement in March 2018, after passing a two-year budget deal weeks earlier.<sup>4</sup> The final package included \$286.5 million for Title X and no new riders related to family planning and sexual health.<sup>x</sup>

Fiscal Year (FY)	NFPRHA Request	President's Budget Request	Senate Labor-HHS Subcommittee Bill	House Labor-HHS Subcommittee Bill	Appropriated	Actual (Includes cuts/recissions)
2010	\$700	\$317	\$317	\$317.5	\$317.5	\$317.5
2011	\$394, w/ request to reach \$700 by 2016	\$327	\$300	\$0	\$299.4	\$299.4
2012	\$327	\$327	\$299.4	\$0	\$296.8	\$293.9
2013	\$327	\$296.8	\$293.8	\$0	\$296.8	\$278.3
2014	\$327	\$327.4	\$327	No bill	\$286.5	\$286.5
2015	\$337	\$286.5	\$300	No bill	\$286.5	\$286.5
2016	\$327	\$300	\$257.8	\$0	\$286.5	\$286.5
2017	\$327	\$300	\$286.5	\$0	\$286.5	\$286.5
2018	\$327	\$286.5	\$286.5	\$0	\$286.5	\$286.5

official publication of the rule in the *Federal Register* is expected on March 4, 2019. Legal challenges to the final rule are likely, and could delay implementation of the rule.

3 In the two years without elimination, the House Appropriations Committee did not present a bill.

4 The federal government shut down briefly from January 20-22, 2018 and for five hours on February 9, 2018 due to gaps in between continuing resolutions.

Because Congress had already negotiated budget parameters for FY 2019 when they raised the budget caps in February 2018, the FY 2019 Labor-HHS appropriations process went more smoothly.<sup>5</sup> As with the FY 2018 bills, the House proposed eliminating Title X and adding a new rider to bar Planned Parenthood,<sup>xi</sup> while the Senate proposed a bill with flat-funding and no new riders.<sup>xii</sup> Ultimately, Congress negotiated and passed a two-bill package that would fund the Department of Defense and Labor-HHS for FY 2019 in September 2018.<sup>xiii</sup>

A Senate floor amendment to bar funds to Planned Parenthood failed 45-48.

Title X was flat-funded at \$286.5 million for the sixth year in a row.<sup>xiv</sup> FY 2019 was the first time since 1996 that Congress had passed a Labor-HHS appropriations bill before the end of the previous fiscal year.

### ***FY 2019 Title X Funding Opportunity Announcement***

The Trump administration released the 2019 Title X FOA in November 2018. OPA, clearly responding to pressure applied by various legal challenges on the FY 2018 Title X FOA, reincorporated references to contraception and took at least some steps to address certain issues that had been highlighted in the *NFPRHA v. Azar* case; however, the tone and intention to reshape the network remained present.<sup>6</sup>

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5 Many other portions of the government were not so lucky; 9 departments and many agencies were shut down in late December 2018 due to a lapse in funding.

6 Funding decisions resulting from the FY 2019 FOA are not expected until March 2019. It remains to be seen to what extent the Title X provider network will be reshaped by the administration's effort.

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## Section 2: Rolling Back ACA Health Care Achievements

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### **Advancing “Repeal and Replace” of the Affordable Care Act**

When the new Republican congressional majority took office in early 2017, they almost immediately turned their full attention towards an effort to repeal the Affordable Care Act (ACA), with the intention of using a “fast-track” **budget reconciliation** process that would only require a simple majority, rather than 60 votes in the Senate for passage. House Republicans presented their proposal, named the American Health Care Act (AHCA),<sup>xv</sup> to repeal and replace the ACA. The bill went through several modifications to appeal to various key constituencies in the Republican-held Congress to secure enough votes to pass in the House. The package would have barred Planned Parenthood from Medicaid reimbursement for one year, restructured Medicaid into a **per capita cap** program with a **block grant** option, ended federal financial support for Medicaid expansion, and repealed major provisions of the ACA, including the requirement for individuals to have health insurance and the subsidies to help people purchase health insurance. Experts estimated that the bill ultimately would have resulted in approximately 24 million Americans losing their coverage.<sup>xvi</sup>

Despite the many changes and concessions made over time, then-Speaker of the House Paul Ryan (R-WI) was forced to pull the bill from floor consideration on March 24, due to a lack of sufficient votes for passage.

#### **Budget reconciliation:**

*An expedited legislative process for certain budgetary legislation on spending, revenues, and the federal debt limit. Passage of a reconciliation bill requires only a simple majority in both the House and Senate.*

#### **Current Medicaid financing:**

*guaranteed funding from the federal government at a specified match rate to state spending, tied to enrollment, costs, and program needs. Coverage for eligible individuals is guaranteed.*

**Per capita cap:** *a capped and fixed amount of funding from the federal government for each Medicaid enrollee in a state; coverage may be guaranteed for some groups, but not necessarily all eligible individuals.*

**Block grant:** *a capped and fixed amount of funding from the federal government for a state Medicaid program as a whole; not tied to enrollment, costs or program needs. Enrollment would not be guaranteed for all eligible individuals.*

After what was seen publicly as a significant failure, Congress restarted efforts to repeal and replace the ACA. The new approach modified the AHCA to include a reinsurance program and would have allowed states to:

- **Waive essential health benefits requirements;**
- **Permit insurance companies to charge enrollees with pre-existing conditions higher premiums if the enrollees had any gaps in coverage; and**
- **Permit insurance companies to charge older adults more than five times more than younger enrollees.**

On May 4, 2017, the House of Representatives narrowly passed (217-213) the AHCA (HR 1628)<sup>xvii</sup> after adding resources to purportedly protect people with pre-existing conditions from facing high health care costs. The bill continued to include substantial changes to Medicaid and repeal of key ACA provisions, as well as prohibiting Planned Parenthood from federal reimbursement of medical services provided to Medicaid beneficiaries for one year.

After weeks of negotiations among Republican senators, and between the Senate and the White House, Senate Majority Leader Mitch McConnell (R-KY) requested a procedural vote to allow debate and consideration of the Senate's version of ACA repeal in July 2017. On July 21, the Senate Parliamentarian ruled that several provisions in the Senate bill, including the Planned Parenthood defunding measure, were in violation of the rules of budget reconciliation. Maintaining these provisions in the bill would have required 60 votes, rather than the simple majority (51) required for budget reconciliation. This first version, called the "Better Care Reconciliation Act"<sup>xviii</sup> failed to pass, and the Senate voted on two other versions that week. The final version, known as "skinny repeal," would have repealed the ACA's individual and employer mandates and other unpopular provisions of the law, but made no changes to the structure of Medicaid or Planned Parenthood's funding. Debate and voting on "skinny repeal" went on late into the night of July 27 and into the morning of July 28, and failed in a dramatic 51-49 vote when the late Sen. John McCain (R-AZ) came to the floor around 2:30 a.m. to vote with Senate Democrats against the bill.<sup>xix</sup> The bill was tabled the next day to allow the Senate to proceed on other legislative business.

Despite last-minute negotiating over another version of "repeal and replace," the Senate failed to craft a measure to substantially alter the ACA that could garner enough votes to pass both chambers. Reconciliation instructions allowing a simple majority vote in the Senate expired on September 30.

### ***Repealing the Individual Mandate***

Following on the failure of ACA repeal efforts tied to FY 2017 budget reconciliation, Congress turned its attention to the FY 2018 budget reconciliation process and another priority: tax reform. On November 16, 2017, the House passed HR 1,<sup>xx</sup> a substantial tax reform bill that proposed extensive tax cuts that would need to be financed through severe cuts to domestic spending in future sessions. In total, the bill would cost approximately \$1.5 trillion over ten years. The bill also included a repeal of the individual

mandate, an ACA provision that imposed tax penalties on individuals above a designated income threshold who did not maintain health insurance. On December 2, the Senate passed (51-49) an amended version of HR 1,<sup>xxi</sup> which went to conference, and the negotiated version<sup>xxii</sup> passed the Senate and House on December 19 and December 20 respectively. The president signed the bill on December 22, 2017.

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The successful elimination of the ACA's individual mandate is the basis for the case, *Texas v. United States*, in which the state of Texas argued that the rest of the ACA is unconstitutional without the individual mandate. In June 2018, the Trump administration announced it would not defend the ACA in the case, and several state attorneys general, led by California Attorney General Xavier Becerra (D), intervened to defend the law instead. On December 14, 2018, a US District Court judge in Texas ruled in favor of Texas's claim and struck down the ACA. Attorney General Becerra vowed to appeal the decision, which could take the case all the way to the Supreme Court.



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### **State-level Medicaid Changes**

In March 2017, CMS Administrator Seema Verma, in conjunction with then-HHS Secretary Tom Price, sent a letter to governors expressing their interest in receiving Medicaid proposals from states seeking additional flexibility, including imposing work requirements and other policies on Medicaid beneficiaries.<sup>xxiii</sup> Many state governments have taken this opportunity to pursue policies that previous administrations had refused to approve.

CMS also [rescinded supportive guidance from April 2016](#) that reinforced and clarified the “free choice of provider” requirement (also known as “freedom of choice”) that protects the right of Medicaid beneficiaries to receive services from any qualified Medicaid provider. In June 2017, Texas submitted a Medicaid family planning waiver request to CMS similar to a request rejected by the Obama administration.<sup>xxiv</sup> The waiver requested reinstatement of federal participation in its family planning expansion program; the federal government had pulled out in 2013 due to Texas's exclusion of abortion providers and organizations that “promote” abortion from the program. The waiver proposal was open for a 30-day federal comment period. The agency received more than 19,019 comments, more than 18,900 of which opposed the waiver.<sup>7, xxv</sup>

Like Texas, Tennessee and South Carolina sought to exclude abortion providers from Medicaid; however, both took their efforts a step further, proposing applying the exclusion to their full-benefit Medicaid program, rather than just the family planning expansion program, as Texas has proposed. In August 2018, both Tennessee<sup>xxvi</sup> and South

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7 The Texas waiver proposal is still pending CMS action.



Carolina<sup>xxvii</sup> submitted proposals to CMS requesting a waiver of the free choice of provider requirement for family planning.

Tennessee, in response to a state law passed by the legislature earlier in 2018, proposed an amendment to its existing Medicaid 1115 waiver that requested permission to establish criteria that would prohibit abortion providers and their affiliates from participating in the Medicaid program. South Carolina proposed establishing a preconception care model for the delivery of family planning services to all Medicaid beneficiaries in the state, requiring that providers of family planning services also offer a range of chronic disease management services in order to qualify to be Medicaid providers. The South Carolina waiver included an exemption for the state Department of Health and Environmental Control health centers, which constitutes the state's entire Title X network. South Carolina also requested the ability to waive the free choice of provider provision with the goal of excluding abortion providers from the program.

In addition to efforts to limit the provider networks, several states have proposed Medicaid 1115 waivers that include **work requirements**, **premiums**, and **lockout periods**, which would also have a significant chilling effect on family planning access. The Centers for Medicare and Medicaid Services (CMS) has thus far approved those waivers for six states; Arkansas, Indiana, Kentucky<sup>8</sup>, Maine<sup>xxviii</sup>, New Hampshire, and Wisconsin. The Maine waiver was different from the others in one critical way: it proposed applying work requirements and premiums of up to \$40/month to individuals enrolled only in the family planning expansion state plan amendment program. The Maine waiver was approved by CMS on December 21, 2018.<sup>9</sup>

**Work requirements:** A policy that makes Medicaid coverage for many adult beneficiaries contingent upon those individuals working for a certain number of hours per month and submitting adequate documentation of that work to the state. These requirements sometimes consider other types of activities, like school, job-training, and volunteer work, as equivalent to work for the purpose of satisfying the requirement.

**Premiums and lockout periods:** A policy that requires Medicaid beneficiaries to pay monthly premiums for their Medicaid coverage. If an individual does not pay their premiums for a predetermined number of consecutive months, the individual is "locked out" of coverage for a set period of time or until those premiums are paid.

8 The Kentucky and Arkansas waivers are the subject of ongoing litigation, and the Arkansas waiver is the only one with work requirements that has been implemented.

9 On January 22, 2019 newly-elected Gov. Janet Mills (D) sent a letter to CMS Administrator Verma declaring her intention not to implement any of the provisions in the approved waiver. The letter is available here: <https://www.maine.gov/governor/mills/sites/maine.gov/governor.mills/files/in-line-files/01-22-19%20CMS%201115%20Waiver.pdf>.

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## Section 3: Reversing Family Planning and Sexual Health Policies

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### ***Teen Pregnancy Prevention Program***

In July 2017, the administration issued a similar pronouncement for the Teen Pregnancy Prevention Program (TPPP) as it did for Title X. HHS stated that 84 program grants would end in the summer of 2018 and that five capacity building grants would end immediately, despite that all grants were awarded for a five-year period, to end in 2020. Unlike the Title X announcement, the TPPP statement said that grants would not be recompeted, as the president's budget eliminated the program.<sup>xxxix</sup>

The abrupt end of the TPPP grants, despite valid grant agreements and congressional funding for the program, led to a series of lawsuits in 2018. In February and March of that year, 10 entities filed a combined four lawsuits against the shortened grants announced by HHS in July 2017. In April, the remaining grantees filed a class action lawsuit on the same matter. By June 2018, judges in all five cases had rules for the grantees.<sup>xxx</sup> Then, in August, the government dropped its appeals process and agreed to provide another year of funding to all current grantees.<sup>xxxi</sup> The five research grants were never restored.

### ***Contraceptive Coverage***

The ACA included a requirement that most private insurance plans cover women's preventive services with no cost-sharing for the patient and left it to the Health Resources and Services Administration (HRSA) to determine the list of services to be included in that benefit. HRSA included coverage of at least one of each of the 18 categories of all FDA-approved methods of contraception in the required benefit, beginning in 2012. In the intervening years, the contraceptive coverage requirement has been a constant subject of litigation from entities claiming religious or moral objections to the coverage. The Obama administration attempted to address the concerns of these entities by establishing a process, referred to as the "accommodation," that would allow certain religiously-affiliated employers to object to the coverage, and for an insurer or a third-party administrator to step in to ensure that employees of the objecting entity would still have access to seamless coverage. Many of the litigating entities maintained that the "accommodation" did not adequately meet their needs.

In October 2017, the Trump administration released two interim final rules (IFRs) that would allow any employer, either nonprofit or for-profit and regardless of size, to claim religious<sup>xxxii</sup> or moral<sup>xxxiii</sup> objections to, and be exempted from, the contraceptive coverage requirement under the ACA. The rules were a significant expansion of current law and made the accommodation process optional. Prior to the publication of the IFRs, only houses of worship were exempt from the requirement. The administration argued that these rules were needed to address the concerns of entities that had ongoing objections. The rules went into effect immediately but were open for a 60-day comment period.

In response to the October 2017 release of the two IFRs<sup>xxxiv,xxxv</sup>, several state attorneys general filed lawsuits to block the rules' implementation. On December 15 and December 21, 2017 respectively, federal courts in Pennsylvania and California issued temporary nationwide injunctions barring the Trump administration from implementing the IFRs. Under the injunctions, HHS could not enforce the rules, pending the outcome of litigation, maintaining access to contraceptive coverage for countless women across the country.

Despite the ongoing litigation and existing nationwide injunctions blocking the IFRs from going into effect, the administration published final versions of the rules in November 2018, the day after the midterm elections. The final rules<sup>xxxvi,xxxvii</sup> were scheduled to go into effect January 14, 2019.<sup>10</sup>

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The administration has contended that women who lose their contraceptive coverage as a result of the contraceptive coverage regulations will still be able to access contraception because they can seek care at a Title X-funded health center. This is a fundamental misunderstanding of the intent of the Title X family planning program.

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### **Religious Refusal Rules**

From its opening days, the Trump administration has made significant efforts to elevate religious belief in federal policy. In May 2017, President Trump signed an Executive Order ([EO 13798](#)) "promoting free speech and religious liberty," which included a provision directing the Secretaries of the Treasury, Labor, and HHS to "consider issuing amended regulations . . . to address conscience-based objections" to the ACA's contraceptive coverage requirement. In October 2017, HHS issued a request for information (RFI) entitled "[Removing Barriers for Religious and Faith-Based Organizations To Participate in HHS Programs and Receive Public Funding](#)." Rather than discussing the needs of the patients and individuals served by HHS' programs, the RFI was exclusively focused on soliciting information to quantify and address presumed regulatory and programmatic barriers to the inclusion of more faith-based organizations in HHS programs.

In January 2018, the Office of Civil Rights at HHS announced the creation of a new "[Conscience and Religious Freedom Division](#)." The division was created to help shield employers who object to providing certain types of care, including abortions or services for transgender persons, and to sanction employers for failing to protect such workers.

In January 2018, the administration promulgated a new proposed rule "[Protecting Statutory Conscience Rights in Health Care; Delegations of Authority](#)," that, if finalized, would reinstate and broaden a regulation promulgated in 2008 under then-President George W. Bush, that sought to significantly expand the ability of health care providers to withhold

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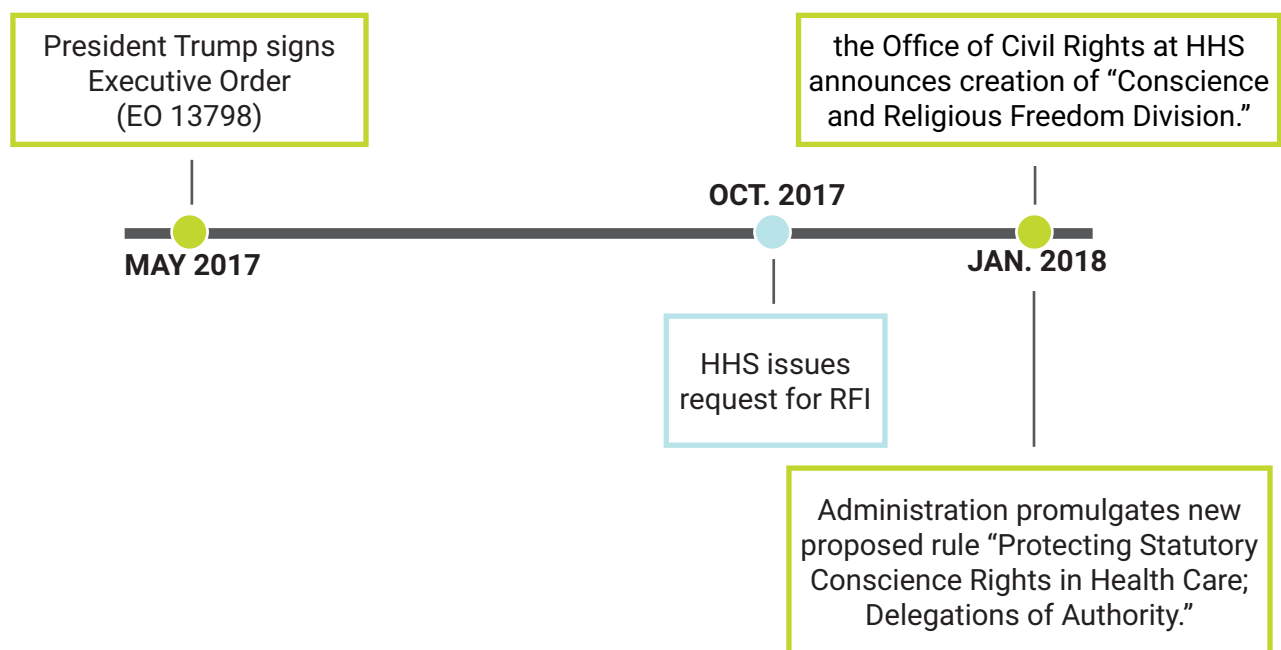
10 The 3rd circuit court of appeals issued a nationwide injunction blocking implementation of the contraceptive coverage final rules on January 14, 2019.

treatment, counseling, or medical information based on their religious or moral beliefs—without any regard for the needs of patients.

The 2018 proposed health care refusal rule addresses how it attempts to interpret three key statutory provisions related to family planning: the Church Amendments, Coats-Snowe Amendments, and the Weldon Amendment. For decades, these federal health care refusal statutes have given specified individuals and institutions certain rights to refuse to perform, assist in the performance, and/or refer for abortion and/or sterilization services.

The proposed health care refusal rule would dramatically expand the scope and reach of these laws, including by expanding the categories of individuals and entities whose refusals to provide information and services are protected; expanding the types of services that individuals and entities are allowed to refuse to provide; and expanding the types of entities that are required to accept such refusals. The proposed rule also attempts to grant HHS' Office for Civil Rights oversight authority and enforcement discretion that is overly broad and vague; unduly punitive; and ripe for abuse.<sup>11</sup>

The proposed health care refusal rule dramatically expands the categories of individuals and entities whose refusals are protected and the types of services that individuals and entities can refuse to provide.



11 As of the end of 2018, a final health care refusal rule had not yet been issued.

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# Conclusion

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The actions taken by the Trump administration and the 115<sup>th</sup> Congress reinforce a need for vigilance and advocacy to protect access to high-quality care and the provider network that delivers it. Notably, all of this federal action has come during rising rates of sexually transmitted diseases (STDs), a trend that advocates and public health officials are struggling to reverse. From 2016 to 2017, there was a 7% increase in confirmed chlamydia cases, a 19% increase in confirmed gonorrhea cases, and an 11% increase in confirmed syphilis cases, a particularly troubling trend given that STD infection rates were at historic lows in the 2000s. Dr. Gail Bolen, the director of the CDC's Division of STD Prevention, noted in the STD Surveillance 2017 that these concerning statistics are "a symptom of a deteriorating public health infrastructure and lack of access to health care."<sup>xxxviii</sup>

The family planning safety net has worked hard to mitigate the harm to patients in communities, continuing to stretch scarce federal resources and committing to delivering the best possible care regardless of how the policy environment in Washington interferes. Efforts to destroy the foundation of Title X and Medicaid family planning remain real and present threats. It is incumbent on public health allies, congressional champions, and the public to defend our nation's family planning framework, now and for generations to come.

## APPENDIX A: FDA Approval of Family Planning and Sexual Health Supplies

In 2018, the Food and Drug Administration (FDA) approved several new or modified drugs and devices for family planning and sexual health needs:

### ***Annovera***

In August 2018, the FDA approved Annovera, a new vaginal ring,<sup>xxxix</sup>

### ***Natural Cycles***

In August 2018, the FDA approved Natural Cycles, the first-ever approved fertility awareness app (Natural Cycles).<sup>xi</sup> Natural Cycles is a fertility awareness-based method (FABM) that relies on the individual user's menstrual cycle pattern and basal body temperature (BBT) to predict non-fertile and fertile days. The app's manufacturer reported a more than 90% efficacy rate for perfect and typical use, but a post-approval systematic review questioned those high rates<sup>12, xli</sup>

### ***Internal Condom***

In September 2018, the FDA approved the internal condom for expanded use. The device, which was formerly referred to as a female condom, garnered approval for use for vaginal and anal intercourse. The FDA further reclassified the internal condom as a Class II device; it had previously been classified as a Class III device, a high level that had deterred manufacturers from bringing new products to market.<sup>xlii</sup>

### ***HPV Vaccine***

In October 2018, the FDA expanded the approved age range for the HPV vaccine to include adults ages 27 through 45. The vaccine had previously been approved for individuals ages six to 26. The approval applies only to Gardasil 9, an expanded version of the original Gardasil vaccine released in 2006.<sup>xliii</sup>

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12 At publication, FDA had not announced any plan to renew the data that led to Natural Cycles' approval.

## APPENDIX B: Updated USPSTF Guidelines

### HIV Guidelines

The United States Preventive Services Task Force (USPSTF) presented two draft recommendations and three new evidence reviews related to screening for and prevention of HIV in November 2018. The new guidelines were particularly notable for the recommendation for pre-exposure prophylaxis (PrEP), a drug that can prevent the spread of HIV. USPSTF recommended an A grade for the medication for persons at high risk of contracting the disease.<sup>xliv</sup> That rating would greatly expand patient access, because USPSTF recommendations with an A or B grade must be covered at no cost for most patients enrolled in private insurance plans.<sup>xlv</sup> Additionally, USPSTF revised the screening intervals for patients at high risk of acquiring the infection, recommending screening annually for people in that risk category between the ages of 15 and 65. Previously, the USPSTF had recommended screening every three to five years for people at high risk and annually for people at very high risk.<sup>xlvi</sup>

## APPENDIX C: Trump Nominees

Name	Position	Tenure	Notes on Record	Actions during tenure
<b>Tom Price</b>	Secretary of Health and Human Services (HHS)	February 2017-September 2017	<ul style="list-style-type: none"> <li>• Former Representative (R-GA) from 2005-2017</li> <li>• Medical doctor</li> <li>• Came into office as Secretary with long history of opposition to the ACA</li> </ul>	<ul style="list-style-type: none"> <li>• Oversaw HHS' support of ACA repeal efforts in Congress, as well as drastic cuts to spending for ACA enrollment outreach and marketing</li> <li>• Resigned after controversy over his use of government funds for private planes and other travel-related expenses</li> </ul>
<b>Alex Azar</b>	Secretary of HHS	January 2018-present	<ul style="list-style-type: none"> <li>• President of U.S. division of pharmaceutical company, Eli Lilly</li> <li>• Held positions at HHS (2001-2007) during George W. Bush's administration, including General Counsel and Deputy Secretary</li> <li>• Came into office with history of opposition to the ACA, support block-granting Medicaid</li> </ul>	<ul style="list-style-type: none"> <li>• Oversees drug pricing initiative, including development of drug pricing blueprint and other regulatory efforts to rein in drug prices</li> </ul>

<b>Seema Verma</b>	Administrator of the Centers for Medicare and Medicaid Services (CMS)	March 2017-present	<ul style="list-style-type: none"> <li>• Worked as consultant to states, assisting in the writing of Medicaid 1115 waiver proposals seeking Medicaid expansion that fulfilled a more conservative ideology</li> <li>• Instrumental in the writing of the Healthy Indiana waiver, a waiver expanding Medicaid eligibility in the state to all adults under 138% FPL, but imposes premiums up to 2% of income, reduction in benefits and imposition of copayments for lack of payment of premiums, etc.</li> </ul>	<ul style="list-style-type: none"> <li>• Oversaw the first CMS approvals of Medicaid waivers that include work requirements for beneficiaries, other provisions that can be barriers to access</li> </ul>
<b>Teresa Manning</b>	Deputy Assistant Secretary for Population Affairs (DAS-PA)	May 2017-January 2018	<ul style="list-style-type: none"> <li>• Previously worked for National Right to Life Committee and the Family Research Council</li> <li>• Made previous statements about her belief that contraception doesn't work, emergency contraception is an abortifacient, and that "family planning is something that occurs between a husband and a wife and God, and it doesn't really involve the federal government."</li> </ul>	<ul style="list-style-type: none"> <li>• Oversaw shortening of Title X project periods</li> <li>• Oversaw cancellation of multi-decade cooperative agreement with Guttmacher Institute for research on the Title X network</li> <li>• Oversaw cancellation of funding of research at UCSF on the development of a patient-reported outcomes measure</li> </ul>
<b>Diane Foley</b>	DASPA	May 2018-present	<ul style="list-style-type: none"> <li>• Pediatrician</li> <li>• Previously served as president and CEO of Life Network, a network of crisis pregnancy centers</li> <li>• Previously served as director of medical ministries for the Wesleyan Church</li> </ul>	<ul style="list-style-type: none"> <li>• Oversaw release of 2018 funding opportunity announcement, currently the subject of NFPRHA litigation</li> <li>• Oversaw crafting and release of Title X regulation</li> </ul>



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# Endnotes

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- i [https://www.regulations.gov/document?D=HHS\\_FRDOC\\_0001-0655](https://www.regulations.gov/document?D=HHS_FRDOC_0001-0655)
- ii <http://clerk.house.gov/evs/2017/roll099.xml>
- iii <https://www.congress.gov/bill/115th-congress/house-joint-resolution/43/text?q=%7B%22search%22%3A%5B%22HJ+Res+43%22%5D%7D&r=1>
- iv [https://www.senate.gov/legislative/LIS/roll\\_call\\_lists/roll\\_call\\_vote\\_cfm.cfm?congress=115&session=1&vote=00101](https://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=115&session=1&vote=00101)
- v The president's budget is a recommendation to Congress and has no force of law, though it does signal an administration's priorities. The budget is due on the first week of February each year for the following fiscal year, though that deadline is rarely met in a president's first term. Congress may use the budget as a model for their own appropriations process, which is what funds the federal government.
- vi Office of Population Affairs. "Announcement of Anticipated Availability of Funds for Family Planning Services Grants." Department of Health and Human Services (October 5, 2016). [www.hhs.gov/opa](http://www.hhs.gov/opa).
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- xiv Department of Defense and Labor, Health and Human Services, and Education Appropriations Act of 2019, Pub. L. No. 115-245 (2018).
- xv <https://www.congress.gov/bill/115th-congress/house-bill/1628/text>
- xvi <https://www.cbo.gov/publication/52486>
- xvii <http://clerk.house.gov/evs/2017/roll256.xml>
- xviii <https://www.budget.senate.gov/imo/media/doc/ERN17500.pdf>
- xix <https://www.nytimes.com/interactive/2017/07/25/us/politics/senate-votes-repeal-obamacare.html>
- xx <http://clerk.house.gov/evs/2017/roll637.xml>
- xxi [https://www.senate.gov/legislative/LIS/roll\\_call\\_lists/roll\\_call\\_vote\\_cfm.cfm?congress=115&session=1&vote=00303](https://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=115&session=1&vote=00303)
- xxii <https://www.congress.gov/bill/115th-congress/house-bill/1?q=%7B%22search%22%3A%5B%22HR+1%22%5D%7D&r=1>
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- xxxv <https://www.federalregister.gov/documents/2017/10/13/2017-21852/moral-exemptions-and-accommodations-for-coverage-of-certain-preventive-services-under-the-affordable>
- xxxvi <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24512.pdf>
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- xli Rachel Peragallo Urrutia et al. "Effectiveness of Fertility Awareness-Based Methods for Pregnancy Prevention." *Obstetrics & Gynecology*, 132.3 (September 2018).
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