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S.323 - Family Planning Amendments Act of 1992

102nd Congress (1991-1992)

Sponsor: Sen. Chafee, John H. [R-RI] (Introduced 01/31/1991)
Committees: Senate - Labor and Human Resources
Committee Reports: S.Rept 102-86; H.Rept 102-767
Latest Action: Senate - 10/02/1992 Message on House action received in Senate. (All Actions)
Roll Call Votes: There have been 7 roll call votes
Tracker:

Introduced Passed Senate Passed House Resolving Differences To President Vetoed by President Passed over veto **Failed to pass over veto**

Summary(4) Text(5) Actions(72) Titles(10) Amendments(10) Cosponsors(48) Committees(1) Related Bills(1)

There are 4 summaries for S.323. Conference report filed in House (07/31/1992)

Bill summaries are authored by CRS.

Shown Here:
Conference report filed in House (07/31/1992)

Family Planning Amendments Act of 1992 - Amends the Public Health Service Act to require recipients of financial assistance under provisions relating to project grants and contracts for family planning services to provide individuals, on request, information on pregnancy management options, defined as nondirective counseling and referrals regarding: (1) prenatal care and delivery; (2) infant care, foster care, and adoption; and (3) termination of pregnancy. Allows a provider who objects, on religious or moral grounds, to providing information on an option to refer the woman to another provider in the geographic area. Prohibits such assistance unless the recipient is in compliance with State law regarding parental notification of or consent for the performance of an abortion on a minor which is enforced in the State in which the entity is located. Authorizes appropriations for such assistance.

Authorizes appropriations for grants and contracts concerning: (1) training to provide family planning services; and (2) informational and educational materials regarding family planning and population growth.

Declares that it is the sense of the Congress that recipients of financial assistance under title X (Population Research and Voluntary Family Planning Programs) of the Public Health Service Act should, when purchasing equipment products with such assistance, purchase only American-made equipment and products.

19-1614, 20-1215 Visited Sept. 1, 2020

USCA4 Appeal: 19-1614 Doc: 155-2 Filed: 09/03/2020 Pg: 1 of 57 Total Pages: (2 of 57)

VETO—S. 323

MESSAGE

FROM

THE PRESIDENT OF THE UNITED STATES

RETURNING

WITHOUT MY APPROVAL S. 323, THE FAMILY PLANNING AMENDMENTS ACT OF 1992

19-1614, Doc. 1215
Sept. 1, 2020

SEPTEMBER 26, 1992.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE
59-011 WASHINGTON : 1992

To the Senate of the United States:

I am returning herewith without my approval S. 323, the "Family Planning Amendments Act of 1992." This legislation would extend and amend the Federal family planning program under title X of the Public Health Service Act.

If the scope of S. 323 were limited to family planning, I would approve it. My Administration has an excellent record in support of family planning. About this there can be no question. Our approach to reauthorizing title X was embodied in a bill transmitted to the Congress on February 25, 1991. We need a family planning program to deliver preventive, pre-pregnancy services.

Unfortunately, S. 323 is unacceptable because it would override current regulations that are designed to maintain the title X program's integrity as a pre-pregnancy family planning program. The bill would require projects supported by title X family planning funds to counsel pregnant women on, and refer them for, abortions. Such a requirement is totally alien to the purpose of the title X program. Title X is a quality health care program that provides pre-pregnancy family planning information and services and refers pregnant women to health care providers who can ensure continuity of care.

19-1614, 20-1078
Sept. 11, 2020

Under current regulations, upheld by the United States Supreme Court, pregnant women who seek services from clinics funded by title X would be referred to qualified providers for prenatal care and other social services, including counseling. Moreover, nothing in these regulations prevents a woman from receiving complete medical information about her condition from a physician. The Supreme Court specifically found that the regulations regarding the title X program in no way violated free speech rights.

In a memorandum to Department of Health and Human Services Secretary Louis Sullivan on November 5, 1991, I reiterated my commitment to preserving the confidentiality of the doctor/patient relationship. In that memorandum, I also repeated my commitment to ensuring that the operation of the title X family planning program is compatible with free speech and the highest standards of medical care. My memorandum makes clear that there is no "gag rule" to interfere with the doctor/patient relationship. There can be no doubt that my Administration is committed to the protection of free speech.

I have repeatedly informed the Congress that I would disapprove any legislation that would transform this program into a vehicle for the promotion of abortion. Unfortunately, the Congress has seen fit to entangle this family planning program in the politics of abortion.

I believe that the title X family planning program should be reauthorized. I now urge the Congress to adopt a bill that promotes true family planning rather than requiring Federal tax dollars to

be used in a manner that promotes abortion as a method of birth control.

GEORGE BUSH.

THE WHITE HOUSE, *September 25, 1992.*

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19-1614, 20-1215
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NATIONAL

Planned Parenthood Officials Say They've Halted Use Of Title X Family Planning Funds

July 17, 2019 · 6:03 PM ET

SARAH MCCAMMON

Supporters of Planned Parenthood demonstrated at New York's City Hall against the Trump administration's Title X rule change in February. Planned Parenthood now says it clinics nationwide will stop using federal Title X family planning funds.

Spencer Platt/Getty Images

Planned Parenthood clinics nationwide have stopped using federal Title X family planning funds, according to the organization. The decision comes after the Trump

Hill said Maine Family Planning provides abortions using private funds. For other services normally funded by Title X, Hill said the group will tap into reserves and explore other potential funding sources.

NATIONAL

Planned Parenthood Removes Leana Wen As President After Less Than A Year

"This rule is so onerous and arrogant that we simply cannot accept the federal funds with these limitations on them and provide what we believe is the full range of reproductive healthcare services that our patients deserve," Hill said.

Reproductive rights groups have seen the regulations as a major blow, and have said the rules will interfere with the doctor-patient relationship.

The president's supporters see them as a fulfillment of his campaign promise to "defund" Planned Parenthood. Federal funding for abortion is already illegal except in a few circumstances, but the new regulations mean many organizations that once provided other reproductive health services through Title X are now barred from receiving those funds.

In a statement this week praising the Trump administration's announcement that it will begin enforcement of the rule,Marjorie Dannenfelser of the Susan B. Anthony List, which opposes abortion rights, praised administration officials for "acting decisively to stop taxpayer funding of the abortion industry."

Reproductive rights groups say they'll continue to fight the rule in court.

family plann - president trump title x reproductive rights reproductive health planned parenthood abortion

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administration announced this week that it has started enforcing regulations that prohibit Title X grant recipients from counseling patients about abortion.

The Trump administration's rules – unveiled last year and finalized this year – forbid groups that provide or refer patients for abortion from receiving funds through Title X, which pays for reproductive health care for about 4 million low-income people.

After a recent series of legal challenges left the rule in place – at least for now – the administration said on Monday that it would begin enforcing the rules.

In a statement, Jacqueline Ayers, vice president of government relations & public policy at Planned Parenthood Federation of America, said the organization is refusing to comply with what critics call a "gag rule" and instead has stopped using Title X dollars.

"It is unethical and dangerous to require health care providers to withhold important information from patients," Ayers' statement said. "During this period of limbo while we wait for the court to rule, our affiliates are not using federal Title X funds to provide care. We are continuing to fight this illegal rule in court and to provide care to all people — no matter what."

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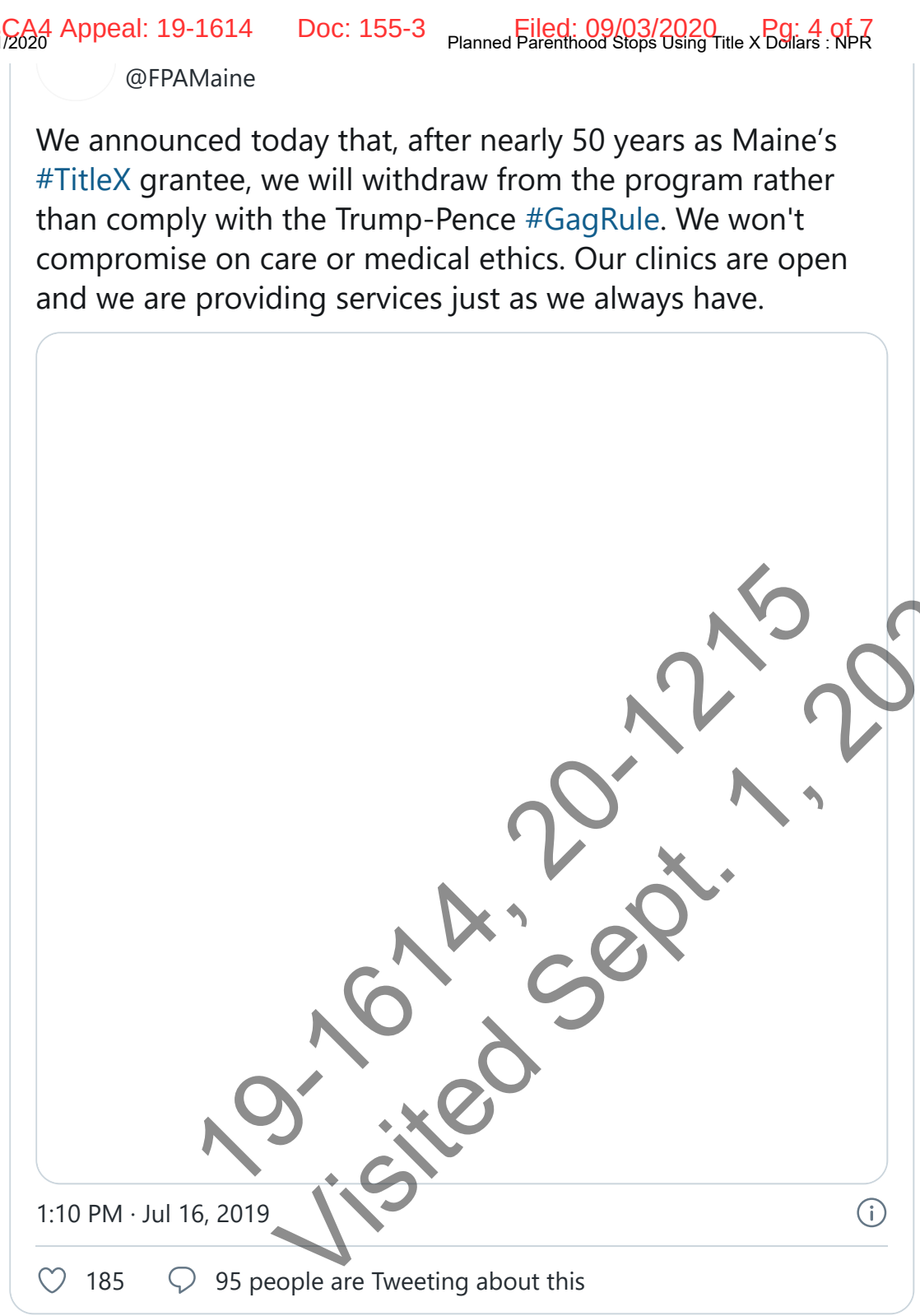
Planned Parenthood says it will dip into emergency funds to continuing providing care. Officials say about 40% of Title X recipients nationwide receive health services at the group's clinics.

This comes at a time of uncertainty for the organization. Earlier this week, Planned Parenthood's board announced it had replaced President Dr. Leana Wen with an interim leader. Wen said she was fired after a "secret" meeting over philosophical differences.

On Tuesday, Maine Family Planning announced it would stop accepting Title X dollars after nearly five decades as a grantee. The organization operates 18 of its own clinics and sub-contracts with other health centers around the state to provide reproductive health services through the federal program.

Maine Family Planning



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President and CEO George Hill said in an interview with NPR that at least 25% of the organization's funding comes from Title X, and a total of 50 sites across Maine could be affected by the rule.

"Our doors are gonna remain open ... It's gonna be an enormous challenge to replace these dollars, but we simply can't accept them," Hill said.

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ACOG COMMITTEE OPINION

Number 385 • November 2007

The Limits of Conscientious Refusal in Reproductive Medicine

Committee on Ethics

Reaffirmed 2019

ABSTRACT: Health care providers occasionally may find that providing indicated, even standard, care would present for them a personal moral problem—a conflict of conscience—particularly in the field of reproductive medicine. Although respect for conscience is important, conscientious refusals should be limited if they constitute an imposition of religious or moral beliefs on patients, negatively affect a patient's health, are based on scientific misinformation, or create or reinforce racial or socioeconomic inequalities. Conscientious refusals that conflict with patient well-being should be accommodated only if the primary duty to the patient can be fulfilled. All health care providers must provide accurate and unbiased information so that patients can make informed decisions. Where conscience implores physicians to deviate from standard practices, they must provide potential patients with accurate and prior notice of their personal moral commitments. Physicians and other health care providers have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that patients request. In resource-poor areas, access to safe and legal reproductive services should be maintained. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place. In an emergency in which referral is not possible or might negatively have an impact on a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care.

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Physicians and other providers may not always agree with the decisions patients make about their own health and health care. Such differences are expected—and, indeed, underlie the American model of informed consent and respect for patient autonomy. Occasionally, however, providers anticipate that providing indicated, even standard, care would present for them a personal moral problem—a conflict of conscience. In such cases, some providers claim a right to refuse to provide certain services, refuse to refer patients to another provider for these services, or even decline to inform patients of their existing options (1).

Conscientious refusals have been particularly widespread in the arena of reproductive medicine, in which there are deep divisions regarding the moral acceptability of pregnancy termination and contraception. In Texas, for example, a pharmacist rejected a rape victim's prescription for emergency contraception, arguing that dispensing the medication was a "violation of morals" (2). In Virginia, a 42-year-old mother of two was refused a prescription for emergency contraception, became pregnant, and ultimately underwent an abortion she tried to prevent by requesting emergency contraception (3). In California, a physician refused to perform intrauterine insemination for a lesbian couple, prompted by religious beliefs and disapproval of lesbians having children (4). In Nebraska, a 19-year-old woman with a life-threatening pulmonary embolism at 10 weeks of gestation was refused a first-trimester pregnancy termination when admitted to a religiously affiliated hospital and was ultimately transferred by ambulance to another facility to undergo the procedure (5). At the heart of each of these examples of refusal is a claim of conscience—a claim that to provide certain services would compromise the moral integrity of a provider or institution.

The American College of Obstetricians and Gynecologists

Women's Health Care Physicians

In this opinion, the American College of Obstetricians and Gynecologists (ACOG) Committee on Ethics considers the issues raised by conscientious refusals in reproductive medicine and outlines a framework for defining the ethically appropriate limits of conscientious refusal in reproductive health contexts. The committee begins by offering a definition of conscience and describing what might constitute an authentic claim of conscience. Next, it discusses the limits of conscientious refusals, describing how claims of conscience should be weighed in the context of other values critical to the ethical provision of health care. It then outlines options for public policy regarding conscientious refusals in reproductive medicine. Finally, the committee proposes a series of recommendations that maximize accommodation of an individual's religious or moral beliefs while avoiding imposition of these beliefs on others or interfering with the safe, timely, and financially feasible access to reproductive health care that all women deserve.

Defining Conscience

In this effort to reconcile the sometimes competing demands of religious or moral freedom and reproductive rights, it is important to characterize what is meant by conscience. *Conscience* has been defined as the private, constant, ethically attuned part of the human character. It operates as an internal sanction that comes into play through critical reflection about a certain action or inaction (6). An appeal to conscience would express a sentiment such as "If I were to do 'x,' I could not live with myself/I would hate myself/I wouldn't be able to sleep at night." According to this definition, not to act in accordance with one's conscience is to betray oneself—to risk personal wholeness or identity. Thus, what is taken seriously and is the specific focus of this document is not simply a broad claim to provider autonomy (7), but rather the particular claim to a provider's right to protect his or her *moral integrity*—to uphold the "soundness, reliability, wholeness and integration of [one's] moral character" (8).

Personal conscience, so conceived, is not merely a source of potential conflict. Rather, it has a critical and useful place in the practice of medicine. In many cases, it can foster thoughtful, effective, and humane care. Ethical decision making in medicine often touches on individuals' deepest identity-conferring beliefs about the nature and meaning of creating and sustaining life (9). Yet, conscience also may conflict with professional and ethical standards and result in inefficiency, adverse outcomes, violation of patients' rights, and erosion of trust if, for example, one's conscience limits the information or care provided to a patient. Finding a balance between respect for conscience and other important values is critical to the ethical practice of medicine.

In some circumstances, respect for conscience must be weighed against respect for particular social values. Challenges to a health care professional's integrity may occur when a practitioner feels that actions required by an external authority violate the goals of medicine and his or her fiduciary obligations to the patient. Established clinical norms may come into conflict with guidelines imposed by law, regulation, or public policy. For example, policies that mandate physician reporting of undocumented patients to immigration authorities conflict with norms such as privacy and confidentiality and the primary principle of nonmaleficence that govern the provider–patient relationship (10). Such challenges to integrity can result in considerable moral distress for providers and are best met through organized advocacy on the part of professional organizations (11, 12). When threats to patient well-being and the health care professional's integrity are at issue, some individual providers find a conscience-based refusal to comply with policies and acceptance of any associated professional and personal consequences to be the only morally tenable course of action (10).

Claims of conscience are not always genuine. They may mask distaste for certain procedures, discriminatory attitudes, or other self-interested motives (13). Providers who decide not to perform abortions primarily because they find the procedure unpleasant or because they fear criticism from those in society who advocate against it do not have a genuine claim of conscience. Nor do providers who refuse to provide care for individuals because of fear of disease transmission to themselves or other patients. Positions that are merely self-protective do not constitute the basis for a genuine claim of conscience. Furthermore, the logic of conscience, as a form of self-reflection on and judgment about whether one's own acts are obligatory or prohibited, means that it would be odd or absurd to say "I would have a guilty conscience if she did 'x.'" Although some have raised concerns about complicity in the context of referral to another provider for requested medical care, the logic of conscience entails that to act in accordance with conscience, the provider need not rebuke other providers or obstruct them from performing an act (8). Finally, referral to another provider need not be conceptualized as a repudiation or compromise of one's own values, but instead can be seen as an acknowledgment of both the widespread and thoughtful disagreement among physicians and society at large and the moral sincerity of others with whom one disagrees (14).

The authenticity of conscience can be assessed through inquiry into 1) the extent to which the underlying values asserted constitute a core component of a provider's identity, 2) the depth of the provider's reflection on the issue at hand, and 3) the likelihood that the provider will experience guilt, shame, or loss of self-respect by performing the act in question (9). It is the genuine claim of conscience that is considered next, in the context of the values that guide ethical health care.

Defining Limits for Conscientious Refusal

Even when appeals to conscience are genuine, when a provider's moral integrity is truly at stake, there are clear-

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ly limits to the degree to which appeals to conscience may justifiably guide decision making. Although respect for conscience is a value, it is only a prima facie value, which means it can and should be overridden in the interest of other moral obligations that outweigh it in a given circumstance. Professional ethics requires that health be delivered in a way that is respectful of patient autonomy, timely and effective, evidence based, and nondiscriminatory. By virtue of entering the profession of medicine, physicians accept a set of moral values—and duties—that are central to medical practice (15). Thus, with professional privileges come professional responsibilities to patients, which must precede a provider's personal interests (16). When conscientious refusals conflict with moral obligations that are central to the ethical practice of medicine, ethical care requires either that the physician provide care despite reservations or that there be resources in place to allow the patient to gain access to care in the presence of conscientious refusal. In the following sections, four criteria are highlighted as important in determining appropriate limits for conscientious refusal in reproductive health contexts.

1. Potential for Imposition

The first important consideration in defining limits for conscientious refusal is the degree to which a refusal constitutes an imposition on patients who do not share the objector's beliefs. One of the guiding principles in the practice of medicine is respect for patient autonomy, a principle that holds that persons should be free to choose and act without controlling constraints imposed by others. To respect a patient's autonomy is to respect her capacities and perspectives, including her right to hold certain views, make certain choices, and take certain actions based on personal values and beliefs (17). Respect involves acknowledging decision-making rights and acting in a way that enables patients to make choices for themselves. Respect for autonomy has particular importance in reproductive decision making, which involves private, personal, often pivotal decisions about sexuality and childbearing.

It is not uncommon for conscientious refusals to result in imposition of religious or moral beliefs on a patient who may not share these beliefs, which may undermine respect for patient autonomy. Women's informed requests for contraception or sterilization, for example, are an important expression of autonomous choice regarding reproductive decision making. Refusals to dispense contraception may constitute a failure to respect women's capacity to decide for themselves whether and under what circumstances to become pregnant.

Similar issues arise when patients are unable to obtain medication that has been prescribed by a physician. Although pharmacist conduct is beyond the scope of this document, refusals by other professionals can have an important impact on a physician's efforts to provide appropriate reproductive health care. Providing complete, scientifically accurate information about options for reproductive health, including contraception, sterilization, and abortion, is fundamental to respect for patient autonomy and forms the basis of informed decision making in reproductive medicine. Providers refusing to provide such information on the grounds of moral or religious objection fail in their fundamental duty to enable patients to make decisions for themselves. When the potential for imposition and breach of autonomy is high due either to controlling constraints on medication or procedures or to the provider's withholding of information critical to reproductive decision making, conscientious refusal cannot be justified.

2. Effect on Patient Health

A second important consideration in evaluating conscientious refusal is the impact such a refusal might have on well-being as the patient perceives it—in particular, the potential for harm. For the purpose of this discussion, harm refers to significant bodily harm, such as pain, disability, or death or a patient's conception of well-being. Those who choose the profession of medicine (like those who choose the profession of law or who are trustees) are bound by special *fiduciary duties*, which oblige physicians to act in good faith to protect patients' health—particularly to the extent that patients' health interests conflict with physicians' personal or self-interest (16). Although conscientious refusals stem in part from the commitment to "first, do no harm," their result can be just the opposite. For example, religiously based refusals to perform tubal sterilization at the time of cesarean delivery can place a woman in harm's way—either by putting her at risk for an undesired or unsafe pregnancy or by necessitating an additional, separate sterilization procedure with its attendant and additional risks.

Some experts have argued that in the context of pregnancy, a moral obligation to promote fetal well-being also should justifiably guide care. But even though views about the moral status of the fetus and the obligations that status confers differ widely, support of such moral pluralism does not justify an erosion of clinicians' basic obligations to protect the safety of women who are, primarily and unarguably, their patients. Indeed, in the vast majority of cases, the interests of the pregnant woman and fetus converge. For situations in which their interests diverge, the pregnant woman's autonomous decisions should be respected (18). Furthermore, in situations "in which maternal competence for medical decision making is impaired, health care providers should act in the best interests of the woman first and her fetus second" (19).

3. Scientific Integrity

The third criterion for evaluating authentic conscientious refusal is the scientific integrity of the facts supporting the objector's claim. Core to the practice of medicine is a commitment to science and evidence-based practice.

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Patients rightly expect care guided by best evidence as well as information based on rigorous science. When conscientious refusals reflect a misunderstanding or mistrust of science, limits to conscientious refusal should be defined, in part, by the strength or weakness of the science on which refusals are based. In other words, claims of conscientious refusal should be considered invalid when the rationale for a refusal contradicts the body of scientific evidence.

The broad debate about refusals to dispense emergency contraception, for example, has been complicated by misinformation and a prevalent belief that emergency contraception acts primarily by preventing implantation (20). However, a large body of published evidence supports a different primary mechanism of action, namely the prevention of fertilization. A review of the literature indicates that Plan B can interfere with sperm migration and that preovulatory use of Plan B suppresses the luteinizing hormone surge, which prevents ovulation or leads to the release of ova that are resistant to fertilization. Studies do not support a major postfertilization mechanism of action (21). Although even a slight possibility of postfertilization events may be relevant to some women's decisions about whether to use contraception, provider refusals to dispense emergency contraception based on unsupported beliefs about its primary mechanism of action should not be justified.

In the context of the morally difficult and highly contentious debate about pregnancy termination, scientific integrity is one of several important considerations. For example, some have argued against providing access to abortion based on claims that induced abortion is associated with an increase in breast cancer risk; however, a 2003 U.S. National Cancer Institute panel concluded that there is well-established epidemiologic evidence that induced abortion and breast cancer are not associated (22). Refusals to provide abortion should not be justified on the basis of unsubstantiated health risks to women.

Scientific integrity is particularly important at the level of public policy, where unsound appeals to science may have masked an agenda based on religious beliefs. Delays in granting over-the-counter status for emergency contraception are one such example. Critics of the U.S. Food and Drug Administration's delay cited deep flaws in the science and evidence used to justify the delay, flaws these critics argued were indicative of unspoken and misplaced value judgments (23). Thus, the scientific integrity of a claim of refusal is an important metric in determining the acceptability of conscience-based practices or policies.

4. Potential for Discrimination

Finally, conscientious refusals should be evaluated on the basis of their potential for discrimination. Justice is a complex and important concept that requires medical professionals and policy makers to treat individuals fairly and to provide medical services in a nondiscriminatory manner. One conception of justice, sometimes referred to as the *distributive paradigm*, calls for fair allocation of society's benefits and burdens. Persons intending conscientious refusal should consider the degree to which they create or reinforce an unfair distribution of the benefits of reproductive technology. For instance, refusal to dispense contraception may place a disproportionate burden on disenfranchised women in resource-poor areas. Whereas a single, affluent professional might experience such a refusal as inconvenient and seek out another physician, a young mother of three depending on public transportation might find such a refusal to be an insurmountable barrier to medication because other options are not realistically available to her. She thus may experience loss of control of her reproductive fate and quality of life for herself and her children. Refusals that unduly burden the most vulnerable of society violate the core commitment to justice in the distribution of health resources.

Another conception of justice is concerned with matters of oppression as well as distribution (24). Thus, the impact of conscientious refusals on oppression of certain groups of people should guide limits for claims of conscience as well. Consider, for instance, refusals to provide infertility services to same-sex couples. It is likely that such couples would be able to obtain infertility services from another provider and would not have their health jeopardized, per se. Nevertheless, allowing physicians to discriminate on the basis of sexual orientation would constitute a deeper insult, namely reinforcing the scientifically unfounded idea that fitness to parent is based on sexual orientation, and, thus, reinforcing the oppressed status of same-sex couples. The concept of oppression raises the implications of all conscientious refusals for gender justice in general. Legitimizing refusals in reproductive contexts may reinforce the tendency to value women primarily with regard to their capacity for reproduction while ignoring their interests and rights as people more generally. As the place of conscience in reproductive medicine is considered, the impact of permissive policies toward conscientious refusals on the status of women must be considered seriously as well.

Some might say that it is not the job of a physician to "fix" social inequities. However, it is the responsibility, whenever possible, of physicians as advocates for patients' needs and rights not to create or reinforce racial or socioeconomic inequalities in society. Thus, refusals that create or reinforce such inequalities should raise significant caution.

Institutional and Organizational Responsibilities

Given these limits, individual practitioners may face difficult decisions about adherence to conscience in the context of professional responsibilities. Some have offered, however, that "accepting a collective obligation does not mean that all members of the profession are forced to violate their own consciences" (1). Rather, institutions and

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professional organizations should work to create and maintain organizational structures that ensure nondiscriminatory access to all professional services and minimize the need for individual practitioners to act in opposition to their deeply held beliefs. This requires at the very least that systems be in place for counseling and referral, particularly in resource-poor areas where conscientious refusals have significant potential to limit patient choice, and that individuals and institutions "act affirmatively to protect patients from unexpected and disruptive denials of service" (13). Individuals and institutions should support staffing that does not place practitioners or facilities in situations in which the harms and thus conflicts from conscientious refusals are likely to arise. For example, those who feel it improper to prescribe emergency contraception should not staff sites, such as emergency rooms, in which such requests are likely to arise, and prompt disposition of emergency contraception is required and often integral to professional practice. Similarly, institutions that uphold doctrinal objections should not position themselves as primary providers of emergency care for victims of sexual assault; when such patients do present for care, they should be given prophylaxis. Institutions should work toward structures that reduce the impact on patients of professionals' refusals to provide standard reproductive services.

Recommendations

Respect for conscience is one of many values important to the ethical practice of reproductive medicine. Given this framework for analysis, the ACOG Committee on Ethics proposes the following recommendations, which it believes maximize respect for health care professionals' consciences without compromising the health and well-being of the women they serve.

1. In the provision of reproductive services, the patient's well-being must be paramount. Any conscientious refusal that conflicts with a patient's well-being should be accommodated only if the primary duty to the patient can be fulfilled.
2. Health care providers must impart accurate and unbiased information so that patients can make informed decisions about their health care. They must disclose scientifically accurate and professionally accepted characterizations of reproductive health services.
3. Where conscience implores physicians to deviate from standard practices, including abortion, sterilization, and provision of contraceptives, they must provide potential patients with accurate and prior notice of their personal moral commitments. In the process of providing prior notice, physicians should not use their professional authority to argue or advocate these positions.
4. Physicians and other health care professionals have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that their patients request.
5. In an emergency in which referral is not possible or might negatively affect a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider's personal moral objections.
6. In resource-poor areas, access to safe and legal reproductive services should be maintained. Conscientious refusals that undermine access should raise significant caution. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place so that patients have access to the service that the physician does not wish to provide. Rights to withdraw from caring for an individual should not be a pretext for interfering with patients' rights to health care services.
7. Lawmakers should advance policies that balance protection of providers' consciences with the critical goal of ensuring timely, effective, evidence-based, and safe access to all women seeking reproductive services.

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ISSN 1074-861X

19-1614, 20-1275
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FEBRUARY 2020 **POLICY ANALYSIS**

Trump Administration's Domestic Gag Rule Has Slashed the Title X Network's Capacity by Half

Ruth Dawson, Guttmacher Institute

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First published online: February 5, 2020

19-1614, 20-1215
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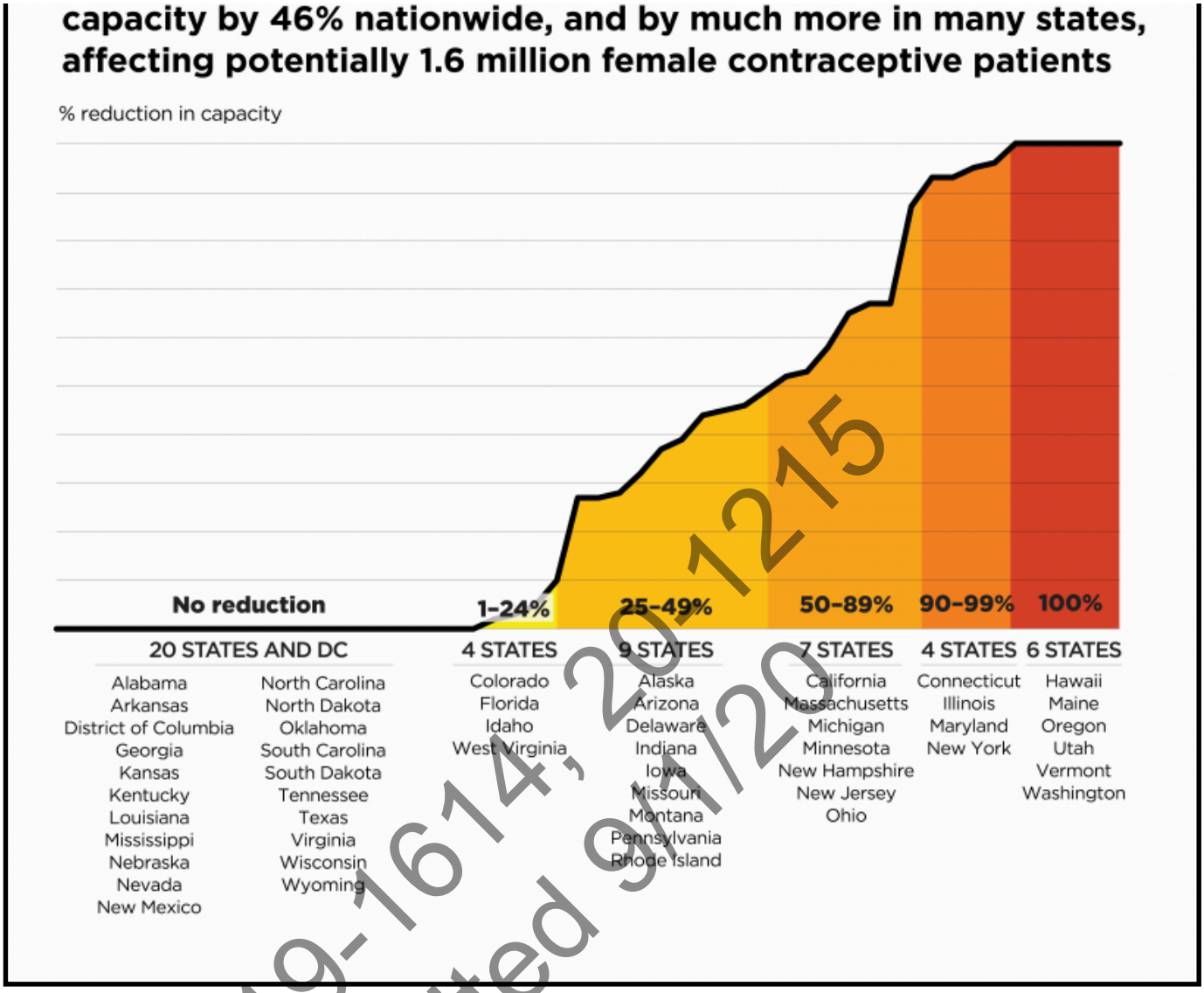
Corrected February 26, 2020. See note below.

New data from the Guttmacher Institute show that the Trump administration's domestic "gag rule" has slashed the Title X national family planning network's patient capacity in half, jeopardizing care for 1.6 million female patients nationwide. On the 50th anniversary of the Title X program, a new analysis estimates that roughly one in every four Title X service sites left the network in 2019 because of the domestic gag rule, shorthand for restrictive regulations that prohibit—among other things—referrals for abortion care.

In 2019, an estimated 981 U.S. clinics receiving Title X funding—approximately one-quarter of all sites that received Title X funding as of June 2019—likely left the Title X network because of the gag rule. These numbers are in line with findings from the Kaiser Family Foundation and Power to Decide, now further contextualized with reliable estimates of the proportion of female patients affected.

Based on data available for 910 of those 981 sites, we estimate that these changes reduced the network's capacity to provide women with contraceptive services by at least 46%, translating to roughly 1.6 million patients. In other words, the impact of the gag rule on the network's capacity is much greater than it might appear when looking at clinic numbers alone, because the gag rule intentionally targeted clinics specializing in reproductive health care services, sites that also serve the highest volume of contraceptive patients.



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The impact is huge. In 17 states, clinics that left the Title X network because of the gag rule served at least half of the program's caseload of female contraceptive patients:

- In six of these states (Hawaii, Maine, Oregon, Utah, Vermont and Washington), the Title X network's capacity has been reduced by 100%. In these states, the entire network of Title X clinics no longer receives any Title X funding.
- In another four states (Connecticut, Illinois, Maryland and New York), the Title X network's capacity has been reduced by 90–99%.
- In seven states (California, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey and Ohio), the Title X network's capacity has been reduced by 50–89%.

In nine states (Alaska, Arizona, Delaware, Indiana, Iowa, Missouri, Montana, Pennsylvania and Rhode Island), the Title X network's capacity has been reduced by 25–49%. In four states (Colorado, Florida, Idaho and West Virginia), the network's capacity was reduced by 1–24%. Capacity for the remaining 20 states and the District of Columbia was not impacted, based on the available data.

continue serving their patients. According to media reports and discussions with providers, clinics have tried a range of options, such as allowing payment on a sliding scale, prioritizing free or low-cost services for young people, and helping patients connect to private or public insurance. But these efforts cannot make up for the havoc wrought by the gag rule, and often carry unexpected bills and confidentiality pitfalls for patients. Some providers have dipped into emergency funds, and some states—including Maryland, Nevada and New Jersey—have passed emergency funding measures. Actions like these to mitigate the negative effects on patients from loss of federal funding are admirable, but ultimately unsustainable.

Finally, some remaining Title X grantees are trying to bring new providers into the network to increase capacity, but we know that other providers—even in areas where they are available—simply do not have the capacity or expertise to absorb this patient load. Contextualizing the attack on Title X in the larger conservative agenda to cut reproductive health care and health care writ large, such as past attempts to chip away at Medicaid via block grants and systemically defund abortion providers, paints an even more dire picture of patients' dwindling options.

Title X and the Gag Rule

Title X is the nation's public family planning program, serving millions of patients who seek birth control services, STI testing and treatment, and related preventive care. The program was established as part of the Public Health Service Act in 1970 with the express intent of addressing inequities in access to contraceptives and related services, helping patients advance their right to exercise power over their own reproductive decisions. For half a century, Title X has funded a long-standing and trusted network of providers throughout the country, providing these critical services to patients who are low income, uninsured, young or otherwise underserved.

The Trump administration finalized its targeted dismantling of the Title X program by overhauling the program's administrative regulations in March 2019, after nearly two years of laying groundwork. Collectively known as the domestic gag rule, these regulations include a prohibition on abortion referrals, coercive counseling standards for pregnant patients, and unnecessary and stringent requirements for the physical and financial separation of Title X–funded activities from a range of abortion-related activities.

On the ground, these changes have the potential to subvert the nationwide network of family planning providers that Title X supports, translate into coercive care for patients, and drastically reduce access to crucial and comprehensive reproductive health care. Many providers have left the network and given up these funds so they may continue to provide the unbiased and complete information, counseling and referral they feel their patients deserve.

Looking Ahead

Unfortunately, these numbers show just the initial damage that the gag rule has done to the Title X network, and likely represent an undercount, because patient caseload data for some clinics are not available and because the analysis excludes all male patients as well as female patients receiving only noncontraceptive services (such as STI testing or treatment or other preventive gynecologic services). Perhaps the most onerous requirement of the gag rule—strict physical separation from any abortion-

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representing even more patients left without Title X support for their reproductive health needs.

Meanwhile, affected parties have initiated eight lawsuits to block the gag rule, a strategy that may yet provide relief to the clinics forced to leave the network. Ultimately, patients are caught in the middle—with no care or imperiled care—as the Trump administration's gag rule continues to eat away at the family planning system created to serve them.

The research in this article was conducted by Mia R. Zolna, Sean Finn and Jennifer J. Frost of the Guttmacher Institute, using data from the Guttmacher Institute and the federal Office of Population Affairs. Full information about the methodology and limitations and a table with state-level findings on clinics that left the network and resulting losses in patient capacity can be found here.

Note: Changes were made to the classification of 20 clinics located in seven states. In these states, one or more clinics were mistakenly counted as having left the Title X network because of the gag rule. After correction, Georgia, Kansas, Nevada, North Carolina and Wisconsin had no sites classified as having left the network because of the rule, and Arizona and New Hampshire had one or two fewer sites classified as having left the network because of the rule. These corrections reduced by one percentage point both the national number of Title X–funded clinics estimated to have left because of the rule (from 23% to 22%) and the number of female contraceptive patients served annually by those clinics (from 47% to 46%).

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Comment on FR Doc # 2018-11673

Posted by the **Department of Health and Human Services** on Jul 23, 2018

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The proposed rule seeks to limit women's access to a medical procedure by forcing providers to omit and elide mention of that procedure, as well as imposing other restrictions that are detrimental to patients' privacy and medical choice.

There is no legitimate medical or legal justification for the proposed rule, which is contrary to the standards of the medical profession, an invasion of patient privacy, and clearly discriminatory in both intent and effect. It is therefore plainly contrary to the public interest and likely unlawful.

Contrary to the automated remarks left by some other commenters, there is no "abortion industry." Abortion is a medical procedure and a private matter between patients and healthcare providers. The Department has no statutory authority to dictate medical discussions between providers and patients, nor to dictate or require specific plans of care.

19-1614.20-1215 Visited Sept. 1, 2020

Comment ID
HHS-OS-2018-0008-69480

Tracking Number
1k2-94b9-rgto

Comment Details | **Submitter Info**

Document Subtype
Comment(s)

Received Date

Jul 16, 2018

Page Count

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PUBLIC SUBMISSION

Comment on FR Doc # 2018-11673

Posted by the **Department of Health and Human Services** on Jun 29, 2018

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I am AGAINST this new rule. Many organizations that do not themselves provide abortions, counsel women on ALL the options that they have a legal right to access, including the option of abortion and where they may obtain one. Patient's have a right to unbiased, informed consent about all of their options. This rule does a great disservice to women and puts unreasonable barriers on general providers of care and hurts the honest, open conversation that healthcare providers should be having with their patients.

Comment ID
HHS-OS-2018-0008-30266

Tracking Number
1k2-93zg-eh48

Comment Details **Submitter Info**

Document Subtype
Comment(s)

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Beta
Your Voice in Federal Decision Making

19-1614, 20-1215
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Honorable Alex Azar
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ADM Brett Giroir, M.D.
Assistant Secretary for Health
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Ms. Diane Foley, M.D., FAAP
Deputy Assistant Secretary
Office of Population Affairs
Department of Health and Human Services
200 Independence Avenue, SW
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Attention: HHS-OS-2018-0008

RE: Comments on Title X Family Planning Program Proposed Rule

19-1614, 20-1215
Sept. 1, 2020

I. Introduction

On behalf of New York Abortion Access Fund (NYAAF), we appreciate the opportunity to comment on the Department of Health and Human Services' proposed rule on the Title X Family Planning Program, entitled *Compliance with Statutory Program Integrity Requirements* ("the proposed rule" hereafter). NYAAF writes with strong objection to the proposed rule on the Title X Family Planning Program. This rule will have a devastating impact on women and families across the country, drastically impacting women and people of color in particular. For this reason and those expanded on below, we urge the Department of Health and Human Services to maintain the integrity of the Title X program in its current form and rescind the proposed rule.

NYAAF supports anyone who is unable to pay fully for an abortion and is living in or traveling to New York State by providing financial assistance and connections to other resources. NYAAF believes strongly that every person should be able to determine their own reproductive destiny and have access to the resources, rights, and respect to be able to do so. We believe that access to affordable reproductive health care, including abortion, is a critical component of full-spectrum healthcare services.

Because of the Hyde Amendment, which forbids federal funding for abortion services, many people who are covered through medicaid or receive benefits through Title X may seek funding support through NYAAF or other abortion funds for financial assistance if they decide to terminate a pregnancy. While we fundamentally disagree with the Hyde Amendment, and are working towards a world where safe abortion care is part of mainstream medical practice and covered fully by all types of insurance, including medicaid, we understand that it's purpose is to prohibit federal funds from covering abortion care. This amendment already ensures that no federal funding supports abortion care, and is one of many reasons why these rule changes are unnecessary.

Title X is an important resource for low-income people to access essential family planning services. Communities of color need essential family planning services to plan their pregnancies, ensure quality health, and protect the future for themselves and their families. The proposed rule as currently written threatens to significantly harm this crucial health care right.

II. Impact of Title X Proposed Rule Changes

The proposed rule not only draws extensively on the Reagan-era domestic gag rule, but also includes new harmful restrictions and requirements that will burden communities of color. If implemented, the proposed rule would undermine the high-quality standards of the Title X program; create barriers for access to comprehensive reproductive health services, including full and accurate information on abortion care; and discourage our communities from accessing the confidential and linguistically-appropriate care that they need. The proposed changes will fundamentally restructure the Title X program as we know it, placing an emphasis on "natural family planning" and excluding necessary unbiased comprehensive counseling about pregnancy options. This is an attack on high-quality family planning, and communities of color will pay the steep price. For the following reasons NYAAF opposes the proposed rule:

- The proposed change to expand coverage to individuals whose employers coverage on religious or moral grounds is not only contrary to the Affordable Care Act (ACA) but also is contrary to the intent or capacity of the Title X program. Title X was not intended to, and cannot, absorb the cost of uninsured individuals with incomes above 250% FPL. The Title X program is already underfunded and the scarce resources available to women of color living with low-incomes should continue to support individuals living near the poverty line.

- This proposed rule change would make it illegal for Title X programs to provide information about access to safe and legal abortion care and or necessary referrals for services. This change to the long-standing Title X requirements not only makes counseling individuals on their full range of reproductive health care options difficult, but also creates barriers to receiving the information needed to obtain abortion care. This current standard puts an individual's own stated needs at the heart of options counseling and referral. It does not mandate the type of counseling or referral pregnant people receive; rather, it ensures that pregnant people are provided the opportunity to receive counseling on all options as well as receiving any referral they request. The proposed rule eliminates this long-standing and medically ethical requirement that Title X projects provide neutral, factual, and nondirective options counseling and referral on all of a pregnant patient's options—including abortion—upon request. By denying the availability of the full range of options, this proposed rule is, in essence, denying an individual's bodily autonomy and limiting their ability to make the best decisions for their own lives.

- These rule changes would tip the providers towards recommending pregnant people carry all pregnancies to term. The elimination of counseling and referral requirements encourages Title X projects to withhold full and accurate information from a pregnant person. For a pregnant person who has clearly stated that they have decided to have an abortion, a medical provider may provide a list of licensed, qualified, comprehensive health service providers. However, under the proposed rule, the list does not have to explicitly include abortion providers, despite the person's request. This is just another mechanism to withhold accurate and complete information from individuals, leaving our communities unable to make fully informed health care decisions and further eroding the trust between the provider and the individual seeking health care services. Communities of color have an ongoing history of distrust of medical staff due to previous experiences of eugenics and the State's continued attempts to control the reproduction and fertility of women of color living with low-incomes. We oppose any effort to withhold information from individuals seeking health care services. It is critical that individuals have all the information they need to make any decisions about their reproductive health, and eliminating requirements that providers counsel

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individuals on all health care options will only create harm. Our communities do not need watered down sex education and sparse medical information; we demand HHS uphold the integrity of the Title X program and provide comprehensive, medically-accurate, evidence-based, culturally- and linguistically-appropriate care to communities of color living with low-incomes.

- The proposed rule would eliminate the ability for minors to seek services at a discount calculated by their own income and instead rely on parental consent and family resources. The proposed rule undermines patient confidentiality, particularly for minors, which could lead to many patients avoiding care in Title X settings. Youth already face unnecessary barriers to care, and further taking away a safe, trusted, and confidential space to seek services will only exacerbate already present health disparities in youth of color. It is critical that youth have a provider where they can receive comprehensive, medically accurate, evidence-based information in their preferred language from a trusted health care provider. By increasing family involvement beyond what is required in the language of the Title X statute and subverting the judgment and expertise of Title X funded providers to family participation, the proposed rule could cause harm to minors. Providers have the expertise to evaluate the situation of each individual unemancipated minor, and we should defer to their judgment.

- The proposed rule would require "physical separation" of Title X funded health centers that separately provide abortion with non-federal dollars. These proposed changes would require strict physical and financial separation between Title X projects and activities associated with abortion, now prohibited under the proposed rule. Additionally, the proposed rule would give wide latitude to HHS to determine how the physical and financial separation requirement would be applied to activities and/or Title X-funded entities. The proposed changes would impact all Title X funded health care providers and place onerous requirements on approximately one in 10 Title X sites that offer abortion using non-federal funds, including health centers operated not only by Planned Parenthood affiliates, but also by entities such as hospitals and independent agencies.[1] By physically separating Title X funded health care centers from abortion providers, the proposed rule exacerbates an already devastating burden on those living in rural areas who are in need of timely, comprehensive reproductive health care services.

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III. Conclusion

Undermining Title X will create a scarcity of clinics where communities that we care about, particularly communities of color can access contraception, life-saving care, and education on abortion related services. Title X has been the only federal program responsible for providing family planning and related health care services to low-income individuals across the country for almost 50 years. The program is critical to a health care system for individuals who may not otherwise be able to access affordable care. The proposed rule as written will drastically impact access to quality family planning and related health care services and will negatively impact our communities the most. Moreover, it denies individuals of the ability to make healthy and fully-informed options for their bodies and their families, undermining individual agency and bodily autonomy. We demand the Department of Health and Human Services to rescind this proposed rule and preserve the integrity of the Title X program as it stands.

[1] Hasstedt, Kinsey. *A Domestic Gag Rule and More: The Administration's Proposed Changes to Title X.* New York: Guttmacher Institute, 2018, https://www.guttmacher.org/article/2018/06/domestic-gag-rule-and-more-administrations-proposed-changes-title-x.

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Office of the President
Lisa M. Hollier, MD, MPH, FACOG

July 31, 2018

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: HHS-OS-2018-0008; Compliance with Statutory Program Integrity Requirements

Dear Secretary Azar:

The American College of Obstetricians and Gynecologists (ACOG) appreciates the opportunity to submit comments in response to the proposed rule, "Compliance with Statutory Program Integrity Requirements" (Proposed Rule), published in the Federal Register on June 1, 2018 by the Department of Health and Human Services (HHS). The Proposed Rule would fundamentally undermine Title X of the Public Health Service Act ("Title X"). It puts at risk the patient-physician relationship and the high-quality evidence-based care that millions of women, men, and adolescents receive each year. The Proposed Rule constitutes an improper restriction on the practice of medicine that, if implemented, would threaten access to reproductive health options and effective family planning methods for the patients who receive care through Title X. It would also place physicians in ethically compromised situations. It contains arbitrary standards and medically inaccurate terminology and, thus, represents a political attempt to interfere with the health care access available to low-income women, and to improperly restrict care that physicians and other medical professionals serving these populations are able to provide.

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ACOG is the nation's leading organization of physicians who provide health services unique to women. As the only national medical specialty society of women's health physicians, ACOG has more than 58,000 members representing more than 90 percent of all board-certified obstetrician-gynecologists (ob-gyns) in the United States. ACOG advocates for policies that ensure access to health care for women throughout their lives and believes that a full array of clinical services should be available to women without costly delays or the imposition of cultural, geographic, financial, or legal barriers. Few federal programs are as important to women's health care access as the Title X program. The services presently available through Title X health care providers include Food and Drug Administration (FDA)-approved contraceptive methods and counseling services, well-woman exams, breast and cervical cancer screenings, screening and treatment for sexually transmitted infections (STIs), testing for HIV, pregnancy testing and counseling, and other patient education and/or health referrals. Title X funds are not used for abortions. ACOG affirms the efforts of its members and other medical providers who practice at Title X-funded facilities to provide access to high-quality reproductive health care to all people regardless of their financial circumstances.

Contrary to the preamble of the Proposed Rule, which states that "the new regulations would contribute to more clients being served, gaps in service being closed, and improved client care that better focuses on the family planning mission of the Title X program,"[i] the proposed changes to the Title X program would jeopardize access to family planning and preventive health care for more than four million low-income women, men, and adolescents, and is antithetical to physicians' codes of ethics and commitment to high-quality patient care. The Proposed Rule is laden with medically inaccurate terminology, prioritizing ideology over scientific evidence, exposing the arbitrary nature of the proposed regulation. For these reasons and those explained in full below, we call for the Proposed Rule's immediate and complete withdrawal.

I. The Title X program plays a critical role in our nation's public health safety net.

As the only federal grant program dedicated exclusively to providing low-income patients with essential family planning and preventive health services and information, Title X plays a vital role in ensuring that safe, timely, and evidence-based care is available to every woman regardless of her financial circumstances. Rates of adverse reproductive health outcomes are higher among low-income and minority women, and unintended pregnancy rates are highest among those least able to afford contraception.[ii] According to the HHS Office of Population Affairs website, "Access to quality family planning and reproductive health services is integral to overall good health for both men and women. Few health services are used as universally. In fact, more than 99 percent of women aged 15–44 who have ever had sexual intercourse have used at least one contraceptive method."[iii]

The care made available to women through the Title X program has contributed to the dramatic decline in the unintended pregnancy rate in the United States, now at a 30-year low.[iv] Improved access to contraception and information for adolescents, including those provided by Title X projects, has contributed to a record low teen pregnancy rate.[v] The services provided by Title X projects help prevent nearly one million unintended pregnancies each year.[vi]

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In addition to pregnancy prevention, Title X projects meet other reproductive health needs for women, men, and adolescents. In 2016, Title X projects provided nearly five million STI tests, and provided more than 700,000 Pap tests and 900,000 clinical breast exams.[vii] Further, it is estimated that in 2010 alone, services provided by Title X projects helped avert 53,450 chlamydia infections, 8,810 gonorrhea infections, 250 HIV infections, and 6,920 cases of pelvic inflammatory disease.[viii]

The Title X program has improved the lives of women and their families, enabling many women to achieve greater educational, financial, and employment success and stability. These public health strides help American society in many ways, including by saving taxpayer dollars. Because of the high-quality health care that individuals have received through the Title X program, there is an estimated taxpayer savings of $7.09 for every dollar invested in the Title X program.[ix]

The Proposed Rule would undermine the Title X program and detrimentally restrict the ability of patients to access care. If implemented, the Proposed Rule would limit access to vital preventive and often life-saving services for the more than four million patients seeking care annually at Title X-funded facilities. In addition, it would reverse our nation's historic achievements in reducing unplanned and teen pregnancy rates, and make evidence-based contraception methods

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inaccessible to women who otherwise cannot afford them, turning back the clock on women's health.

II. The Proposed Rule would interfere with the patient-physician relationship, restrict the information available to patients, and hinder the ability of physicians to practice medicine in accordance with their ethical obligations.

ACOG's Code of Professional Ethics for ob-gyns unequivocally states that "the patient-physician relationship is the central focus of all ethical concerns, and the welfare of the patient must form the basis of all medical judgments."[x] The patient-physician relationship is essential to the provision of safe and quality medical care, and political efforts to regulate elements of patient care and counseling can drive a wedge between a patient and her medical provider.[xi] HHS acknowledges in the preamble of the Proposed Rule that:

> "…[O]pen communication in the doctor-patient relationship would foster better over-all care for patients. While the benefit of open and honest communication between a patient and her doctor is difficult to quantify, one study showed that even "the quality of communication [between the physician and patient] affects outcomes . . . [and] influences how often, and if at all, a patient would return to that same physician." Facilitating open communication between providers and their patients helps to eliminate barriers to care, particularly for minorities."[xii]

However, if implemented, the Proposed Rule would put the patient-physician relationship in jeopardy by placing restrictions on the ability of physicians to make available important medical information, permitting physicians to withhold information from pregnant women about the full range of their options, and erecting greater barriers to care, especially for minority populations.

1. *The Proposed Rule includes vague restrictions on counseling and removes the requirement that providers offer nondirective pregnancy options counseling, limiting information available to women.*

ACOG supports a woman's right to decide whether to have children, to determine the number and spacing of her children, and to have the information, education, and access to health services to make those decisions.[xiii] ACOG's Code of Professional Ethics states that physician respect for the right of patients to make their own choices about their health care is fundamental.[xiv] Physicians have an "ethical obligation to provide accurate information that is required for the patient to make a fully informed decision."[xv] Yet, the Proposed Rule removes the requirement that providers receiving Title X funds offer the opportunity for pregnant women to receive nondirective counseling and information about their full range of pregnancy options, including prenatal care and delivery; infant care, foster care, or adoption; and pregnancy termination. This concerning deletion also removes the exception that counseling of pregnant women exclude those "option(s) about which the pregnant woman indicates she does not wish to receive."[xvi] If implemented, the Proposed Rule would permit providers to withhold information from patients, and would permit, and in some cases require, the provision of counseling, information, and referral for services that the patient has clearly stated she does not wish to receive. In the case where a patient seeks counseling once pregnant, under the Proposed Rule a provider would not be permitted to offer such counseling, and instead would be required to provide the patient with a list of prenatal and/or social services, and would require that the patient "be provided with

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information necessary to protect her health and the health of her unborn child."[xvii] ACOG opposes efforts to restrict the medical information that Title X providers can make available to their patients, especially where, as here, the restriction would prevent Title X providers from sharing complete and accurate medical information necessary to ensure that their patients are able to make fully informed medical decisions and obtain timely care.[xviii] Moreover, it is imperative that HHS, the nation's foremost health policy agency, understand and orient all of its activities on a foundation firmly based on scientifically valid and appropriate terms and evidence. The term "unborn child" used in §59.14(b) of the Proposed Rule is not a medical term and should not be used in regulations governing a federal public health program. The agency's use of terms such as this only further emphasizes the fact that the Proposed Rule is ideologically driven and does not align with evidence-based medicine.

In addition to improperly restricting a physician's ability to provide complete and accurate information to his or her patients, the requirements in the Proposed Rule surrounding what information a physician is permitted to share during nondirective counseling are vague and confusing. Specifically, the Proposed Rule contains a new requirement that grantees are not permitted to "promote, refer for, support, or present" abortion as a method of family planning.[xix] It is unclear to what extent counseling that references abortion would be permissible. For instance, would sharing ACOG's patient education document, Frequently Asked Questions #168 "Pregnancy Choices: Raising the Baby, Adoption, and Abortion" be considered a violation?[xx] Without additional guidance, grantees may interpret this language as a complete prohibition on any conversation with their patients that references abortion. At a minimum, these changes would have a chilling effect on providers, who could fear even mentioning the word abortion while counseling a patient on their options would violate the Title X regulations. Merely stating in the preamble of the Proposed Rule that "a doctor would be permitted to provide nondirective counseling on abortion," while subjecting that counseling to vague and confusing restrictions, is not sufficient to describe the requirements the Proposed Rule is seeking to impose.

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2. *The Proposed Rule dictates how physicians treat their patients, denies the ability of physicians to refer for abortion care, and discriminates among providers.*

Safe, legal abortion is a necessary component of women's health care. In the United States, where nearly half of all pregnancies are unintended, almost one third of women will seek an abortion by age 45.[xxi] Despite reductions in the unintended pregnancy and abortion rates in recent years, rates remain higher among low-income and minority populations.[xxii] Many factors influence or necessitate a woman's decision to seek abortion care. They include, but are not limited to, contraceptive failure, barriers to contraceptive use and access, rape, incest, intimate partner violence, fetal anomalies, and exposure to teratogenic medications. Additionally, pregnancy complications may be so severe that an abortion is the only measure to preserve a woman's health or save her life.[xxiii] As is acknowledged in the preamble of the Proposed Rule, Title X funds have never been used for abortion. However, the Proposed Rule goes beyond the statute in an effort to further restrict access to abortion care outside of the Title X program.

Like all medical matters, decisions regarding abortion should be made by patients in consultation with their health care providers and without undue interference by outside parties. Like all patients, women obtaining abortion are entitled to privacy, dignity, respect, and support.[xxiv] The Proposed Rule inappropriately regulates provider interactions with patients, going so far as to

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detail restrictions governing when a provider may offer certain referral information, and dictate how that information may be shared.

ACOG's Code of Professional Ethics states that ob-gyns should "serve as the patient's advocate and exercise all reasonable means to ensure that appropriate care is provided to the patient."[xxv] Yet, under the Proposed Rule, only when a patient who is currently pregnant "clearly states that she has already decided to have an abortion," is a physician permitted to share a list of "licensed, qualified, comprehensive health service providers (some, but not all, of which also provide abortion, in addition to comprehensive prenatal care)."[xxvi] This provision could be read to arbitrarily deny the ability of a physician to provide a referral to a woman who decides after presenting to a Title X facility for care to have an abortion. In addition, the Proposed Rule states that "The list shall not identify the providers who perform abortion as such."[xxvii] This proposed regulation restricts the ability of physicians to provide clear, direct information to patients, and it even goes so far as to actively require physicians to withhold full and accurate information and provide referrals to providers that do not offer the service requested by the patient.

The Proposed Rule further clarifies in the examples provided in proposed §59.14(e) that projects do not have to provide any referrals to abortion providers, even if directly requested by the patient, meaning that these changes would also lead to inconsistency in the information offered to patients at different Title X facilities. These provisions represent an improper intrusion into the patient-physician relationship, the importance of which is underscored in the preamble of the Proposed Rule. HHS has provided no justification for this complex and incredibly prescriptive requirement, nor is it supported by the statute. The result of such a regulation would be to mislead patients and delay their access to abortion care, placing providers in ethically compromised positions.

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As written, the Proposed Rule requires that a list of referrals for abortion defined by proposed §59.14(a) be provided by a medical doctor, and the preamble of the Proposed Rule suggests that counseling is also confined to a physician. This restriction will unnecessarily further limit access to information that can be – and often is today – provided by a qualified non-physician provider, and delay care for patients. ACOG recognizes that advanced practice clinicians, such as nurse-midwives, physician assistants, and nurse practitioners, possess the clinical skills necessary to provide first-trimester medical abortion.[xxviii] There is no question that these non-physician providers are qualified to provide counseling and referrals to patients. In addition, roughly half of counties in the United States lack an ob-gyn, and those shortages are exacerbated in rural and underserved communities.[xxix] Ob-gyn workforce shortages are expected to increase – not decrease – in the coming years, with a projected shortage of 18 percent by 2030.[xxx] Through arbitrarily limiting the providers who can provide referrals to physicians, the Proposed Rule erects an unnecessary and unsupported barrier to care.

The requirement that the list of referral providers be restricted only to those physicians who provide comprehensive prenatal care (as opposed to providers who only offer gynecological services) would further limit the care options offered to patients, and is not consistent with evidence-based medicine. The Proposed Rule would exclude physicians and medical providers who specialize in the provision of abortion and contraception. In addition, the Proposed Rule's restrictions on referred providers would exclude older ob-gyns who have retired their obstetric practice but continue to provide gynecologic care, including abortion. According to ACOG's 2015 Survey on Professional Liability, the average age at which surveyed physicians stopped

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practicing obstetrics was 48 years, which is considered the near-midpoint of a physician's career.[xxxi]

In cases where a patient is pregnant and does not "clearly state" her decision to have an abortion, the Proposed Rule requires that the patient be "referred for appropriate prenatal and/or social services (such as prenatal care and delivery, infant care, foster care, or adoption), and shall be given assistance with setting up a referral appointment to optimize the health of the mother and unborn child."[xxxii] In addition to the inappropriate use of nonmedical language, as already addressed, proposed §59.14(b) undermines the patient-physician relationship, and is not reflective of the realities of that relationship, where a patient regularly seeks the counsel of their provider. It is also counter to the ethical obligations that physicians have to provide a pregnant woman who may be ambivalent about her pregnancy full information about all options in a balanced manner, including raising the child herself, placing the child for adoption, and abortion. ACOG has long recognized the physician's "ethical obligation to provide accurate information that is required for the patient to make a fully informed decision."[xxxiii]

The restrictions on counseling and referral information that can be shared by Title X providers may put them at increased risk of medical liability. As one example, the decision in *Wickline v. State of California* found that "it is no defense in a medical liability case to argue that physicians simply have followed a payer's instructions."[xxxiv] Ob-gyns already face greater liability risks than many of their physician colleagues, and many ob-gyns report changing their practice due to liability risks. Of those ob-gyns surveyed by ACOG in 2015, "delay in or failure to diagnose" was cited as one of the top three gynecologic liability allegations.[xxxv] By restricting the provision of clear, direct referrals to patients, based on the politically motivated requirements in proposed §59.14(a), the patient is faced with unnecessary barriers and delayed access to care, placing Title X providers at elevated risk of liability.

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Restrictions on counseling and referrals undercut a woman's access to safe, legal abortion and jeopardize quality of care. The Institute of Medicine (now National Academy of Medicine) study titled "Crossing the Quality Chasm: A New Health System for the 21st Century" defines high quality care as health care that is safe, effective, patient-centered, timely, efficient, and equitable.[xxxvi] Any changes to the regulations governing the Title X program should aim to advance the quality of care received, in order to best meet patient needs and improve the safety, reliability, responsiveness, integration and availability of care. ACOG has long recognized that "[l]aws [or regulations] should not interfere with the ability of physicians to determine appropriate treatment options and have open, honest, and confidential communications with their patients. Nor should laws [or regulations] interfere with the patient's right to be counseled by a physician according to the best currently available medical evidence and the physician's professional medical judgment."[xxxvii] The Proposed Rule's restrictions on counseling and referral for abortion are a violation of the patient-physician relationship, undermine the quality of care provided to patients, place physicians in ethically compromising situations, and, accordingly, should not be implemented.

III. The Proposed Rule's onerous new reporting requirements for grantees raise safety concerns and are not required to ensure statutory compliance.

The Title X program, as currently regulated, has considerable oversight and reporting requirements. Yet, the Proposed Rule seeks unprecedented additional oversight of Title X

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grantees' subrecipients, referral agencies and individuals, and other partners. The stated purpose of the newly proposed §59.5(a)(13) is to "ensure transparency in the delivery of services" by requiring that all grant applications and required reports include (1) name, location, expertise, and services provided or to be provided by subrecipients, referral individuals and agencies; (2) detailed description of collaboration with those entities, as well as less formal community partners; and (3) a clear explanation of how a grantee will "ensure adequate oversight and accountability for the quality and effectiveness of outcomes" for patients seen by subrecipients or referrals.[xxxviii] The preamble appears to call into question the "governmental accountability for [Title X] funds" if HHS does not have this information, but does not offer any evidence to support this claim and fails to adequately justify these new requirements, nor account for the added costs to grantees.[xxxix] These requirements are burdensome at best and dangerous at worst; they do not improve patient care and are contradictory to other initiatives currently being undertaken at HHS.

1. *The Proposed Rule is inconsistent with other administrative efforts to reduce regulatory burden.*

President Donald Trump's Executive Order to "lower regulatory burdens on the American people," and the Centers for Medicare and Medicaid Services' (CMS) initiative titled "Patients Over Paperwork" are representative of an Administration-wide effort to reduce unnecessary regulatory burdens in federal programs, in particular those that impact health care providers.[xl] The stated goals of the Patients Over Paperwork initiative are to streamline regulations in order to "reduce unnecessary burden, increase efficiencies, and improve the beneficiary experience."[xli] Despite this trend elsewhere within the Administration and HHS, the Proposed Rule seeks to add to the regulatory burden of the Title X program, by implementing new costly and time-consuming reporting requirements.

2. *The Proposed Rule's requirement that grantees report on all referral agencies and individuals, including services provided, is burdensome and raises safety concerns.*

It is not standard practice for providers to keep a dedicated and exhaustive list of all of the providers they interact with, whether through referral or consultation, nor to keep a comprehensive list of the services provided by those colleagues. The Proposed Rule would require Title X-funded entities to track services among referral networks that they are not funded to provide, and appears to suggest that Title X-funded entities would be held accountable for outcomes of patients who receive services at other facilities. This is outside the scope and purpose of the Title X program, and holds Title X providers to an unreasonable standard that is inconsistent with other federally-funded programs.

The collection and reporting to HHS of the names, locations, expertise, and services provided by referral agencies and individuals, as required by proposed §59.5(a)(13)(i), raises several serious questions and concerns. For instance, what happens if a referral agency or individual is inadvertently left off of an application or report to HHS? Is a patient then unable to be referred to or receive care from that agency or individual? Alternatively, how would HHS manage a request by an agency or individual that wishes to be removed from a reported list? In addition, because the Proposed Rule only permits referral for abortion to providers who also offer comprehensive prenatal care, proposed §59.5(a)(13)(i) would require grantees to provide the names and locations of those providers who may not otherwise advertise their abortion services to the

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public. It is unclear what purpose collecting this information would serve aside from establishing an inventory or registry at HHS of the names and locations of abortion providers. Abortion providers face violence and threats to themselves, their staff, and their families.[xlii] The Proposed Rule provides no assurance of confidentiality for those referral providers listed, nor does it provide a guarantee that the information would not be used for other purposes.

HHS seeks comment on whether HHS should impose additional policies or requirements on referral agencies, specifically "expanding the requirement that referral agencies that do not receive Title X funds but nevertheless provide information, counseling, or services to Title X clients be subject to the same reporting and compliance requirements as do grantees and subrecipients."[xliii] Such an expansion of reporting requirements is well beyond the scope of the Title X program and should not be pursued. Requiring providers that do not receive federal Title X funding to comply with onerous reporting requirements is inappropriate and would serve as a disincentive for those providers to serve as referrals for Title X patients. This would exacerbate barriers to specialty care already faced by low-income patients, particularly those living in rural or other underserved communities.[xliv]

IV. The Proposed Rule undermines access to evidence-based family planning methods.

All people seeking care in Title X programs should have access to the contraceptive method that works best for their individual circumstances. We are concerned that the Proposed Rule lowers the threshold on the contraceptive services available at Title X-funded organizations, limiting access to a woman's contraceptive method of choice, and negatively impacting the quality of care provided to patients. The Proposed Rule also appears to prioritize new Title X projects that do not offer a broad range of the most effective contraceptive methods. Collectively, if implemented, these changes will result in reduced access to the most effective contraception methods, threatening to reverse decades of progress, including our nation's historic achievements in reducing unplanned and teen pregnancy rates.

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1. *The Proposed Rule lowers the standards for what family planning services must be offered.*

As stated above, ACOG supports a woman's right to decide whether to have children, and to determine the number and spacing of her children. ACOG believes a woman must have unhindered access to information, education, and health services, including the full range of contraceptive methods, in order to make the best decision for herself and her family.[xlv] Currently, Title X projects must provide a "broad range of acceptable and effective medically approved family planning methods (including natural family planning) and services."[xlvi] Access to "the full range of FDA-approved contraceptive methods" has likewise been deemed an essential feature of quality family planning by the U.S. Office of Population Affairs, which administers Title X, and the Centers for Disease Control and Prevention in their authoritative clinical guidelines for quality care, the Quality Family Planning (QFP) recommendations.[xlvii] Despite this body of evidence, the Proposed Rule removes the requirement that methods of family planning be "medically approved," instead placing increased emphasis on the provision of natural family planning (NFP) and "other fertility-awareness based methods."[xlviii] In contrast, the QFP recommendations emphasize that family planning care should be "medically accurate, balanced, and provided in a nonjudgmental manner."[xlix] This modification to the requirements that must be met by family planning projects, together with the newly proposed definition of "family

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planning" appears to be diluting long-standing Title X program requirements, lowering the standards governing the services that must be offered. These changes threaten the quality of family planning available to Title X patients. In addition, the Proposed Rule inserts "adoption" as a service to be offered by a family planning project.[l] Such an expansion of services is puzzling and appears outside the intended scope of the Title X program.

2. *The Proposed Rule's permissive language may result in fewer Title X-funded sites providing the broad range of contraceptive methods that have been a core part of the program since its inception.*

The current regulations allow, though do not encourage, organizations receiving Title X funds to offer only a single method of family planning "as long as the entire project offers a broad range of family planning services."[li] The Proposed Rule is much more permissive, appearing to encourage the inclusion of more providers within a Title X project that only offer a single contraceptive method or very limited methods, putting at risk access to the most effective – and often most desired and expensive – forms of contraception, such as long-acting reversible contraception (LARC).[lii]

The Proposed Rule appears to justify this new emphasis by stating in the preamble that "it has become increasingly difficult and expensive for a Title X project to offer all acceptable and effective forms of family planning."[liii] However, the Proposed Rule does not provide evidence to support this statement. In fact, a recent study by the Kaiser Family Foundation and George Washington University found that Title X-funded health centers are far more likely than non-Title X-funded health centers to provide a larger range of effective family planning methods onsite and to offer services associated with high quality care.[liv] This study found that health centers that receive Title X funds were nearly twice as likely to offer onsite dispensing of oral contraceptives (78 percent versus 41 percent) and more than 1.5 times more likely to offer LARCs, including the contraceptive implant and intrauterine devices (IUDs).[lv] In fact, the availability of onsite oral contraceptive pills has significantly decreased among clinics that do not receive Title X funding, from 53 percent in 2011 to 41 percent in 2017.[lvi] While the Proposed Rule suggests the proposed changes would improve access to and quality of care provided at Title X-funded sites, evidence indicates that Title X-funded sites are more likely than non-Title X-funded sites to follow recommendations of the U.S. Preventive Services Task Force and QFP recommendations, such as screening sexually active women age 25 or younger for chlamydia that can result in infertility if untreated. [lvii,lviii]

Additionally, while Title X does not currently require each service site to offer the full range of contraceptive methods, Title X service sites are required to consult with existing local and regional projects that serve the same population. The Proposed Rule removes the requirement that new Title X applicants communicate with existing health resources serving the same area. By removing this requirement for open communication and coordination between service sites for a shared population, there is no assurance that the population in a particular area has sufficient access to a broad range of the most effective methods of contraception. The Proposed Rule erroneously argues that "loosening the status quo" will allow sites a broader reach, but there is no evidence to support this assumption.[lix]

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3. *The Proposed Rule appears to give preference to Title X projects that provide only limited contraception options, risking access to comprehensive contraceptive care for large parts of the traditional Title X population.*

By lowering the threshold for participation in the Title X program, we are concerned that HHS will prioritize organizations with little or no experience providing sexual and reproductive health care. While NFP and fertility awareness-based methods of family planning have always been included in the full range of contraceptive options offered to women seeking family planning care, the new emphasis on NFP in the Proposed Rule is a major departure from the previous focus on counseling women on the most effective methods. When fertility awareness is used to prevent pregnancy, in the first year of typical use, as many as one in four women will have an unintended pregnancy.[lx] Underserved women, including those who are low-income, already experience the highest rates of unintended pregnancy and abortion, and the Proposed Rule could further exacerbate those disparities.[lxi]

HHS's apparent preference for organizations utilizing fertility awareness-based methods could leave large populations without access to the most effective methods of family planning. Medically underserved populations, including racial and ethnic minorities, LGBTQ individuals, and adolescents will be most harmed by this reduction in access. ACOG's recommendations for adolescent contraceptive care specifically advise that discussions about contraception begin with the most effective methods first.[lxii] Deviating from this recommendation is of significant concern as there is a knowledge gap among this population. Data on unmarried young adults aged 18-29 years in the U.S. suggests misperceptions are common regarding contraception use, and there is a gap between intent and behavior in preventing unintended pregnancy.[lxiii] Encouraging more single-method or limited method service providers within a Title X project will threaten access to comprehensive information about the full range of contraception methods, and is at odds with evidence-based recommendations.

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Moreover, the suggested preference for providers offering only NFP methods over medical providers who offer a larger range of FDA-approved contraceptive methods is out of proportion with the known preferences of many Americans. The Proposed Rule contends many people would prefer "single-method NFP service sites," however, utilization of NFP methods in the U.S. is in fact low, with only approximately 2 percent of sexually active women aged 15-44 choosing NFP in 2014.[lxiv,lxv] By contrast, 67 percent of women who use contraception choose more effective methods of contraception (the pill, patch, implant, injectable, vaginal ring, and condom).[lxvi] Clinical recommendations including both the QFP recommendations and the Health Resources and Services Administration-supported Women's Preventive Services Initiative (WPSI) assert that offering the full range of FDA-approved methods is a core component of quality family planning care.[lxvii] The proposed changes would put at risk women's access to their preferred method of contraception. How does HHS plan to ensure that quality care is safeguarded for all Title X patients, including the QFP and ACOG recommendations that women have access to their preferred method of contraception?[lxviii,lxix]

Of note, the preamble of the Proposed Rule references ACOG and WPSI's inclusion of "fertility awareness-based methods" in its clinical recommendations of contraception as a women's preventive service. However, HHS selectively excludes the substance of WPSI's clinical recommendations for contraception, incorrectly suggesting that ACOG either supports fertility awareness-based methods over other methods, or views fertility awareness-based methods as

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equally effective as FDA-approved methods.[lxx] Indeed, the WPSI recommendations were clear that fertility awareness-based methods are "less effective" than FDA approved methods of contraception but should be provided for women desiring an alternative method. To ensure there is no confusion as to ACOG and WPSI recommendations, read in full, the WPSI clinical recommendation for contraception states:

> "The Women's Preventive Services Initiative recommends that adolescent and adult women have access to the full range of female-controlled contraceptives to prevent unintended pregnancy and improve birth outcomes. Contraceptive care should include contraceptive counseling, initiation of contraceptive use, and follow-up care (eg, management, and evaluation as well as changes to and removal or discontinuation of the contraceptive method). The Women's Preventive Services Initiative recommends that the full range of female-controlled U.S. Food and Drug Administration-approved contraceptive methods, effective family planning practices, and sterilization procedures be available as part of contraceptive care.
>
> The full range of contraceptive methods for women currently identified by the U.S. Food and Drug Administration include: (1) sterilization surgery for women, (2) surgical sterilization via implant for women, (3) implantable rods, (4) copper intrauterine devices, (5) intrauterine devices with progestin (all durations and doses), (6) the shot or injection, (7) oral contraceptives (combined pill), 8) oral contraceptives (progestin only, and), (9) oral contraceptives (extended or continuous use), (10) the contraceptive patch, (11) vaginal contraceptive rings, (12) diaphragms, (13) contraceptive sponges, (14) cervical caps, (15) female condoms, (16) spermicides, and (17) emergency contraception (levonorgestrel), and (18) emergency contraception (ulipristal acetate), and additional methods as identified by the FDA. Additionally, instruction in fertility awareness-based methods, including the lactation amenorrhea method, although less effective, should be provided for women desiring an alternative method."[lxxi]

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It is ACOG's unequivocal position that all women and adolescents should have unhindered and affordable access to comprehensive contraceptive care and contraceptive methods as an integral component of women's health care. The Proposed Rule threatens that access.

V. The Proposed Rule creates substantial burdens on qualified providers and puts at risk access to quality family planning services for low-income women and adolescents.

The Proposed Rule is designed to make it impossible for specialized reproductive health providers, like Planned Parenthood health centers, to continue to participate in the program, by requiring more than mere programmatic separation between Title X project activities and abortion-related activities, including referrals and counseling. These requirements threaten patient access to comprehensive reproductive health care, ignore the significant role specialized providers play in the Title X program, and further marginalize comprehensive reproductive health-focused providers from mainstream medical care.

Requiring complete financial and physical separation is a clear effort to force out reproductive health-focused providers and prioritize providers that do not specialize in reproductive health care. Planned Parenthood plays an outsized role in the Title X program, and the loss of these

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service sites would disproportionately affect medically underserved patients including women of color, who make up more than half of all Title X patients, and women living in rural areas.[lxxii] The Proposed Rule provides HHS broad discretion to evaluate individual Title X funding recipients' compliance with the new physical and financial separation standard, considering at least four factors: (1) separate accounting records; (2) degree of separation of facilities; (3) the existence of separate personnel, electronic or paper-based health care records and work stations; and (4) the extent to which signs and other forms of identification of the Title X program are present, and signs and material referencing or promoting abortion are absent.[lxxiii] These factors reverse HHS's longstanding interpretation that if a Title X grantee can demonstrate separation of financial records, counseling and service protocols, and administrative procedures, "then it is hard to see what additional statutory protection is afforded by the imposition of a requirement for 'physical' separation."[lxxiv] HHS does not adequately justify this reversal.

The preamble of the Proposed Rule states that the "optics and practical operation of two distinct services within a single collocated space are difficult, if not impossible to overcome." However, this statement is not supported by evidence, as can be seen by the emergence of multi-specialty practices (MSPs). MSPs are defined as practices offering various types of medical specialty care within one organization. There is some evidence to suggest these practices may provide higher quality care at a lower cost, when compared to small group practices, including one analysis published in *Health Affairs* that found that patients of MSP providers received more evidence-based care than patients of non-MSP providers.[lxxv]

HHS requests comment on whether additional regulatory provisions are necessary, yet offers no justification for why even this proposed separation is warranted. The proposed reorganization of Title X provider sites will already have significant repercussions on patient access, and should be revoked. No further regulatory modifications should be pursued.

1. *Eliminating specialized reproductive health-focused providers will result in a significant gap in access that the health care system is not equipped to handle.*

Planned Parenthood sites represent only 13 percent of Title X service sites yet serve 41 percent of all Title X patients.[lxxvi] While Planned Parenthood is not explicitly named in the Proposed Rule, the dramatic changes to Title X compliance requirements would have an immense effect on Planned Parenthood service sites. Evidence demonstrates that other providers, including Federally Qualified Health Centers (FQHCs), would not have the capacity to absorb the nearly 2 million contraceptive patients who would lose access to care.[lxxvii] Not all FQHC sites offer contraceptive care services, and among those who do, the average site serves 320 contraceptive clients in a year. By contrast, the average Planned Parenthood health center serves 2,950 contraceptive clients annually.[lxxviii] Moreover, FQHC sites often score lower on critical indicators of quality contraceptive care than Planned Parenthood health centers. For example, Planned Parenthood sites are more likely to offer the full range of contraceptive methods, and specific services such as same-day insertion of LARC methods and on-site dispensing of oral contraceptives.[lxxix]

There is also strong evidence of adverse changes in contraception provision and serious public health consequences in states that have eliminated Planned Parenthood from their family planning programs. When Texas excluded Planned Parenthood from a state program serving low-income patients, the number of women using the most effective methods of birth control

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decreased by 35 percent, and the number of births covered by Medicaid increased by 27 percent.[lxxx] In addition to losing access to family planning services, communities also lose access to STI testing and treatment. When public health funding cuts in Indiana forced many clinics, including Planned Parenthood health centers, to close, rural areas of the state experienced a dramatic HIV outbreak. Access to STI testing at Planned Parenthood clinics could have minimized or even prevented the outbreak.[lxxxi] Targeting comprehensive reproductive health care providers, like Planned Parenthood, puts a larger range of health care services at risk for medically underserved communities.

We are also concerned by the requirement that grantees provide comprehensive primary care on site. Not only is that not a statutorily permissible use of Title X funds, it will further limit eligible entities, cutting otherwise qualified women's health providers from the program. The existing primary care workforce is poorly distributed, with fewer physicians, advanced practice nurses, and physician assistants located in underserved communities, particularly in rural areas. More than half of Planned Parenthood health centers are located in rural and medically underserved areas, helping to minimize the gap in both preventive and reproductive health services for populations in those communities.[lxxxii] If the Proposed Rule were implemented, the U.S. health system would not be prepared to meet this need; both ob-gyns and primary care physicians face workforce shortages. As stated above, ACOG projects an ob-gyn shortage of 18 percent by 2030, and the Association of American Medical Colleges has projected a shortfall of as many as 49,300 primary care physicians and as many as 72,700 nonprimary care physicians by 2030.[lxxxiii,lxxxiv] Limiting the eligibility of current Title X providers would exacerbate this women's health workforce shortage.

The Proposed Rule does suggest applicants can meet this requirement via a robust referral linkage with primary care providers who are "in close physical proximity," but HHS neglects to define this term.[lxxxv] For Title X clinics located in rural areas facing severe primary care provider shortages, how does HHS suggest they meet these new requirements to provide 'holistic' primary care? How will this requirement be measured in health professional shortage areas where there are few primary care providers?

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If implemented, the Proposed Rule would exacerbate racial and socioeconomic disparities in access to care by leaving Title X patients, who are disproportionately black and Latinx, without alternate sources of care. Restricting access to qualified providers will increase rates of unplanned pregnancy, pregnancy complications, and undiagnosed medical conditions, leaving patients worse off than they are today.

VI. The Proposed Rule undermines critical confidentiality protections for minors, erecting additional barriers to care.

Family planning services are particularly important for adolescents. The United States has the highest adolescent pregnancy rate in the industrialized world.[lxxxvi] In addition, adolescents and young adults are more likely to acquire sexually transmitted infections than older individuals.[lxxxvii] Projects funded through Title X are expressly required by law to provide care to adolescent patients. The current Title X regulations fulfill this mandate through requiring that Title X facilities provide services to adolescents on a confidential basis. Existing law requires that Title X grantees certify that they encourage minors to include their family in their decisions to seek family planning services.

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The Proposed Rule threatens access to care for adolescents particularly through its weakening of confidentiality protections for adolescents seeking family planning care. Without these protections, adolescents, especially those without adult support systems, may be more likely to delay or not receive needed, sometimes lifesaving care.[lxxxviii] ACOG and other major medical associations support efforts to reasonably encourage adolescents to involve their parents in their decision to seek reproductive healthcare. However, when taking a health history, clinicians sometimes learn of circumstances (short of abuse) in a minor's family that make it not "practicable," or unrealistic or even harmful, to encourage the minor to involve their parents or guardians.[lxxxix] In these situations, clinicians should not be mandated to take "specific actions" to encourage the minor to do so (and then document those specific actions) as the Proposed Rule requires.[xc] ACOG and other major medical associations recommend that adolescents receive confidential, comprehensive reproductive health care without mandated parental notification or consent.[xci] According to the American Academy of Pediatrics, "…policies supporting adolescent consent and protecting adolescent confidentiality are in the best interests of adolescents. Accordingly, best practice guidelines recommend confidentiality around sexuality and sexually transmitted infections (STIs) and minor consent for contraception."[xcii] Ensuring adolescent confidentiality is not only consistent with medical ethics, but also with the importance of ensuring a strong patient-physician relationship.

The Proposed Rule creates barriers to adolescents receiving confidential care. The Title X program should continue to ensure that adolescents are able to access confidential care, while maintaining compliance with all state and federal laws. Failure to do so will erect additional barriers to adolescents seeking preventive and lifesaving reproductive health care and will also undermine the patient-physician relationship.

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VII. The Proposed Rule redefines "low-income family" in a way that is contrary to Title X and puts low-income patients presently relying on Title X services at risk of losing access.

The current Title X regulations require that "no charge will be made for services provided to any person from a low-income family" except to the extent that payment can be made by a third-party payer, such as commercial insurance or Medicaid.[xciii] The preamble of the Proposed Rule highlights the increased need for publicly funded family planning services, "as the number of Americans at or below the poverty level has increased," yet at the same time redefines "low-income family" to include women whose employer-based health insurance coverage does not cover contraception due to the employer's religious or moral objections.[xciv,xcv] This expanded definition would potentially require Title X providers to provide free contraceptive services to any woman whose employer objects to insurance coverage of contraception, regardless of her income. HHS has recently expanded the availability of exceptions to the contraceptive coverage requirements of the Affordable Care Act to a broad range of employers. By proposing to expand the definition of "low-income family," the Proposed Rule would greatly increase the number of women who qualify for Title X-funded services, without providing any additional funding or support to ensure the program can sustain this patient increase. The Title X program was not designed to absorb the unmet needs of all individuals above 250 percent of the federal poverty level. Additionally, Title X is designed to subsidize a program of care, not pay the full cost of any service or activity. Title X regulations encourage Title X projects to work with third-party payers to reduce the cost of the program. The Title X program is already underfunded, and

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without additional funding from Congress, the Proposed Rule would result in even fewer resources to serve low-income patients, in direct contrast to the Proposed Rule's stated intent. The Title X network does not have the capacity to serve a flurry of new middle-income patients who have insurance coverage through their employer, nor the resources to serve those patients at low- or no-cost.

***

Policy decisions about public health must be firmly rooted in science, and increase access to safe, effective and timely care. Policies and regulations that improperly restrict the practice of medicine, place political preferences over medical necessities, and restrict the ability of millions of women, men, and adolescents to access high quality care should not be implemented. The Proposed Rule would interfere with the patient-physician relationship, exacerbate disparities for low-income and minority women, men, and adolescents, and harm patient health. We urge HHS to immediately withdraw the Proposed Rule. Thank you for your full consideration of our comments.

Sincerely,

Lisa M. Hollier, MD, MPH, FACOG
President

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UNIVERSAL HEALTH CARE
FOUNDATION OF CONNECTICUT

VIA ELECTRONIC TRANSMISSION

July 31, 2018

Alex Azar, Secretary of Health and Human Services
Attention: Family Planning
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 716G
200 Independence Avenue SW
Washington, DC 20201

Diane Foley, Deputy Assistant Secretary for Population Affairs
Office of the Assistant Secretary for Health, Office of Population Affairs
Attention: Family Planning
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 716G
200 Independence Avenue SW
Washington, DC 20201

Valerie Huber, Senior Policy Advisor, Assistant Secretary for Health
Attention: Family Planning
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 716G
200 Independence Avenue SW
Washington, DC 20201

19-1614, 20-1215
Sept. 1, 2020

RE: HHS–OS–2018–0008, Proposed Rule for Compliance With Statutory Program Integrity Requirements

Dear Secretary Azar, Senior Advisor Huber, and Deputy Assistant Secretary Foley:

I am writing on behalf of Universal Health Care Foundation of Connecticut in response to the request for public comment on the proposed rule entitled: "Compliance With Statutory Program Integrity Requirements" published in the Federal Register on June 1, 2018. If enacted, the proposed rule puts the health and health care of over 43,000 people in Connecticut at risk.

Universal Health Care Foundation of Connecticut is dedicated to achieving universal access to quality and affordable health care and to promoting health in Connecticut. We envision a health care system that is accountable and responsive to the people it serves.

Title X funds reproductive health services for low income women. It also funds preventive health care such as well woman exams, cancer screenings, screening and treatment for sexually transmitted infections, testing for HIV, and patient education. These services save lives.

Government Interference in the Practice of Medicine

The proposed rule would prohibit doctors, nurses and other health care providers from counseling pregnant patients about the full range of medically appropriate options available to them, including pregnancy termination, or from referring patients for abortion services, even when requested. Denying or delaying Title X patients' ability to obtain abortions jeopardizes their health and well-being. And this

"gag rule" goes completely against the ethical standards of health care professionals, jeopardizing an open, trusting relationship with their patients.

Furthermore, the proposed rule would no longer require Title X providers to offer all FDA-approved contraceptive methods to their patients. In fact, the proposed definition of "family planning" appears to favor much less effective methods such as abstinence.

This approach undermines a law passed with bipartisan support in the Connecticut General Assembly in the 2018 session, HB 5210, *An Act Mandating the Coverage of Essential Health Benefits*. This new state law specifically requires insurance coverage of all FDA-approved contraceptive methods and requires these preventive services be offered without cost-sharing.

Impact on Planned Parenthood

The proposed rule appears to directly target Planned Parenthood, by requiring complete physical and financial separation of abortion services from other services the agency provides. Planned Parenthood of Southern New England is a crucial provider of affordable reproductive health care services in our state. In 2017, the organization cared for the large majority of Title X patients: 37,973 out of a total of 43,835 (87%). Eliminating Planned Parenthood from the Title X program would leave many people without access to care, as other health care providers do not have the capacity to handle the additional patient load.

Health Disparities

The proposed rule would have a particularly negative impact on people of color and people with low incomes, widening the health disparities that exist in Connecticut. In 2017, 28% of the patients served by Title X were Hispanic or Latino, and 23% were Black or African American. The large majority (85%) of patients served had incomes under 200% of the federal poverty level. Access to care should not be based on ability to pay. If the rule goes through, the harmful impacts will fall most heavily on the people who are most in need of comprehensive, affordable, reproductive, and preventive health care services.

Expanding the Comment Period

Finally, I would like to request that HHS expand the comment period at least until October 1, 2018. This extension would allow more organizations and individuals to assess the impact of the proposed rule, which would deprive so many people in our state of vital health care services they rely on.

In summary, I urge you to reject this proposed rule, which would keep tens of thousands of people in Connecticut, and millions of people across the country, from accessing the comprehensive services and unbiased information they need to protect their health and make informed decisions about their care.

Sincerely,

Frances G. Padilla

Frances G. Padilla
President

19-1614, 20-1215
Sept. 1, 2020

AMERICAN ACADEMY OF NURSING
transforming health policy and practice through nursing knowledge

July 26, 2018

Alex Azar, Secretary of Health and Human Services
Attention: Family Planning
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 716G
200 Independence Avenue SW
Washington, DC 20201

Valerie Huber, Senior Policy Advisor, Assistant Secretary for Health
Attention: Family Planning
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 716G
200 Independence Avenue SW
Washington, DC 20201

Diane Foley, Deputy Assistant Secretary for Population Affairs
Office of the Assistant Secretary for Health, Office of Population Affairs
Attention: Family Planning
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 716G
200 Independence Avenue SW
Washington, DC 20201

19-1614, 20-1215
Sept. 1, 2020

RE: HHS–OS–2018–0008, Proposed Rule for Compliance with Statutory Program Integrity Requirements

Dear Secretary Azar, Senior Advisor Huber, and Deputy Assistant Secretary Foley:

The American Academy of Nursing (the Academy) submits these comments[1] in response to the Department of Health and Human Services' (the Department's) proposed rule entitled Compliance with Statutory Program Integrity Requirements, which was published in the Federal Register on June 1, 2018.[2] The proposed rule would significantly and detrimentally alter the Title X Family Planning Program (Title X), the only federal program exclusively dedicated to providing low-income patients (including adolescents) with access to family planning and preventive health services and information, including health and cancer screenings, well woman exams, contraception and testing and treatment for sexually transmitted infections.

[1] Comments prepared by the Academy's Women's Health Expert Panel (Diana Taylor, chair)
[2] Compliance with Statutory Program Integrity Requirements, 83 Fed. Reg. 25,502 (proposed Jun. 1, 2018) (to be codified at 42 C.F.R. pt. 59). https://www.regulations.gov/document?D=HHS-OS-2018-0008-0001

The **American Academy of Nursing** (the "Academy") serves the public and the nursing profession by advancing health policy, practice, and science through organizational excellence and effective nursing leadership. The Academy influences the development and implementation of policy that improves the health of populations and achieves health equity including advancing policies that improve ethical and evidence-based standards of care and women's access to safe, quality sexual/reproductive health care without interference with the patient-provider relationship. Specifically related to our comments on the proposed changes to Title X regulations, the Academy is on record supporting evidence-based policies that 1) ensure that all people have full access to affordable, sexual and reproductive health services,[3] 2) facilitate expansion of clinical knowledge and evidence-based women's preventive health services especially related to preventing unintended pregnancies,[4] and 3) assure that all women's health care, including reproductive health services, is grounded in scientific knowledge and evidence-based policies and standards of care.[5] [6]

Nurses are the most trusted professionals in the United Sates, and we have an ethical and moral responsibility to maintain this trust. Trust requires that health care providers give patients complete and accurate information about their health care so that patients can make meaningful, informed decisions about their own health. For nearly two decades, the Title X law has been clear—health care providers cannot withhold information from patients about their pregnancy options. **The Academy strongly opposes these proposed changes to the Title X program and urges rescission of the proposed rules.**

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The proposed rules targets qualified health care providers and restricts access to medically accurate preventive health services

The proposed HHS/Title X rule further restricts state governments to apportion Title X funds based on a provider's ability to perform SRH services effectively and discriminates against certain "focused reproductive health providers" (e.g., Planned Parenthood) that have demonstrated successful outcomes in reducing unintended pregnancy, improving sexual and reproductive health (SRH) care[7], and providing essential preventive services. The proposed rule conflicts with established Medicaid/Medicare criteria for qualified providers based on professional and facility scope of practice and licensing.

Title X providers offer a broader range of SRH services (e.g., long-acting contraceptives such as IUDs, HPV vaccinations, preconception services) compared to primary care providers (community health centers (CHCs) or federally qualified health centers (FQHCs)) as evidenced by the HHS/Title X analysis of observational and experimentation data. With a loss of Planned

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[6] Berg JA, Shaver J, Olshansky E, Woods NF, Taylor D (2013). A call to action: Expanded research agenda for women's health, 61(4):252, DOI: http://dx.doi.org/10.1016/j.outlook.2013.05.008

[7] Sexual and reproductive health (SRH) care has been defined to broaden the focus on family planning or maternal-child health. To produce optimal health outcomes, many experts believe SRH care should include the reproductive health of men and women throughout their lifespan and adolescents of both sexes with a focus on social determinants of health and health equity. Under this definition, a minimum package of SRH care accessible to all would include preconception care, contraception, pregnancy and unplanned pregnancy care, women's health/common gynecology care, genitourinary conditions of men, assessment of specialty gynecology problems including infertility, sexual health promotion, and coordination with public health and primary care services (WHO, 2011).

Parenthood (PP) health centers, which serve about one-third of the Title X patients (2 million individuals) across the country, empirical evidence indicates a decline in the use of the most effective methods of birth control and an increase in births among the women who previously used long-acting reversible contraception (Stevenson et al, 2016).[8] Comprehensive primary care providers from CHCs and FQHCs (who care for the millions of the most poor and vulnerable) rely on PP health centers to expand their SRH services since for every patient served by CHCs today, nearly three residents of low-income communities remain without access to primary health care.[9]

Recent reports from HHS clearly outline the evidence indicating that restricting specific providers of Title X services has harmful effects on access to gender-sensitive SRH services (e.g., pregnancy diagnosis/counseling, contraceptive services, basic infertility services, STD screening, and preconception health care) and is linked with increased pregnancy rates that differ substantially from rates of unaffected populations. Such restrictions also impact the education and training of health professionals and front-line health workers that provide these services since focused SRH providers serve as clinical training sites for medical and nursing students.

Nurses (primarily nurse practitioners, nurse midwives and public health nurses) have been the mainstay of SRH care in both community health clinics and Title X clinics and are crucial providers for vulnerable, low-income and ethnic populations. Nurse practitioners (NPs) comprise about 75% of clinicians employed by PP affiliates.[10] With closures of PP health centers, the lack of clinical training sites for NP students (and other health professionals) who will provide SRH services results in a workforce that varies widely in SRH exposure, knowledge, and clinical skill and reduces the pipeline of trained frontline clinicians.[11]

Planned Parenthood health centers are often located in communities where there is little to no access to health care, especially reproductive health care that offers a broad range of services. In fact, Title X services provided by PP health centers frequently serve as the sole health care source for underinsured, uninsured and low-income women in these communities.[12] Without ease of access to the most effective contraception methods available, the incidence of unintended pregnancies increases significantly (statistic is referenced in previous DHHS reports), and at a time when prematurity is on the rise along with the potential for additional global epidemics affecting maternal and fetal health is of particular concern, ease of access to contraception should be increased rather than barriers created.

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[8] Stevenson A, Flores-Vazquez IM, Allgeyer RL, Schenkkan P, Potter JE (2016). The effect of removal of Planned Parenthood from Texas women's health program. Available at https://www.nejm.org/doi/full/10.1056/nejmsa1511902

[9] Rosenbaum S (2015). Planned Parenthood, community health centers, and women's health: Getting the facts right. Health Affairs Blog, http://healthaffairs.org/blog/2015/09/02/planned-parenthood-community-health- centers-and-womens-health-getting-the-facts-right/

[10] Bednash G, Worthington S, and Wysocki S, "Nurse Practitioner Education: Keeping the Academic Pipeline Open to Meet Family Planning Needs in the United States," *Contraception*, 80, 2009, 409–411.
Fowler, C., S. Lloyd, J. Gable, et al., Family Planning Annual Report: 2010. Research Triangle Park, NC: National Summary RTI International, September 2011.

[11] Auerbach DI., Pearson ML, Taylor D, Battistelli M, Sussell J, Hunter LE, Schnyer C, Schneider EC. Nurse Practitioners and Sexual and Reproductive Health Services: An Analysis of Supply and Demand. Santa Monica, CA: RAND Corporation, 2012. http://www.rand.org/pubs/technical_reports/TR1224.

[12] Flynn, A. (2013). The Title X factor: Why the health of America's women depends on more funding for family planning. The Roosevelt Institute. Accessed on 9/28/16 from www.ROOSEVELTINSTITUTE.ORG

The proposed rule would force providers to violate professional ethics and harms the patient-provider relationship.

High-quality health care is founded on complete, accurate, and unbiased information and relies on a relationship of the utmost trust between a patient and their health care professional. Currently, consistent with the highest professional and ethical standards of care, Title X-funded providers must offer pregnant patients counseling on and referrals for all of their options, including adoption, prenatal care, and abortion.[13] [14] However, the proposed rule would inject politics and ideology into the examination room by prohibiting providers from giving patients information on how and where to access abortion. This restriction would undermine the health professional's ethical obligations and hinder open and honest conversations between patients and their providers.

As the most "honest and ethical" profession, nurses guard against any erosive policy that hinders patients from making meaningful, informed decisions about their own health, or that blocks access to care. The Code of Ethics for Nurses outlines that the nurse's primary commitment is to the patient, whether an individual, family, group, community, or population. This proposed rule interferes with that relationship and violates basic ethics of the profession.[15]

In addition, the Code of Ethics for Nurses stipulates that patients have the right "to be given accurate, complete, and understandable information in a manner that facilitates an informed decision,"[16] and the American Nurses Association's position is that health care providers must "share with the client all relevant information about health choices that are legal and to support that client regardless of the decision the client makes."[17]

These ethical obligations recognize that a patient's informed consent and access to medically appropriate care is dependent upon both having all treatment options presented and referrals to appropriate providers. In short, the proposed rule places Title X providers in a situation whereby they would have to violate their professional ethics in order to participate in Title X, which is an untenable position for any health care provider.

The proposed rule undermines the decades long successes of the Title X program and the HHS goals and past efforts

In 1999, the Centers for Disease Control and Prevention (CDC)—an HHS division—declared family planning as one of the 10 greatest public health achievements of the twentieth century.[18] In a

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[13] Christina Fowler, et al., *Family Planning Annual Report: 2016 National Summary,* RTI International (Aug. 2017), available at https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf ("FPAR 2016").

[14] Simmonds, K. and F. E. Likis (2011). Caring for women with unintended pregnancies." Journal of Obstetric, Gynecologic, & Neonatal Nursing **40**(6): 794-807. Cappiello, J., M. W. Beal, et al. (2011). Applying ethical practice competencies to the prevention and management of unintended pregnancy. Journal of Obstetric, Gynecologic, & Neonatal Nursing **40**(6): 808-816.

[15] American Nurses Association. (2016). The nurse's role in ethics and human rights: Protecting and promoting individual worth, dignity, and human rights in practice settings (position statement). Silver Spring, MD: Author. https://www.nursingworld.org/~4af078/globalassets/docs/ana/ethics/ethics-and-human-rights-protecting-and-promoting-final-formatted-20161130.pdf

[16] American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. Provision 1.4. Silver Spring, MD. Retrieved from http://www.nursingworld.org/code-of-ethics.

[17] American Nurses Association. *Position Statement: Reproductive Health* (1989, 2010). https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/reproductive-health/

[18] CDC (Centers for Disease Control and Prevention). 1999. Ten great public health achievements: United States, 1900–1999. Morbidity and Mortality Weekly Report 48(12):241–243.

2009 review of the HHS Family Planning Program, an Institute of Medicine review panel[19] reported the role and history of family planning policies and programs in the United States: The provision of family planning services has important benefits for the health and well-being of individuals, families, communities, and the nation as a whole. Planning for families—helping people have children when they want to and avoid conception when they do not—is a critical social and public health goal. The federal government has a responsibility to support the attainment of this goal. There is an ongoing need for public investment in family planning services, particularly for those who are low income or experience other barriers to care.

The federal government's continuing recognition of the contribution of family planning and reproductive health to the public well-being is evidenced by their inclusion in the nation's top health priorities as outlined in the HHS Strategic Plan and Healthy People 2010. A 2015 report of federally funded family planning programs demonstrated that Title X–supported services alone helped women to avoid more than 822,000 unintended pregnancies (out of 1.3 million unintended pregnancies avoided by all safety-net family planning centers), thus preventing 278, 000 abortions (out of 453,400 abortions avoided by safety-net family planning centers overall).[20] Along with yielding important public health benefits, every public dollar invested in Title X saves $7.[21] In spite of this history of successful public health outcomes supported by decades of evidence, current government policy and regulatory proposals will deal a devastating blow to safety-net family planning providers and the communities who rely on them.

The nation's 4 million nurses are deeply committed to ensuring that all people have access to affordable health care, including preventive services as intended by the Affordable Care Act and the Title X programs. Nurses know and understand the importance of women having seamless and comprehensive reproductive health care to protect their health and ability to work, both of which are essential for the economic security of families across America.[22] Specifically, the **American Academy of Nursing is opposed to the following changes in the Title X program**:

- Imposes new rules that are designed to make it impossible for millions of patients to get birth control or preventive care from reproductive health care providers like Planned Parenthood.
- Restricts doctors, nurses, hospitals, and community health centers who could no longer refer their patients for safe, legal abortion.
- Removes the guarantee that people get full and accurate information about health care from their health care providers.
- Creates a new policy stipulating that Title X projects do not have to provide every effective and acceptable method of birth control. This is a sharp departure from the way the program has been operating, where HHS put an emphasis on ensuring women have access to all 18 FDA-approved contraceptive methods.

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[19] IOM (Institute of Medicine). 2009. A Review of the HHS Family Planning Program: Mission, Management, and Measurement of Results. Washington, DC: The National Academies Press. Available at https://www.nap.edu/download/12585

[20] Frost JJ, Frohwirth LF, Blades N, Zolna MR, Douglas-Hall A, Bearak J. Publicly funded contraceptive services at US clinics, 2015. Guttmacher Institute. 2017. Available at: https://www.guttmacher.org/ report/publicly-funded-contraceptiveservices-us-clinics-2015.

[21] Sonfield A. Beyond preventing unplanned pregnancy: the broader benefits of publicly funded family planning services. Guttmacher Policy Rev. 2014;17(4): 2–6. Available at: https://www. guttmacher.org/gpr/2014/12/beyondpreventing-unplanned-pregnancybroader-benefits-publicly-fundedfamily-planning#table3

[22] Berg JA, Taylor D, Woods NF (2013). Where we are today: Prioritizing women's health services and health policy. A report by the Women's Health Expert Panel of the American Academy of Nursing. Nursing Outlook **61**(1): 5-15, http://dx.doi.org/10.1016/j.outlook.2012.06.004

- Allows women to receive family planning services under the Title X program if their employer refuses to cover contraceptive care based on religious or moral objections, regardless of their income. Redefining "low income" to include this population will divert scarce resources away from serving the low-income patients at the heart of Title X's purpose.

Final Statements

As the nation's health policy center, the Department of Health and Human Services (HHS) policies and activities must be firmly based on scientifically valid and appropriate terms and evidence. Instead, the Department makes several false and misleading statements in these proposed rules to undermine the Title X program. Furthermore, these rules prioritize ideology over evidence-based professional recommendations and the government's own independent evaluations.

The proposed Title X rules undermine the decades long successes of the Title X program and HHS goals by eroding access to sexual and reproductive health care and individual freedom to make reproductive health decisions. The Academy unequivocally opposes the Departments' effort to undermine the Title X program. We urge HHS to remain religiously and morally neutral in its funding, policies, and activities to ensure that individuals receive do not receive a limited scope of services and that the ethical obligations of healthcare providers are not compromised.

We stand in opposition to the proposed rule and any other policy proposals that interfere with the patient-provider relationship, violate professional ethics, and limit access to high-quality, affordable family planning care under the Title X program.

Sincerely,

Karen S. Cox

Karen S. Cox
President
American Academy of Nursing

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