July 31, 2018

Office of Population Affairs, Attn: Family Planning
Office of the Assistant Secretary for Health
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Attn: RIN 0973-ZA00 (Compliance with Statutory Program Integrity Requirements)

On June 1, 2018, the Office of Population Affairs (OPA) published a proposed rule that seeks to significantly revise the regulations governing the Title X national family planning program. I am pleased to submit the following comments on the proposed rule on behalf of the Guttmacher Institute, a nonprofit research and policy organization committed to advancing sexual and reproductive health and rights in the United States and globally.

We strongly oppose the proposed regulatory changes, which if finalized and implemented, stand to fundamentally overhaul the Title X program. Specifically, the proposed regulatory changes seem intended to alter the purpose and scope of services supported by Title X; eliminate nondirective counseling and referral for all of a pregnant patient's options; reduce access to care by reshaping the network of providers; infringe on Title X patients' ability to obtain family planning services confidentially; and divert Title X funds to address gaps in contraceptive coverage created by other administration regulations.

Altering the Purpose and Scope of Title X–Supported Services

The proposed rule would impose a new definition of "family planning" that would alter the scope of services Title X providers would be required to offer. This shift would be at odds with nearly 50 years of legislative, administrative and operational history of the program, undermining Congress's clear intent that Title X patients have free and informed contraceptive choices that will help them avoid unintended pregnancies.

Current Title X regulations are in line with Congress's intent. They require that all family planning "projects" provide "a broad range of acceptable and effective medically approved family planning methods (including natural family planning methods) and services (including infertility services and services for adolescents)." This mandate is intended to guarantee patients a true choice of contraceptive methods, and has been interpreted and implemented as such for decades. Ensuring that patients can choose from a truly broad range of contraceptive options is essential to guaranteeing their choices are voluntary and free from coercion—cornerstones of Title X–supported care. This principle is articulated

in the *Quality Family Planning* guidelines, national, evidence-based clinical recommendations published by the Office of Population Affairs and the Centers for Disease Control and Prevention in 2014[1] and updated as recently as December 2017.[2] The proposed rule would depart from these regulations and guidelines in multiple harmful ways.

Reducing contraceptive choice

The proposed definition of "family planning" would deemphasize the provision of modern contraceptive methods, particularly those approved by the Federal Drug Administration (FDA). Moreover, instead of further clarifying what it means to offer a meaningfully "broad range" of contraceptive methods and related services as it purports to do, the proposed rule would create confusion and raise serious concerns about the scope of services that Title X projects would be required to make available in their communities.

The proposed rule does this via a combination of multiple proposed changes. It removes the requirement that the range of family planning methods offered by a Title X project include methods that are "medically approved," suggesting this deletion "provides better guidance for the types of methods and services that Congress sought to fund." It also suggests that modern contraceptives are but one of a few categories of contraceptive options that Title X projects might offer (the others being natural family planning, other fertility awareness–based methods and abstinence).

The Department further suggests in the preamble that as methods of family planning have evolved, "it has become increasingly difficult and expensive for a Title X project to offer all acceptable and effective forms of family planning." It notes that "staffing limitations, technological capacity, economics (including costs and demand), and conscience concerns may be taken into account" in determining the scope of methods offered by a Title X project. And although Title X projects have never been required to offer all available contraceptive methods, the preamble and proposed rule reiterate that fact multiple times, suggesting a willingness for projects to offer fewer as opposed to greater numbers of contraceptive options.

Finally, the proposed rule seems to disregard a long-standing interpretation of the statutory requirement that Title X projects provide a "broad range of acceptable and effective family planning methods and services." Historically, it has been understood that projects must provide a broad range of contraceptive options, in addition to related services. Instead, the proposed rule seems to suggest it would be permissible for a Title X project to offer a broad range of services, defined to include modern contraceptive care as but one of multiple—but not necessary—choices for projects to consider and make available. For instance, it appears possible that the proposed rule would allow a Title X project to include only abstinence-only-until-marriage counseling for adolescents, natural family planning and adoption services (see below), together representing a "broad range" of methods and services.

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[1] Gavin L et al., Providing quality family planning services: recommendations of CDC and the U.S. Office of Population Affairs, *Morbidity and Mortality Weekly Report*, 2014, Vol. 63(No. RR-4), https://www.hhs.gov/opa/guidelines/clinical-guidelines/quality-family-planning/index.html.

[2] Gavin L, Pazol K and Ahrens K, Update: providing quality family planning services—recommendations from the CDC and the Office of Population Affairs, *Morbidity and Mortality Weekly Report*, 2017, Vol. 66(50): 1383–1385, https://www.cdc.gov/mmwr/volumes/66/wr/mm6650a4.htm.

Collectively, these proposed changes would be a remarkable departure from the Title X program's mission. Title X's core purpose has always been clear: to help people obtain patient-centered care that best enables them to determine for themselves whether and when to have children. For the vast majority of Title X clients, this means obtaining contraceptive services and counseling: In 2016, 80% (2.8 million) of all female patients at Title X sites left their visit having newly started or continuing use of some method of contraception; among those patients, the vast majority are using contraceptive methods deemed most or moderately effective at preventing pregnancy, all of which require a prescription or services provided by a medical professional.[3]

For decades, the Title X program has helped to ensure that patients have a true choice of contraceptive options. Compared with publicly funded health centers that do not receive Title X funding, sites supported by Title X are more likely to offer the full range of contraceptive methods.[4] Moreover, Title X–supported providers make it easier for women to obtain highly effective and long-acting reversible contraceptive methods, as these health centers are particularly likely to offer on-site insertion of IUDs and implants on the same day as a client's initial appointment. Similarly, nearly three-quarters of Title X sites offer initial supplies of oral contraceptives and refills on-site, enabling women who choose the pill to avoid additional trips to a pharmacy. Plus, nearly nine in 10 Title X providers allow women to delay a pelvic exam when medically appropriate in initiating hormonal contraceptives, and nearly nine in 10 use the "quick-start" protocol, enabling a client to start the pill on the day of her visit, regardless of where she is in her menstrual cycle.

Although projects have never been required to provide all available contraceptive methods, it is misguided to suggest that Title X providers should not be expected to provide patients with a true choice of methods. Doing so discounts the importance of patient-centered and voluntary care. Moreover, the evidence is clear that individuals' ability to obtain and use whatever methods of contraception will work best for them is critical to ensuring satisfaction with their methods.[5] This in turn enables patients to use those methods consistently and correctly, increasing their likelihood of successfully avoiding unintended pregnancies: The two-thirds of women at risk for unintended pregnancy who consistently and correctly use a contraceptive method account for only 5% of unintended pregnancies.[6]

We urge the Department to reject its revised definition of "family planning" at Sec. 59.2 and to return to the current regulatory definition, and to reject its deletion of "medically approved" at Sec. 59.5. We also urge the Department to return to its long-standing interpretation of the statute to require Title X projects to offer a meaningfully broad range of contraceptive methods, in addition to related services.

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[3] Fowler CI et al., *Title X Family Planning Annual Report: 2016 National Summary*, Research Triangle Park, NC: RTI International, 2017, https://www.hhs.gov/opa/title-x-family-planning/fp-annual-report/index.html.

[4] Zolna MR and Frost JJ, *Publicly Funded Family Planning Clinics in 2015: Patterns and Trends in Service Delivery Practices and Protocols*, New York: Guttmacher Institute, 2016, http://www.guttmacher.org/report/publicly-funded-family-planning-clinic-survey-2015.

[5] Sonfield A, Why family planning policy and practice must guarantee a true choice of contraceptive methods, *Guttmacher Policy Review*, 2017, 20:103–107, https://www.guttmacher.org/gpr/2017/11/why-family-planning-policy-and-practice-must-guarantee-true-choice-contraceptive-methods.

[6] Sonfield A, Hasstedt K and Gold RB, *Moving Forward: Family Planning in the Era of Health Reform*, New York: Guttmacher Institute, 2014, https://www.guttmacher.org/report/moving-forward-family-planning-era-health-reform.

Prioritizing fertility awareness–based methods and natural family planning

The proposed definition of "family planning" inappropriately promotes one particular approach to family planning over ensuring patients' true choice of contraceptive methods. The proposal emphasizes fertility awareness–based methods (FABMs)—specifically, natural family planning. Natural family planning methods are a subset of FABMs that are calendar-based, rely on abstinence (as opposed to using a back-up contraceptive method) during fertile windows, and are often motivated by religious convictions.

The rule would make natural family planning the only contraceptive option that each Title X project must make available to patients as part of a range of Title X–supported services. Moreover, it explicitly seeks to direct Title X funds to "specialized, single-method [natural family planning] sites," based on an inaccurate assertion that these options have historically not been adequately available to Title X patients.

The federal government promoting any single family planning method within Title X would actively undermine the program's mandate to ensure patients' choices are wholly voluntary and free from coercion. Furthermore, actively directing Title X funds toward natural family planning is unnecessary: It has always been provided for under the statute, and 93% of Title X–funded sites specifically report offering "natural family planning instruction or supplies."[4]

Moreover, less than 0.5% of female Title X contraceptive users rely on some type of FABM, including natural family planning, as their primary method.[3] This is likely in part because these methods do not meet a number of different needs that women have for their methods of birth control. Their effectiveness is highly sensitive to a couple's ability to correctly and consistently use them, which can lead to high failure rates; they require the cooperation of a male sexual partner; and they do not offer protection against STIs. A study on contraceptive features preferred by women at high risk of unintended pregnancy conducted in 2010 found that natural family planning specifically was tied with withdrawal for having the fewest features women find important in a contraceptive method.[7]

We urge the Department to reject its revised definition of "family planning" at Sec. 59.2 and to return to the current regulatory definition, and to reject its deletion of "medically approved" at Sec. 59.5. We also urge the Department to eliminate language in the preamble that prioritizes natural family planning and other FABMs over other contraceptive methods.

If the Department does not remove this language, we ask the Department to clarify whether it intends to prioritize and promote natural family planning and other FABMs for Title X patients over other contraceptive options, and if so, to provide its justification for so undermining patients' ability to obtain voluntary care free from coercion.

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[7] Lessard LN et al., Contraceptive features preferred by women at high risk of unintended pregnancy, *Perspectives on Sexual and Reproductive Health*, 2012, 44(3):194–200, https://www.guttmacher.org/journals/psrh/2012/09/contraceptive-features-preferred-women-high-risk-unintended-pregnancy.

Supporting the provision of adoption services and abstinence-only messaging

The proposed rule would expand the definition of family planning services supported by Title X to include two new areas: adoption services and abstinence-only-until-marriage messaging.

The rule would newly define "infertility services" to include adoption services. Infertility services have long been provided for under Title X statute, but have previously been understood and implemented as clinical services intended to help people experiencing infertility. For example, the *Quality Family Planning* guidelines advise that "infertility visits to a family planning provider are focused on determining potential causes of the inability to achieve pregnancy and making any needed referrals to specialist care."[1] These services are to be provided to patients who want to have children but are experiencing difficulty becoming pregnant, and should include counseling, medical histories, sexual health assessments and physical exams, as well as referrals for specialized care or social supports as needed.

Nowhere in these clinical recommendations, or in Title X statute, regulations or programmatic guidelines, is adoption suggested as a service that is necessary or appropriate for family planning providers to offer directly. Similarly, there is no precedent for providing Title X funds to support the work of adoption agencies. Notably, the proposed rule offers no rationale for such a radical shift in its definition of family planning and infertility services, nor for diverting limited Title X funds away from medical family planning care and toward adoption services (which have other, dedicated sources of government funding).

Similarly, the proposed rule explicitly includes "choosing not to have sex" among the range of contraceptive "choices" supported by Title X. The preamble further explains that abstinence-only-until-marriage messaging—which the Department refers to as "sexual risk avoidance"—would be considered a method that would be supported by Title X. The Department also advanced abstinence-only messages as a Title X–funded service in its fiscal year 2018 Title X services grant funding opportunity announcement, misrepresenting the body of available evidence on these approaches in doing so.[8,9]

The proposed rule and earlier funding announcement together suggest the Department seeks to advance abstinence not within the context of comprehensive family planning counseling for younger patients, but by seeking to advance abstinence-only programming as a family planning method for all Title X patients. This is in direct contrast with clinical recommendations from the federal government and professional medical associations; these recommendations consistently advise that counseling on abstaining from sexual activity should be one piece of a broader, patient-centered approach for adolescent patients, and that factual information on remaining abstinent should be provided to adolescent patients interested in that approach, along with contraceptive and STI prevention services

[8] Hasstedt K, Big four threats to the Title X family planning program: examining the administration's new funding opportunity announcement, *Health Affairs* Blog, Mar. 5, 2018, https://www.guttmacher.org/article/2018/03/four-big-threats-title-x-family-planning-program-examining-administrations-new.

[9] Lindberg LD and Hasstedt K, The Trump administration's irresponsible use of research in pushing its abstinence-only agenda into Title X, *News in Context*, May 16, 2018, https://www.guttmacher.org/article/2018/05/trump-administrations-irresponsible-use-research-pushing-its-abstinence-only-agenda.

for sexually active adolescents, as appropriate.[1,10,11,12] The administration's proposal is deeply concerning, given that extensive evidence demonstrates that this programming can cause considerable harm to young people,[13] and that public policies seeking to restrict the sexual activity of unmarried adults do not meet the sexual and reproductive health needs of most single adult women.[14]

We urge the Department to reserve the Title X program's limited resources for the medical family planning services that the program has supported so effectively for decades. Specifically, we urge the Department to eliminate regulatory language at Sec. 59.2 and 59.5 that include adoption as an infertility service, and to eliminate language at Sec. 59.2 around "choosing not to have sex" and language in the preamble around "sexual risk avoidance."

If the Department does not remove this language, we ask the Department to clarify whether it intends for Title X dollars to be directed to adoption services and agencies and to the promotion of abstinence-only-until-marriage messaging, and if so, to offer its justification for so dramatically altering the scope of services supported by Title X.

Eliminating Nondirective Pregnancy Options Counseling and Referral

The proposed rule would eliminate the Title X program's long-standing commitment to neutral, factual information on and nondirective counseling for all of a pregnant patient's options—including maternity and infant care, foster care and adoption, and abortion—and referral, on request, for services related to any of these options. The rule would do so by eliminating the requirement for nondirective counseling, undermining or possibly banning counseling on abortion, barring abortion referral, and mandating referral for prenatal care even against a patient's wishes.

More specifically, the proposed rule would eliminate the long-standing guarantee that all pregnant patients at Title X–funded sites be offered unbiased, factual and comprehensive counseling on all pregnancy options. Instead, providers would be given the authority to deny patients information on abortion—even when a patient directly requests it. Moreover, given the proposed rule's extensive and confusing additional restrictions on "activities that encourage, promote or advocate for abortion," it seems difficult if not impossible for Title X–funded providers to counsel pregnant patient on abortion as one of their options. At the very least, the proposed rule may create a "chilling effect," whereby even providers dedicated to delivering high-quality care are deterred from offering comprehensive and unbiased pregnancy options counseling for fear of losing Title X funding.

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[10] Ott MA, Sucato GS and Committee on Adolescence, Contraception for Adolescents, *Pediatrics*, 2014, 134: e1257–e1281.
[11] Society for Adolescent Health and Medicine, Sexual and reproductive health care: a position paper of the Society for Adolescent Health and Medicine, *Journal of Adolescent Health*, 2014, 54(4):491–496, https://www.jahonline.org/article/S1054-139X%2814%2900052-4/fulltext?code=jah-site.
[12] American College of Obstetricians and Gynecologists (ACOG), Adolescent pregnancy, contraception, and sexual activity, *Obstetrics & Gynecology*, 2017, 129(5):965–966, https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Adolescent-Pregnancy-Contraception-and-Sexual-Activity.
[13] Boyer J, New name, same harm: rebranding of federal abstinence-only programs, *Guttmacher Policy Review*, 2018, 21:11–16, https://www.guttmacher.org/gpr/2018/02/new-name-same-harm-rebranding-federal-abstinence-only-programs.
[14] Lindberg LD and Singh S, Sexual behavior of single adult American women, *Perspectives on Sexual and Reproductive Health*, 2008, 40(1): 27–33, https://www.guttmacher.org/journals/psrh/2008/sexual-behavior-single-adult-american-women.

On the subject of counseling, the proposed rule would bar clinicians from referring pregnant patients to appropriate providers for abortion services. If a pregnant patient who has already decided to have an abortion clearly states this intent and asks for referral, the proposed rule would give providers only two options: either deny the request entirely, or provide an intentionally misleading list of "comprehensive health services providers (some, but not all, of which also provide abortion, in addition to comprehensive prenatal care);" that list cannot identify which sites actually provide abortion. Beyond denying patients abortion referral, the proposed rule would mandate that all pregnant patients at Title X sites be referred for prenatal and social services (such as infant or foster care, or adoption), regardless of the patient's wishes.

The Department's justifications for these changes are seriously flawed. For example, the Department claims a bar on abortion referral is necessary to comply with federal law, asserting that "[r]eferrals for abortion are, by definition, directive," and therefore abortion referrals are not in compliance with the requirement that all pregnancy options counseling be "nondirective" under Title X. However, the Department's reasoning is inconsistent: It does not find referral for prenatal or social services to be similarly directive, and the proposed rule goes so far as to prescribe referral for those services to all pregnant patients in a highly directive, and in fact coercive, manner. The Department claims this referral—even against a patient's wishes—is necessary "to optimize the health of the mother and the unborn child." This use of subjective rather than medical language belies the Department's ideological motivations and willing departure from clinical standards.

Similarly, the Department asserts that its elimination of the requirement to provide nondirective counseling on abortion is justified out of "respect for conscience" among providers who object to the procedure. This prioritization of provider beliefs over patient needs is particularly troubling given the Department's express interest in directing Title X funds to entities "that refuse to provide abortion counseling and referrals."

Contrary to the Department's assertions, Title X's long-standing counseling and referral requirements do not violate the Title X statute. Rather, they are essential to ensuring informed consent in reproductive health care—a bedrock principle of modern medical practice in the United States deeply rooted in legal, ethical and medical standards developed over the course of decades.[15] The proposed rule constitutes an unacceptable repudiation of the doctrine of informed consent by denying Title X patients factual, unbiased information on abortion.

In effect, the proposed rule rejects clinical recommendations from professional medical associations, including the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics, which state that providers must offer appropriate referrals for needed follow-up care to all pregnant patients—even if a patient requests information on services to which an individual provider personally objects, such as abortion.[16,17] Similarly, many leading professional medical organizations have ethical guidelines that unequivocally and consistently call for comprehensive,

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[15] Hasstedt K, Unbiased information on and referral for all pregnancy options are essential to informed consent in reproductive health care, *Guttmacher Policy Review*, 2018, 21:1–5, https://www.guttmacher.org/gpr/2018/01/unbiased-information-and-referral-all-pregnancy-options-are-essential-informed-consent.

[16] ACOG, Informed consent, Committee Opinion No. 439, Obstetrics & Gynecology, 2009, 114(2):401–408, https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/Informed-Consent.

[17] Committee on Adolescence, American Academy of Pediatrics, Counseling the adolescent about pregnancy options, Pediatrics, 1998, 101(5):938–940.

unbiased counseling on all pregnancy options.[17,18,19,20] These recommendations are echoed in the national *Quality Family Planning* guidelines for providing high-quality family planning services.[1]

If implemented, the proposed rule would impose substandard care on those who rely on Title X–funded providers and services. Denying or delaying Title X patients' ability to obtain abortions jeopardizes the health and well-being of those who have decided to terminate their pregnancies in a number of ways, including: denying patients necessary information to appropriately compare the safety of their medical options; interfering with pregnant patients' ability to obtain additional services in a timely manner; and obstructing pregnant patients with complicating medical conditions from obtaining potentially life-saving abortions.[15] Similarly, dictating that all patients must be referred to "comprehensive health services providers" rather than allowing for referral to whatever provider best meets individual patients' unique needs, such as those offering specialized care, could cause further harm.

Moreover, and particularly troubling, the proposed rule stands to further entrench existing health disparities. Many who rely on Title X–funded providers and services are already marginalized and often facing other obstacles to obtaining care: two-thirds of Title X patients have incomes at or below the federal poverty limit (currently $12,140 annually for a single person[21]), 43% are uninsured, 13% have limited English proficiency, 30% identify with one or more nonwhite race categories and one-third identify as Hispanic or Latino.[3]

Forcing clinicians to sabotage the rapport and trust they have built with patients stands in sharp conflict with patients' right to self-determination. It may also cause patients to retreat, possibly from seeking health care for other needs; this may be particularly true for women of color, low-income women and others who have historically experienced coercive treatment in the context of reproductive health care.[22,23] In the words of former U.S. Senate Majority Leader George Mitchell in opposing a previous attempt by the Department to impose similar restrictions: "A society like ours, based upon the fundamental principle of equality, ought not tolerate, let alone encourage, even less insist upon a system in which there are two standards of care: One for the wealthy, the affluent, the powerful; and another, lower standard, for the poor."[24]

We urge the Department to rescind its proposed changes to the regulations at Sec. 59.5(a)(5) (which eliminate the requirement to provide nondirective pregnancy options counseling and referral upon request) and to rescind its proposed additions at Sec. 59.14 (which bars abortion referral and mandate

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[18] ACOG, Guidelines for Women's Health Care: A Resource Manual, fourth ed., Washington, DC: ACOG, 2014.
[19] American Academy of Physician Assistants, Guidelines for Ethical Conduct for the PA Profession, 2013, https://www.aapa.org/wp-content/uploads/2017/02/16-EthicalConduct.pdf.
[20] Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), AWHONN position statement: Health care decision making for reproductive care, *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 2016, 45(5):718, http://www.jognn.org/article/S0884-2175(16)30229-5/fulltext.
[21] Office of the Assistant Secretary for Planning and Evaluation, HHS, U.S. federal poverty guidelines used to determine financial eligibility for certain federal programs, 2017, https://aspe.hhs.gov/poverty-guidelines.
[22] SisterSong, National Latina Institute for Reproductive Health and Center for Reproductive Rights (CRR), *Reproductive Injustice: Racial and Gender Discrimination in U.S. Health Care*, New York: CRR, 2014, https://www.reproductiverights.org/document/reproductive-injustice-racial-and-gender-discrimination-in-us-health-care.
[23] Gold RB, Guarding against coercion while ensuring access: a delicate balance, *Guttmacher Policy Review*, 2014, 17(3): 8–14, https://www.guttmacher.org/gpr/2014/09/guarding-against-coercion-while-ensuring-access-delicate-balance.
[24] The Alan Guttmacher Institute, Bill to reauthorize Title X, overturn gag rule is sent to president, *Washington Memo*, New York: Guttmacher Institute, Sept. 22, 1992.

directive referral for prenatal care) and at Sec. 59.16 (which bars "activities that encourage, promote or advocate for abortion" and will have at least a chilling effect on abortion counseling).

If the Department does not rescind these changes and additions, we ask that it articulate the rationale behind its decision to prioritize an antiabortion agenda and the religious and moral objections of antiabortion providers over the medical and ethical importance of facilitating patients' informed decisions about their own reproductive health care—particularly in the context of a publicly funded program.

Similarly, we ask the Department to clarify its reasoning behind and inconsistent application of the standard that all pregnancy options counseling be nondirective.

We also ask the Department to clarify whether the proposed rule would, in practice, allow for unbiased, factual and comprehensive pregnancy options counseling that includes information on abortion.

Reducing Access to Care by Reshaping the Network of Providers

The proposed rule stands to drastically alter the types of agencies that receive Title X funding, which would fundamentally shift the program's intent and impact. Specifically, the proposed rule would: bar agencies that provide abortion; discourage participation by agencies that provide abortion counseling and referral; favor primary care–focused health centers over specialized reproductive health providers; and open the door to entities that provide an inadequate package of medical care. These moves would all significantly diminish patients' access to care. Moreover, they would fundamentally disregard the important role Title X providers play in their patients' lives as entry points into the healthcare system: For six in 10 women who obtain contraceptive care at a Title X–funded sites, that provider was their only source of medical care over the past year.[25]

Barring agencies that provide abortion

By imposing extensive physical and financial separation requirements, the proposed rule would effectively exclude from Title X any safety-net health center that provides abortion using non-federal funds. Specifically, Title X–funded entities would have to maintain separate accounting records, physical spaces (such as waiting and exam rooms, entrances, and exits), workstations, phone numbers, email addresses, staff, patient health records, educational programs, and signs. The Department seems willing to go even further, asking for public comment on whether these requirements are enough or if additional considerations should be added.

The proposed separation requirements would harm the people who rely on the Title X program for family planning services. Most immediately, these proposed requirements would directly impact the approximately one in 10 Title X sites that offer abortion using non-federal funds, including health centers operated by Planned Parenthood affiliates, and entities such as hospitals and independent agencies.[4] All of these sites—and potentially sites that do not offer abortion but are in some way

[25] Kavanaugh ML, Zolna MR and Burke K, Use of health insurance among clients seeking contraceptive services at Title X-funded facilities in 2016, Perspectives on Sexual and Reproductive Health, 2018, 50(3), https://www.guttmacher.org/journals/psrh/2018/06/use-health-insurance-among-clients-seeking-contraceptive-services-title-x.

affiliated with those that do so—could be barred from Title X. Losing these qualified providers from the program would put unrealistic expectations on other Title X sites, which are already stretching to meet their communities' needs and unable to readily fill such a gap. This would make it more difficult for people in many parts of the country to obtain high-quality, affordable family planning services.

This provision is a clear attempt to bar health centers operated by Planned Parenthood affiliates, a move that would have considerable ramifications and severely diminish women's access to care. Planned Parenthood health centers serve 41% of women who rely on Title X sites for contraceptive care.[26] In order to serve all the women who currently obtain contraceptive care at Title X–supported Planned Parenthood health centers nationwide, Guttmacher analyses estimate that other Title X sites would have to increase their client caseloads by 70%, on average (see Table 1, attached).[27] The impact would vary by state; without Title X–supported Planned Parenthood sites, other providers in 13 states would have to at least double their contraceptive client caseloads to maintain the program's current reach in their states.

In addition, research shows that Planned Parenthood sites are better able to deliver high-quality contraceptive care to greater numbers of women than other types of safety-net providers.[28] Planned Parenthood sites are particularly likely to offer same-day appointments and extended evening or weekend hours, and they have half the average wait times of all other types of safety-net providers.[4] Nearly all Planned Parenthood health centers offer the full range of FDA-approved reversible contraceptive methods, compared with about two-thirds of health departments and half of FQHCs. Planned Parenthood sites are also particularly likely to offer same-day insertion of IUDs and implants, on-site provision of oral contraceptives, and protocols to help patients initiate hormonal contraceptives immediately, regardless of where they are in their menstrual cycle. And, among Title X−funded sites, on average, Planned Parenthood health centers serve 3,340 contraceptive clients each year, compared with only 610 clients at health department sites and 750 clients at FQHC sites.[26]

The proposed separation requirements are unwarranted: Title X funds have been prohibited from going toward abortion services since the program's inception. Current regulations thoroughly operationalize that statutory requirement, and are not confusing to Title X-funded health centers. Furthermore, the Department fails to identify failures of compliance or other evidence sufficient to justify its proposed overhaul of the Title X network. Indeed, the Department bases its rationale for physical separation on "the appearance and perception that Title X funds being used in a given program may also be supporting that program's abortion activities," and the "potential for co-mingling and confusion."

The Department additionally hinges its proposed requirements on the argument that spending government money on family planning "frees up" private dollars to be used for abortion. That concept,

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[26] Frost JJ et al., *Publicly Funded Contraceptive Services at U.S. Clinics*, 2015, New York: Guttmacher Institute, 2017, https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015.

[27] Frost JJ and Zolna MR, Response to inquiry concerning the impact on other safety-net family planning providers of "defunding" Planned Parenthood, memo to Senator Patty Murray, Senate Health, Education, Labor and Pensions Committee, New York: Guttmacher Institute, June 15, 2017, https://www.guttmacher.org/article/2017/06/guttmacher-murray-memo-june-2017.

[28] Hasstedt K, Understanding Planned Parenthood's critical role in the family planning safety net, *Guttmacher Policy Review*, 2017, 20: 12–14, https://www.guttmacher.org/gpr/2017/01/understanding-planned-parenthoods-critical-role-nations-family-planning-safety-net.

referred to as "fungibility," is one that the Department is applying to abortion but not anywhere else.[29] The U.S. government has a long tradition of involving private-sector organizations in achieving its goals in areas like public health, social welfare and global development. For example, many billions of federal and state dollars go to religious organizations and charities every year, and, in fact, Title X dollars may go to religious organizations under the proposed rule. By the logic of fungibility, all of that money would free up private funding to proselytize or engage in other religious activities—something that would be have to be considered a violation of the U.S. Constitution's Establishment Clause, since it would indirectly subsidize religion.

In advancing this "fungibility" argument, the Department disingenuously utilizes Guttmacher analyses to justify its assertion that Title X–funded family planning services must be provided wholly apart from sites that also offer abortion, using non-federal funds. The preamble quotes at length from Guttmacher publications on Title X, citing these analyses as supposed proof that Title X funds support the physical "infrastructure" of sites that also provide abortions—and thereby abortions themselves.

This framing is inaccurate and misleading. The Guttmacher work cited in the preamble unambiguously refers to the basic and underlying infrastructure of the family planning safety net, the systems and activities necessary to providers' ability to deliver high-quality family planning services to those who need them. These investments include activities such as stocking contraceptive methods, training and paying staff, modernizing patient health records, covering brick-and-mortar costs, and engaging in outreach and education activities—all in direct service of sustaining the delivery of family planning care provided for under the statute, regulations and legislative mandates governing Title X.

Such expenditures are wholly appropriate uses of Title X funds. A 2009 panel convened by the Institute of Medicine to provide an independent evaluation of the Title X program "Title X grants are not limited to specific expenses but allow recipients flexibility to pay for overhead and infrastructure (facilities, equipment, information technology), staffing and staff training, supplies, and costs associated with needs assessments and reporting. This support is critical to keeping the clinics functioning and to meeting patients' needs."[30]

Moreover, the panel recommended that "Title X should receive the funds needed to fulfill its mission of providing family planning services to all who cannot obtain them through other sources and to finance such critical supplemental services as infrastructure, education, outreach, and counseling that many other financing systems do not cover. Consistent with legislative intent, financing for the program must also support research and evaluation, training, the development and maintenance of needed infrastructure, and the adoption of important new technologies."[31]

The proposed rule's preamble also highlights safety-net providers' need for the flexibility of Title X funds, particularly as the range of available contraceptive methods has expanded to meet patients' unique needs. The Department notes: "family planning projects are confronted with a variety of pharmacological, technological, or medical device options to consider in service delivery, with widely

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[29] Dreweke J, "Fungibility": the argument at the center of a 40-year campaign to undermine reproductive health and rights, *Guttmacher Policy Review*, 19:53–60, https://www.guttmacher.org/gpr/2016/10/fungibility-argument-center-40-year-campaign-undermine-reproductive-health-and-rights.

[30] Institute of Medicine, *A Review of the HHS Family Planning Program: Mission, Management, and Measurement of Results*, Washington, DC: The National Academies Press, 2009, https://www.nap.edu/read/12585/chapter/6#123.

[31] Institute of Medicine, *A Review of the HHS Family Planning Program: Mission, Management, and Measurement of Results*, Washington, DC: The National Academies Press, 2009, https://www.nap.edu/read/12585/chapter/2#14.

varying costs." However, the Department makes this observation in support of the erroneous conclusion that this means Title X providers should be given latitude to offer fewer rather than more contraceptive method options. In fact, the opposite is true: Title X funds' ability to cover those very costs is what enables the providers supported by the program to deliver patient-centered care that helps patients to choose from and obtain the best possible methods of contraception for them.[4]

We urge the Department to rescind the proposed rule, particularly Sec. 59.15 on physical and financial separation, and to eliminate language in the preamble that inaccurately cites Guttmacher analyses. We also urge against any further separation requirements.

Discouraging participation by agencies that provide abortion counseling and referral

In addition to barring Title X participation by providers who offer abortion, the proposed rule would likely lead to the exclusion of numerous other family planning providers. As noted above, the rule's proposed ban on abortion referral and its chilling effect (or possibly an effective ban) on abortion counseling are repudiations of ethical and professional standards around informed consent and have the potential to harm patients and undermine the patient-provider relationship. It is likely that many providers would deem it unethical and be unable to remain in Title X under these counseling and referral restrictions.

Similarly, the proposed restrictions on "activities that encourage, promote or advocate for abortion"—which include providing speakers or educators, attending conferences, paying membership dues, and developing or disseminating materials—are likely to have additional chilling effects on providers' willingness to participate in Title X. Collectively, the proposed restrictions are so broad and so vague that many providers may determine that Title X participation would put them in legal jeopardy.

The full impact of these restrictions on the Title X provider network and the patients who rely on them cannot be readily quantified in advance of the rules' implementation. However, it is clear that by dissuading dedicated, high-quality family planning providers from participating in Title X, these restrictions would make it more difficult for patients to receive the family planning care they need.

As noted above, we urge the Department to rescind its proposed changes to the regulations at Sec. 59.5(a)(5) and to rescind its proposed additions at Sec. 59.14 and Sec. 59.16.

Favoring primary care–focused sites over reproductive health–focused sites

The proposed rule requires Title X providers to "offer either comprehensive primary health services onsite or have a robust referral linkage with primary health providers who are in close physical proximity to the Title X site." In doing so, the rule displays a clear preference for funding sites that offer family planning services in the context of broader primary care, such as federally qualified health centers (FQHCs). Shifting funding to primary care–focused sites would inevitably come at the expense of safety-net centers focused on reproductive health.

This proposed provision represents an inappropriate emphasis on primary care services. It also poses considerable potential for confusion and abuse in the awarding of funds, as "close physical proximity" is left undefined.

Furthermore, the provision is unnecessary to promote referral and linkages between Title X and primary care. The current Title X regulations require Title X projects to "provide for coordination and use of referral arrangements with other providers of health care services, local health and welfare departments, hospitals, voluntary agencies, and health services projects supported by other federal programs."[32] Moreover, the national *Quality Family Planning* guidelines already emphasize the need for family planning providers to screen for numerous health issues (such as high blood pressure, diabetes and depression) and to establish referral arrangements both to and from other providers.[1] According to a recent Guttmacher Institute analysis, nearly all Title X-funded providers reported making referrals to other providers: 97% reported that they refer clients to other public providers and 90% reported that they refer clients to other private providers.[4]

Shifting funding from reproductive health–focused sites to primary care–focused sites would undermine the Title X network and its ability to care for patients. Title X has long relied on a robust and diverse network of safety-net providers operated by many different types of agencies—most of which specialize in providing reproductive health services.

Overall, 72% of Title X sites focus on reproductive health, including all of those operated by Planned Parenthood affiliates, and a majority of those operated by public health departments (81%), hospitals (70%), and other independent providers (86%).[33] Excluding sites operated by FQHCs, reproductive health–focused sites provide contraceptive care to an estimated 2.7 million women each year, or seven in 10 who rely on Title X for such services.[33,34]

Moreover—and further demonstrating that the proposed rule stands to impact providers far beyond Planned Parenthood—excluding reproductive health–focused sites would collectively impact 81% of centers operated by health departments, hospitals and other independent providers.[33] Together, these sites provide contraceptive care to an estimated 1.2 million women, or 32% of those relying on Title X–supported care.[33,34]

Denying people access to reproductive health–focused providers means denying many people access to providers they trust. Six in 10 women who choose reproductive health–focused providers for their contraceptive care do so even when there is a primary care–focused site available; for the remaining four in 10 of these women, that reproductive health–focused provider is their only source of care.[35] Top reasons women cite for this decision include feeling respected by staff, being able to obtain confidential services, and feeling that staff are well-versed in women's health. It is unacceptable for Title X patients to be denied their preferred, trusted source of care.

Moreover, reproductive health–focused providers are often able to offer more comprehensive and more timely family planning services to their patients. Compared with primary care–focused sites, those focused on reproductive health are more likely to offer the full range of reversible contraceptive

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[32] 42 CFR 59.5.

[33] Zolna MR and Frost JJ, special analysis of the Guttmacher Institute's 2015 Publicly Funded Family Planning Clinic Survey, https://www.guttmacher.org/report/publicly-funded-family-planning-clinic-survey-2015.

[34] Zolna MR and Frost JJ, special analysis of the Guttmacher Institute's 2015 Publicly Funded Family Planning Clinic Census, https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015.

[35] Frost J, Gold RB and Bucek A, Specialized family planning clinics in the United States: why women choose them and their role in meeting women's health care needs, *Women's Health Issues*, 2012, 22(6):519–525, https://www.guttmacher.org/article/2012/11/specialized-family-planning-clinics-united-states-why-women-choose-them-and-their.

methods; to offer same-day insertion of IUDs and implants; to offer supplies of oral contraceptives on-site; to use protocols that help patients start their contraceptive method quickly; and to offer advance provision of emergency contraceptive pills for a client to keep at home.[4]

Of course, primary care–focused sites and FQHCs specifically have become an increasingly integral part of the Title X provider network.[26] However, these providers serve far fewer contraceptive clients each year compared to sites that focus on reproductive health care, and Guttmacher analyses show that FQHC sites alone could not sustain the current reach of Title X: Nationwide, six in 10 report delivering contraceptive care to at least 10 women each year (the threshold to be counted among the nation's safety-net family planning centers).[36] If asked to serve all of the women who rely on many different types of providers for Title X–supported contraceptive care, these FQHC would have to at least double their contraceptive client caseloads in 41 states, and at least triple them in 27 states (see Table 2, attached).[36] Nationwide, this would add up to an additional 3.1 million contraceptive clients FQHCs would need to serve.

At the local level, there are Title X sites in just over 2,000 U.S. counties.[36] In 33% of these counties, there is no FQHC site providing contraceptive services, meaning women living there could lose access to Title X–supported services altogether. In another 47% of these counties, the FQHC sites that offer contraceptive care would have to at least double their contraceptive client caseloads in order to serve all of those currently served by other Title X sites. In 24% of all counties with a Title X site, FQHCs would have to serve at least six times their current number of contraceptive clients.

Put another way, 2.8 million (91%) of the contraceptive clients currently served by Title X–supported centers that are not FQHCs are in the 1,625 counties where FQHC sites would have to at least double their capacity, or where there is no FQHC site providing contraceptive care.[36]

FQHCs are already struggling to meet a rapidly increasing demand for services, and they do not—and cannot—specialize in reproductive health care. Expecting them to expand their capacity to serve millions of additional clients, and to consistently provide family planning services in a way comparable to reproductive health–focused providers, is unrealistic.[37] According to a 2017 national survey, FQHCs themselves report they could not handle large increases to their client caseloads; only 6% said they could sustain a caseload increase of 50% or greater, and the majority said they could increase their caseloads by at most 24%.[38] That is far below what Guttmacher's analysis projects those FQHCs would have to do in most states, if they were to take the entire Title X client load.

Moreover, a recent expert analysis has raised questions as to whether FQHCs could legally participate in Title X were the proposed rule to go into effect, which could result not only in no new FQHCs stepping into the gap left by excluding others from Title X, but in a departure of sites currently

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[36] Frost JJ and Zolna MR, Response to inquiry concerning the availability of publicly funded contraceptive care to U.S. women, memo to Senator Patty Murray, Senate Health, Education, Labor and Pensions Committee, New York: Guttmacher Institute, May 3, 2017, https://www.guttmacher.org/article/2017/05/guttmacher-murray-memo-2017.

[37] Hasstedt K, Federally qualified health centers: vital sources of care, no substitute for the family planning safety net, *Guttmacher Policy Review*, 2017, 20:67–72, https://www.guttmacher.org/gpr/2017/05/federally-qualified-health-centers-vital-sources-care-no-substitute-family-planning.

[38] Wood SF et al., *Community Health Centers and Family Planning in an Era of Policy Uncertainty*, Menlo Park, CA: Kaiser Family Foundation, 2018, https://www.kff.org/report-section/community-health-centers-and-family-planning-in-an-era-of-policy-uncertainty-report/.

receiving Title X from the program.[39] Indeed, the National Association of Community Health Centers has stated its grave concerns with the proposed rule, urging the Department to withdraw it.[40]

We urge the Department to rescind its proposed addition at Sec. 59.2(a)(12), which unduly emphasizes primary health services.

Funding sites that provide an inadequate package of care

By drastically altering the scope and purpose of the services Title X can support, and by pointedly undermining patients' right to informed consent in their own health care, the proposed rule opens the door for organizations and programs to receive Title X funds despite providing inadequate medical care. The preamble further illustrates the Department's intent, stating it hopes these changes will engage entities "that refuse to provide abortion counseling and referrals," those that serve "patients who seek providers who share their religious or moral convictions," and "specialized, single-method [natural family planning] service sites."

Sites that offer only a single contraceptive method have always been permitted as part of a Title X project, as long as the project overall makes a broad range of methods available to clients. However, the preamble's explicit invitation to single-method sites, its emphasis on natural family planning in particular, and its call for particular applicants seem to open the door to entities like antiabortion counseling centers (or "crisis pregnancy centers"). Those entities most commonly do not have any medical staff and are not able or willing to provide many or all modern and FDA-approved methods of contraception. The proposed rule also suggests the Department's interest in funding abstinence-only-until-marriage programs, an intent put forward in the fiscal year 2018 funding opportunity announcement.

Collectively, these proposed changes herald a sharp and concerning shift away from the fundamental purpose of the Title X program, which is to offer access to a broad range of family planning methods and services. Entities such as antiabortion counseling centers and abstinence-only programs approach family planning in a way that actively undermines Title X's core tenets of ensuring patients' contraceptive choices are voluntary and free from coercion. Moreover, shifting Title X dollars to such entities—and away from qualified health care providers that are able and equipped to provide comprehensive, patient-centered contraceptive and related services—would jeopardize individuals' ability to obtain such care, and advance an unacceptably coercive agenda on Title X patients.

We urge the Department to reconsider and rescind this redirection of Title X funds and programming.

Infringing on Patient Confidentiality

The proposed rule threatens the Title X program's strong, decades-old protections for patient confidentiality, particularly for adolescent clients. It has the potential to do so in two main ways: by instituting increased and inappropriate pressure on Title X providers and their clients—particularly

[39] Rosenbaum S et al., The Title X family planning proposed rule: what's at stake for community health centers? *Health Affairs* Blog, June 25, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180621.675764/full/.

[40] National Association of Community Health Centers, New: NACHC statement regarding the proposed rule for Title X funding, 2018, http://www.nachc.org/news/new-nachc-statement-regarding-the-proposed-rule-for-title-x-funding/.

adolescents—to involve family members in their family planning decision-making, and by improperly inserting the Secretary into the enforcement of state reporting laws.

The Title X statute encourages familial involvement in family planning decisions "to the extent practicable," but does not mandate such involvement. The proposed rule disregards this important statutory limitation. Sec. 59.2 of the proposed rule adds a requirement that Title X providers document in the medical records of unemancipated minors "the specific actions taken by the provider to encourage the minor to involve her/his family (including her/his parents or guardian) in her/his decision to seek family planning services." Without this documentation (and putting aside an extremely limited exception for circumstances where child abuse or incest is suspected), an unemancipated minor would appear to be barred from receiving confidential services for free. In addition, Sec. 59.5(a)(14) requires Title X projects to ensure that the records for every minor "document the specific actions taken to encourage such family participation (or the specific reason why such family participation was not encouraged)."

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. In these situations, clinicians should not be required to take "specific actions" to encourage the minor to do so (and then document those specific actions) as the proposed rule requires. Doing so would violate medical ethics, and could deter adolescent clients concerned about maintaining their confidentiality from seeking needed family planning services.[41]

On the subject of reporting requirements, Title X projects are required by law to comply with state law requiring notification or reporting of child abuse, child molestation, sexual abuse, rape, and incest. Clinicians providing services in Title X-funded already abide by and make reports in compliance with state and local reporting obligations. Appropriately, states and localities are charged with determining providers' compliance with these laws.

Sec. 59.17 of the proposed rule expands these reporting requirements to include intimate partner violence and human trafficking. It also may dramatically expand the Department's authority to substitute its own judgment for that of the responsible state or locality: It would require Title X projects to provide "appropriate documentation or other assurance satisfactory to the Secretary" that it has met compliance requirements, and gives the Secretary the authority to review records "for the sole purpose of determining compliance" with reporting obligations. Such expanded authority on the part of the Department and Secretary would be inappropriate, and the threat of revoking Title X funding may result in harmful over-reporting on the part of providers.

Further, Sec. 59.17 creates a problematic and entirely new requirement that requires providers to "conduct a preliminary screening of any teen" who has an STI or is pregnant "to rule out victimization." It is unclear whether this provision is to be applied to minors (those under the age of consent, or 18 years old) or to all teens, which would include 18- and 19-year old young adults who are not subject to child abuse reporting laws. Regardless, this requirement is an unnecessary step beyond

[41] Fuentes L et al., Adolescents' and young adults' reports of barriers to confidential health care and receipt of contraceptive services, *Journal of Adolescent Health*, 2018, 62(1):36–43, https://www.guttmacher.org/article/2017/11/adolescents-and-young-adults-reports-barriers-confidential-health-care-and-receipt.

federal and state reporting requirements—one that stigmatizes sexually active adolescents and could discourage them from seeking the care they need.

Collectively, these proposed changes stand to undermine Title X's long-standing commitment to patient confidentiality. Indeed, Title X's longstanding and strong confidentiality protections are cited by patients as an important reason for seeking care at Title X–supported sites.[35,42] The Department's proposed rule demonstrates distrust in providers' professional judgment and would harm the provider-patient relationship by turning health care providers into interrogators. Furthermore, the proposed changes could stigmatize adolescents who are sexually active, lead them to withhold information from providers, discourage them from seeking care they need and potentially make care unaffordable for them. Ultimately, that would undermine patients' health and safety.

We urge the Department to rescind its proposed changes at 59.2 (regarding free care for unemancipated minors), 59.5(a)(14) (regarding documentation of family participation), 59.11 (adding new language expressing distrust in providers' judgement around confidentiality and reporting) and 59.17 (expanding requirements around potential abuse of minors).

Diverting Already-Inadequate Program Resources

The proposed rule would explicitly enable, and may in fact require, Title X–funded entities to provide free contraceptive care to patients whose employer-based insurance does not cover contraception without cost-sharing because of the employer's religious or moral opposition. This represents a radical and unjustified expansion of eligibility for free or reduced-cost services under Title X that could be costly and difficult for providers to implement.

The statute requires that priority for Title X–funded services be given to "persons from low-income families," and that services be free for those individuals, "except to the extent that payment will be made by a third-party payer." Long-standing regulations define "low-income" as an individual or household whose income is at or below the federal poverty level, and further provide that patients whose incomes are between 100% and 250% of the poverty level receive services discounted on a sliding fee scale. The statute gives the Secretary authority to define "low-income," explaining that definition should "insure that economic status shall not be a deterrent to participation in the program."

At a minimum, the proposed rule would allow Title X sites to deliver contraceptive methods and counseling free of charge (as opposed to on a sliding fee scale) to individuals who have insurance through their employer, but whose employer denies such coverage under exemptions from the Affordable Care Act's (ACA) contraceptive coverage guarantee. The proposed rule states these individuals "can" be considered low-income for purposes of eligibility under Title X, and the preamble states the rule would provide "free or low-cost family planning services for such women."

It is also seems possible the proposed rule intends to not just allow, but mandate, that all of these individuals receive care for free. The preamble explains "this proposed rule would amend the definition of 'low-income family' to include women who are unable to obtain certain family planning services under their employer-sponsored health insurance policies." By definition, "low-income" individuals are to receive free care under Title X. Moreover, because the ACA's contraceptive coverage guarantee

[42] English A, Adolescent confidentiality protections in Title X, June 5, 2014, https://www.nationalfamilyplanning.org/document.doc?id=1559.

promises contraceptive methods, services and counseling without additional out-of-pocket costs, it seems any proposed "substitute" would be expected to deliver similarly free care.

Regardless of whether these individuals are to receive free or reduced-cost services, Title X is simply not intended to—nor can it—meet the needs of insured individuals with incomes above 250% of poverty. The proposed change is not in keeping with the statutory requirement that the Secretary define eligibility for free services based on individuals' "economic status." Rather, it seems intended to fill a gap the Department itself is creating, by drastically expanding exemptions to the ACA's contraceptive coverage guarantee.[43] This would redirect limited Title X funding away from helping to deliver affordable contraceptive care to the low-income individuals who need it, and whom Congress clearly intended the Title X program to prioritize and support.

Title X funding is already not able to keep pace with that need: According to Guttmacher's most recent estimates, in 2014, Title X–funded providers were able to meet only 19% of the need for publicly funded contraceptive care.[44] This is a marked decline from previous years, likely due in part to reductions in Title X funding—and therefore providers' capacity to meet the need for care—and to increasing proportions of individuals with health insurance coverage, specifically for contraceptive care without additional cost-sharing, under the ACA.

It is unclear how many of those insured individuals would look to Title X for free care under the proposed rule, as the Department has not implemented any mechanism to track which organizations avail themselves of the exemption from the ACA's contraceptive coverage guarantee, or how many enrollees and dependents would be affected by those exemptions.[43] Thus, it is not feasible for the Department to appropriately estimate the economic impact of this provision of the proposed rule, nor to appropriately request and allocate funds in response to this type of new demand for Title X–funded services.

Implementing this new definition would also likely prove difficult and costly for service providers. They would have no clear way to determine eligibility for free or reduced-cost services, because employers objecting to contraceptive coverage are not required to report their use of the exemption to the Department. Moreover, if the Department intends for some services to be delivered at "low cost" (rather than free) as stated in the preamble, it is unclear how Title X–funded sites would be expected to implement a sliding fee scale for these individuals, many of whom likely earn more than 250% of poverty.

We urge the Department to rescind this expanded definition of "low income family" in Sec. 59.2 and to abandon its effort to divert Title X resources to fix a problem of its own creation.

If the Department does not rescind these changes, we ask the Department to clarify whether it intends for all individuals affected by exemptions from the ACA's contraceptive coverage guarantee to be provided free contraceptive methods, services and counseling by all Title X–funded sites, in all circumstances.

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[43] Sonfield A, Despite leaving key questions unanswered, new contraceptive coverage exemptions will do clear harm, *Health Affairs* Blog, Oct. 17, 2017, https://www.guttmacher.org/article/2017/10/despite-leaving-key-questions-unanswered-new-contraceptive-coverage-exemptions-will.

[44] Frost JJ, Frohwirth LF and Zolna MR, *Contraceptive Needs and Services, 2014 Update,* New York: Guttmacher Institute, 2016, https://www.guttmacher.org/report/contraceptive-needs-and-services-2014-update.

We further ask the Department to specify how it would appropriately allocate funding based on this additional demand. And we ask the Department to specify how Title X providers would be expected to implement this requirement, including how they would be expected to verify that a prospective patient's employer-based insurance is in fact refusing to cover contraceptive care.

Underestimating the Economic Impact of the Proposed Rule

The Department claims that the proposed rule would not be "economically significant," meaning that it would not have an impact of $100 million or more in any one year. It makes similar claims around whether the rule would be an unfunded mandate for state, local or tribal governments or the private sector (with a $150 million threshold). We believe the Department is dramatically underestimating the potential economic costs of the proposed rule, has not properly conducted the required analyses to make those estimates, and has not shown sufficient data to support its contentions that the proposed rule would not be economically significant or constitute an unfunded mandate.

According to Guttmacher Institute estimates from 2010 (the most recent year for which these data are available), the services provided within the Title X network saved approximately $7 for every public dollar invested, by helping patients avoid unintended pregnancies, STIs, cervical cancer and other health outcomes that have costs for Medicaid and other public health programs.[45] This amounted to an estimated $7 billion in net federal and state government savings in a single year. The $100 million threshold for the rule to be economically significant would amount to only 1.4% of this $7 billion in savings to federal and state governments. The $150 million threshold for unfunded mandates would amount to only 2.1% of $7 billion.

Available data suggests the proposed rule would result in far more than 2% of Title X's contraceptive clients losing access to the comprehensive, high-quality services they need to avoid unintended pregnancies, STIs, cervical cancer, and other negative and potentially costly health outcomes.

For example, the proposed rules seems designed to make it impossible for sites affiliated with Planned Parenthood to participate in Title X. As noted above, Planned Parenthood sites currently serve 41% of women who rely on Title X sites for contraceptive care and other Title X sites would have to dramatically increase their client loads in order to compensate for the loss of Planned Parenthood.[27] In many areas, that simply would not be possible: According to a 2016 nationally representative survey of clients at Title X–funded health centers, 24% percent of clients at a Planned Parenthood site reported that it was the only place they could get the services they need.[25] It is difficult if not impossible to imagine a scenario where the loss of Planned Parenthood from the Title X network does not result in an economic impact that is many times greater than $100 million per year.

Similarly, the proposed rule would directly bar participation in Title X by entities that offer abortion with non–Title X dollars. In 2015, 10% of Title X–supported sites offered medication or surgical abortion with non-Title X funds.[33] Losing those sites alone from the Title X network could have an economic impact well above the $100 million threshold, if the Department reallocated the Title X grant money to entities that do not provide high-quality, comprehensive contraceptive care.

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[45] Frost JJ et al., Return on investment: a fuller assessment of the benefits and cost savings of the US publicly funded family planning program, *Milbank Quarterly*, 2014, 92(4):696–749, http://onlinelibrary.wiley.com/enhanced/doi/10.1111/1468-0009.12080/.

In addition, the proposed rules would clearly disadvantage reproductive health–focused providers in the allocation of Title X grants. These reproductive health–focused sites include 81% of Title X–funded sites operated by health departments, hospitals and other independent providers.[33] Collectively, these 1,840 sites provide contraceptive care to an estimated 1.2 million women, or 32% of those who look to Title X for such services. [33,34] Again, the loss of these sites from the Title X network could easily have an economic impact well in excess of $100 million, assuming that the Department instead funded entities that lower quality and less-comprehensive contraceptive care.

More broadly, 21% of Title X sites are in counties that do not have another safety-net family planning center (see Table 3, attached). Moreover, in 21% of all 3,142 U.S. counties, a Title X site is the only safety-net family planning center. Many of these sites may end up losing Title X funding under the proposed rule—for instance, because they cannot or will not comply with rule's unethical restrictions on abortion counseling and referral or its efforts to undermine patient confidentiality, or because the Department uses the rule as a means of funneling Title X funds toward unqualified entities such as antiabortion pregnancy centers.

We urge the Department to conduct proper, thorough analyses of the proposed rule's economic significance and its potential to create an unfunded mandate, as required by federal law.

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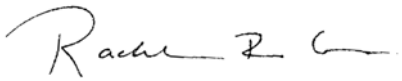
In sum, the proposed rule seeks to: impose unwarranted and harmful requirements for the separation of Title X–supported family planning from abortion services, impose substandard care on some of our nation's most marginalized communities, and fundamentally subvert the very purpose of the Title X program. We strongly urge the Department to rescind the proposed rule in its entirety.

If you need additional information about the issues raised in this letter, please contact Kinsey Hasstedt in the Institute's Washington office. She may be reached by phone at 202.296.4012, or by email at khasstedt@guttmacher.org.

Thank you for your consideration.

Sincerely,



Rachel Benson Gold
Vice President for Public Policy

Table 1. Estimated impact on contraceptive client caseload among other types of Title X–funded centers if there were no Title X–funded Planned Parenthood centers, by state, 2015

State	Contraceptive clients served at Title X–funded centers:			% increase in contraceptive client caseload among non–Planned Parenthood Title X–funded centers if there were no Title X–funded Planned Parenthood centers*
	Number served at all centers	Number served at Planned Parenthood centers	% served at Planned Parenthood centers	
Alabama	86,180	0	0%	0%
Alaska	5,290	3,360	64%	174%
Arizona	31,820	16,750	53%	111%
Arkansas	51,510	4,590	9%	10%
California	1,014,320	704,630	69%	228%
Colorado	50,280	0	0%	0%
Connecticut	46,790	41,330	88%	757%
Delaware	13,480	4,200	31%	45%
District of Columbia	30,750	0	0%	0%
Florida	149,950	11,020	7%	8%
Georgia	59,450	0	0%	0%
Hawaii	19,750	960	5%	5%
Idaho	12,610	660	5%	6%
Illinois	119,730	50,340	42%	73%
Indiana	30,750	9,640	31%	46%
Iowa	35,970	19,360	54%	117%
Kansas	25,530	1,800	7%	8%
Kentucky	47,950	3,260	7%	7%
Louisiana	40,580	0	0%	0%
Maine	18,200	7,060	39%	63%
Maryland	67,410	26,390	39%	64%
Massachusetts	72,150	19,160	27%	36%
Michigan	67,250	40,520	60%	152%
Minnesota	61,280	43,400	71%	243%
Mississippi	46,920	0	0%	0%
Missouri	56,540	22,720	40%	67%
Montana	18,090	7,720	43%	74%
Nebraska	22,520	6,570	29%	41%
Nevada	10,310	0	0%	0%
New Hampshire	17,680	8,210	46%	87%
New Jersey	82,950	59,530	72%	254%
New Mexico	22,900	0	0%	0%
New York	275,510	144,640	52%	111%
North Carolina	111,010	12,860	12%	13%
North Dakota	9,620	0	0%	0%
Ohio	76,580	44,290	58%	137%
Oklahoma	56,290	8,520	15%	18%
Oregon	48,990	20,000	41%	69%
Pennsylvania	169,700	65,280	38%	63%

Table 1. Estimated impact on contraceptive client caseload among other types of Title X–funded centers if there were no Title X–funded Planned Parenthood centers, by state, 2015

State	Contraceptive clients served at Title X–funded centers:			% increase in contraceptive client caseload among non–Planned Parenthood Title X–funded centers if there were no Title X–funded Planned Parenthood centers*
	Number served at all centers	Number served at Planned Parenthood centers	% served at Planned Parenthood centers	
Rhode Island	25,510	6,190	24%	32%
South Carolina	73,500	0	0%	0%
South Dakota	7,750	0	0%	0%
Tennessee	88,420	3,940	4%	5%
Texas	163,980	29,960	18%	22%
Utah	35,570	30,120	85%	553%
Vermont	8,200	8,200	100%	§
Virginia	70,320	3,460	5%	5%
Washington	82,520	66,210	80%	406%
West Virginia	46,680	660	1%	1%
Wisconsin	30,850	24,240	79%	367%
Wyoming	9,790	0	0%	0%
Total	**3,827,650**	**1,581,760**	**41%**	**70%**

*Percentage increase takes into account the additional number of clients that existing sites would need to serve if there were no Title X–funded Planned Parenthood centers. §In 2015, there were no non-Planned Parenthood Title X–funded centers in the state.

Notes: Counts may not sum to total due to rounding. For more detailed information on how many additional contraceptive clients other Title X–funded centers would have to serve, by type of center and by state, see Table 2 here: https://www.guttmacher.org/article/2017/06/guttmacher-murray-memo-june-2017.

Source: Zolna MR and Frost JJ, special analysis of the Guttmacher Institute's 2015 Publicly Funded Family Planning Clinic Census, https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015.

Table 2. Summary data on numbers of contraceptive clients served at Title X–funded centers and at Federally Qualified Health Center (FQHC) sites, and level of increased capacity needed among FQHCs in order to serve all contraceptive clients obtaining care at non–FQHC Title X–funded centers, all by state, 2015

State	Number of contraceptive clients served at Title X–funded centers:		Number of contraceptive clients served at all FQHCs (Title X and not Title X–funded):		% increase in contraceptive client caseload among FQHCs if serving all Title X clients*
	All	Not FQHC	Current caseload	Caseload if serving all Title X clients	
Alabama	86,200	78,900	16,860	95,760	468%
Alaska	5,290	5,290	8,850	14,140	60%
Arizona	31,820	28,080	31,060	59,140	90%
Arkansas	51,560	51,510	3,410	54,920	1521%
California	1,014,340	772,160	600,420	1,372,580	129%
Colorado	50,320	37,310	36,060	73,370	103%
Connecticut	46,800	41,710	18,260	59,970	228%
Delaware	13,480	10,350	3,460	13,810	299%
District of Columbia	30,750	-	31,460	31,460	0%
Florida	149,970	130,340	65,570	195,910	199%
Georgia	59,450	7,090	64,110	71,200	11%
Hawaii	19,750	3,000	17,380	20,380	17%
Idaho	12,640	12,610	5,200	17,810	243%
Illinois	119,750	75,790	106,620	182,410	71%
Indiana	30,760	17,620	28,430	46,050	62%
Iowa	35,980	33,000	7,580	40,580	437%
Kansas	25,570	25,530	6,770	32,300	378%
Kentucky	48,010	43,060	21,280	64,340	202%
Louisiana	40,620	40,030	16,240	56,270	247%
Maine	18,210	15,460	6,950	22,410	223%
Maryland	67,440	58,290	25,950	84,240	225%
Massachusetts	72,160	46,720	50,870	97,590	92%
Michigan	67,240	64,600	26,660	91,260	242%
Minnesota	61,300	61,280	8,580	69,860	714%
Mississippi	46,970	41,920	13,190	55,110	318%
Missouri	56,540	51,290	22,590	73,880	227%
Montana	18,110	15,090	6,120	21,210	247%
Nebraska	22,530	16,180	9,490	25,670	171%
Nevada	10,340	10,060	2,740	12,800	369%
New Hampshire	17,660	12,480	6,990	19,470	179%
New Jersey	82,970	68,600	35,480	104,080	193%
New Mexico	22,930	19,320	15,660	34,980	123%
New York	275,540	228,500	149,120	377,620	153%
North Carolina	111,040	108,380	16,970	125,350	639%
North Dakota	9,620	9,620	840	10,460	1144%
Ohio	76,630	74,700	34,080	108,780	219%
Oklahoma	56,300	55,720	8,270	63,990	676%
Oregon	49,020	39,500	23,760	63,260	166%
Pennsylvania	169,710	146,370	47,600	193,970	308%

Table 2. Summary data on numbers of contraceptive clients served at Title X–funded centers and at Federally Qualified Health Center (FQHC) sites, and level of increased capacity needed among FQHCs in order to serve all contraceptive clients obtaining care at non–FQHC Title X–funded centers, all by state, 2015

State	Number of contraceptive clients served at Title X–funded centers:		Number of contraceptive clients served at all FQHCs (Title X and not Title X–funded):		% increase in contraceptive client caseload among FQHCs if serving all Title X clients*
	All	Not FQHC	Current caseload	Caseload if serving all Title X clients	
Rhode Island	25,520	7,150	21,600	28,750	33%
South Carolina	73,540	73,500	19,250	92,750	381%
South Dakota	7,770	4,850	3,930	8,780	124%
Tennessee	88,470	88,130	18,720	106,850	472%
Texas	163,990	140,680	98,520	239,200	143%
Utah	35,560	35,570	6,070	41,640	586%
Vermont	8,210	8,200	4,470	12,670	184%
Virginia	70,430	68,210	10,660	78,870	643%
Washington	82,510	75,420	39,360	114,780	192%
West Virginia	46,700	19,180	35,930	55,110	53%
Wisconsin	30,860	30,850	13,300	44,150	232%
Wyoming	9,800	6,930	3,690	10,620	188%
Total	**3,827,650**	**3,116,100**	**1,875,710**	**4,991,810**	**166%**

*Percentage increase takes into account the additional number of clients that existing FQHC sites would need to serve if there were no Title X–funded centers.

Notes: Counts may not sum to total due to rounding. FQHC=federally qualified health center site that served at least 10 contraceptive clients. For more detailed information on how many additional contraceptive clients FQHC sites would have to serve, see table 4 here: https://www.guttmacher.org/article/2017/05/guttmacher-murray-memo-2017.

Source: Zolna MR and Frost JJ, special analysis of the Guttmacher Institute's 2015 Publicly Funded Family Planning Clinic Census, https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015.

Table 3. Total number of Title X–funded centers and number that are in counties with no other publicly funded provider, and total number of U.S. counties and number with only Title X–funded centers, by state, 2015

State	Number of Title X–funded centers:		Number of U.S. counties:	
	All	In counties with no other provider	All	With at least one Title X–funded center and no other provider
Alabama	83	18	67	17
Alaska	5	0	29	0
Arizona	36	0	15	0
Arkansas	92	35	75	32
California	353	1	58	1
Colorado	64	13	64	12
Connecticut	20	0	8	0
Delaware	38	10	3	1
District of Columbia	23	0	1	0
Florida	142	12	67	9
Georgia	125	0	159	0
Hawaii	32	0	5	0
Idaho	33	10	44	10
Illinois	95	16	102	14
Indiana	33	10	92	10
Iowa	47	25	99	22
Kansas	63	47	105	46
Kentucky	128	73	120	70
Louisiana	67	13	64	12
Maine	43	6	16	2
Maryland	77	5	24	5
Massachusetts	90	1	14	1
Michigan	94	18	83	17
Minnesota	40	15	87	12
Mississippi	106	34	82	25
Missouri	79	20	115	18
Montana	26	7	56	6
Nebraska	28	13	93	13
Nevada	17	1	17	1
New Hampshire	22	4	10	3
New Jersey	49	3	21	3
New Mexico	65	3	33	3
New York	175	24	62	14
North Carolina	120	36	100	33
North Dakota	16	12	53	11
Ohio	78	21	88	20
Oklahoma	103	25	77	22
Oregon	81	8	36	6
Pennsylvania	169	21	67	15
Rhode Island	22	1	5	1
South Carolina	59	5	46	5
South Dakota	33	19	66	18

Table 3. Total number of Title X–funded centers and number that are in counties with no other publicly funded provider, and total number of U.S. counties and number with only Title X–funded centers, by state, 2015

State	Number of Title X–funded centers:		Number of U.S. counties:	
	All	In counties with no other provider	All	With at least one Title X–funded center and no other provider
Tennessee	129	37	95	30
Texas	96	14	254	13
Utah	14	0	29	0
Vermont	10	1	14	1
Virginia	135	53	133	51
Washington	64	10	39	6
West Virginia	146	45	55	20
Wisconsin	19	10	72	10
Wyoming	16	8	23	8
Total	**3,700**	**763**	**3,142**	**649**

Notes: For more detailed information on numbers and types of clinics and clients by state and county, see: https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015.

Source: Zolna MR and Frost JJ, special analysis of the Guttmacher Institute's 2015 Publicly Funded Family Planning Clinic Census, https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015.