Planned Parenthood Federation of America, Inc.

May 17, 2021

VIA ELECTRONIC TRANSMISSION

Xavier Becerra, Secretary of Health and Human Services
Attention: Title X Rulemaking
Office of Population Affairs, Office of the Assistant Secretary for Health
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

Re: RIN 0937-AA11 Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services

Dear Secretary Becerra,

Planned Parenthood Federation of America (Planned Parenthood) submits these comments in response to the notice of proposed rulemaking (Proposed Rule) issued by the U.S. Department of Health and Human Services (Department) entitled "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services."[1]

The Proposed Rule concerns the Title X family planning program. Since its inception five decades ago, the Title X program has been an extraordinary success, serving to ensure that all individuals have access to vital family planning care, regardless of where they live or their economic means. For almost all of those 50 years, the Title X program operated under essentially one set of rules—in particular, those ensuring that pregnant patients have the opportunity to receive nondirective counseling on all their medical options, including abortion. A 2019 rulemaking issued by the Trump Administration, however, imposed drastic changes on the program—among other things, harmfully restricting the information Title X providers may give their pregnant patients—and resulted in grave public health consequences, just as all major medical associations warned it would do. Moreover, Planned Parenthood's affiliates, among many other providers, were forced out of the program as a result of that rule. In the Proposed Rule, the Department seeks to return to the regulations that governed the program for virtually its entire history, "with several modifications."[2]

Planned Parenthood strongly supports the Proposed Rule. The Department rightly seeks to return Title X to a regime that recognizes the importance of full, open communication between a patient and provider—a fundamental tenet of medical ethics.

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[1] Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services, 86 Fed. Reg. 19,812 (proposed Apr. 15, 2021).

[2] *Id.* at 19,818.

We applaud the Department for working to ensure access to "equitable, affordable, client-centered, quality family planning services for all clients, especially for low income clients," and welcome proposed modifications that will "strengthen" the Title X program.[3] We propose several changes, however, to ensure the provision of Title X care in accordance with the program's central mission—client-centered family planning care, regardless of economic circumstances. In sum, we are eager to see the program restored and improved, to see the 2019 rulemaking's changes antithetical to client care discarded, and to rejoin a resumed and reinvigorated Title X program.

BACKGROUND

Planned Parenthood, through its affiliates, is the nation's leading sexual and reproductive health care provider and advocate and is a trusted, nonprofit source of primary and preventive care for women, men, and young people in communities across the United States. Each year, Planned Parenthood's approximately 600 health centers provide affordable birth control, lifesaving cancer screenings, testing and treatment for sexually transmitted infections (STIs), and other essential care to 2.4 million patients. Planned Parenthood also provides abortion services—outside the Title X program—and ensures that patients have accurate information about all their sexual and reproductive health care options. One in five women in the United States has visited a Planned Parenthood health center. The majority of Planned Parenthood patients have incomes at or below 150% of the federal poverty level.

Before being forced out of the Title X program as a result of the 2019 rulemaking, Planned Parenthood affiliates had participated in the program since its inception over 50 years ago. Planned Parenthood was the largest Title X provider, serving 40% of the 4 million patients who received care through the program every year.

A. The 2019 Rule And Resulting Litigation

Despite the success of the Title X program under a regulatory framework largely unchanged for decades, in 2019, the Trump Administration issued a rulemaking that altered the program in drastic ways and, as a direct result, forced nearly 1000 health centers, including Planned Parenthood affiliates and others, out of the Title X program.[4] This action slashed the Title X network's capacity to serve patients with low incomes nearly in half.[5]

The 2019 Rule requires that Title X providers withhold certain information about abortion from pregnant patients—even if the patient wants that information; and it requires providers to force information about non-abortion options onto patients—even if

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[3] *Id.* at 19,812.

[4] *See generally* Compliance With Statutory Program Integrity Requirements, 84 Fed. Reg. 7714 (Mar. 4, 2019) (codified at 42 C.F.R. pt. 59) (2019 Rule).

[5] Ruth Dawson, *Trump Administration's Domestic Gag Rule Has Slashed the Title X Network's Capacity by Half*, Guttmacher Institute (Feb. 26, 2020), https://www.guttmacher.org/article/2020/02/trump-administrations-domestic-gag-rule-has-slashed-title-x-networks-capacity-half.

a patient does not want or need that information (the gag requirement). It also imposes burdensome and unnecessary physical separation requirements on Title X providers, mandating that providers establish separate facilities and employ duplicative personnel and medical records if they engage in virtually any abortion-related activity outside the Title X program (the separation requirement).

The comments in opposition to the 2019 Rule were extensive and unequivocal about its many flaws. Planned Parenthood submitted a detailed comment urging the Department to withdraw the proposed rule on numerous grounds—including that it would contravene the ethical and professional commitments of health care providers, and would create major gaps in access to care by forcing many providers, including Planned Parenthood, out of the Title X program. Yet the Department adopted the 2019 Rule in largely identical form to what it originally proposed.

Planned Parenthood—together with the American Medical Association and others—therefore filed suit in the United States District Court for the District of Oregon, challenging the 2019 Rule as contrary to law because, among other flaws, the 2019 Rule violated the Title X appropriations act—which requires that "all pregnancy counseling" under Title X "shall be nondirective," Pub. L. No. 116-94, Div. A, tit. II, 133 Stat. 2534, 2558 (2019)—as well as the Affordable Care Act, 42 U.S.C. §18114. Moreover, it interfered with providers' ethical responsibilities, undermined Title X's goal of providing comprehensive family-planning services to people with low incomes, and ignored the clear evidence that the 2019 Rule would have an adverse impact on the public health—and thus was arbitrary and capricious. As the administrative record made clear, the 2019 Rule would undermine access to reproductive health care, resulting in higher rates of unintended pregnancies and higher rates of STIs, among other harms.

Planned Parenthood secured a preliminary injunction against the 2019 Rule, allowing its affiliates to remain in the Title X program. In no uncertain terms, the district court concluded that the 2019 Rule was likely unlawful in numerous ways and harmful to public health. As the district court found:

> The harms … are extensive and are not rebutted by the government. A review of the scores of declarations from public health policy experts, medical organizations, doctors, and Title X providers lead to the inescapable conclusion that the [2019 Rule] will result in negative health outcomes for low income women and communities. It will result in less contraceptive services, more unintended pregnancies, less early breast cancer detection, less screening for cervical cancer, less HIV screening, and less testing for sexually transmitted disease.[6]

[6] *Oregon v. Azar*, 389 F. Supp. 3d 898, 903 (D. Or. 2019).

But a divided Ninth Circuit Court of Appeals ultimately stayed, and then vacated, the preliminary injunction, allowing the 2019 Rule's enforcement.[7] As a result, Planned Parenthood affiliates were forced to withdraw from the Title X program after 50 years of participation—rather than contravene their providers' ethical and professional obligations to convey complete, accurate, and unbiased health care information consistent with patient preferences.[8]

B. The Proposed Rule

On April 15, 2021, following the inauguration of President Biden, the Department published the Proposed Rule, entitled "Ensuring Access to Equitable, Affordable, Client-Centered, Qualify Family Planning Services."[9] The Proposed Rule unravels the many harmful elements of the 2019 Rule that "undermined the public health of the population the program is meant to serve."[10] In particular, the Proposed Rule rejects the 2019 Rule's gag requirement. As the Department explained, the gag requirement "abandoned" the proper client-centered approach to provide nondirective options counseling—"over the objection of every major medical organization without any countervailing public health rationale."[11] Moreover, "the 2019 rule required prenatal referral even over the objection of the patient."[12] "[T]hat approach," the Department concluded, "cannot be squared with well-accepted public health principles."[13] Thus, consistent with essentially the entire history of the Title X program, the Proposed Rule "allow[s] Title X providers to refer their patients for all family planning related services desired by the client, including abortion services."[14] The Proposed Rule also rejects the separation requirement as a "burdensome additional requirement[]" that failed to "provide discernible compliance benefits" or benefits to public health.[15]

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7 *California v. Azar*, 950 F.3d 1067, 1082, 1105 (9th Cir. 2020) (en banc). In separate litigation, the Fourth Circuit Court of Appeals reached opposite conclusions from the Ninth Circuit, holding the 2019 Rule both arbitrary and capricious and contrary to law and affirming the grant of a permanent injunction in the State of Maryland. *See Mayor & City Council of Baltimore v. Azar*, 973 F.3d 258, 266 (4th Cir. 2020) (en banc).

8 Press Release, Planned Parenthood, *Trump Administration Gag Rule Forces Planned Parenthood Out Of Title X National Program For Birth Control* (Aug. 19, 2019), https://www.plannedparenthood.org/about-us/newsroom/press-releases/trump-administration-gag-rule-forces-planned-parenthood-out-of-title-x-national-program-for-birth-control-2.

9 86 Fed. Reg. at 19,812.

10 *Id.*

11 *Id.* at 19,816.

12 *Id.*

13 *Id.*

14 *Id.* at 19,818.

15 *Id.* at 19,817.

In its place, the Proposed Rule would essentially "readopt[] the 2000 regulations," but with "several modifications."[16]

COMMENTS ON THE PROPOSED RULE

Planned Parenthood supports the vast majority of the changes contained in the Proposed Rule. The 2019 Rule has been an unmitigated and unequivocal disaster for the Title X program and the patients it is intended to serve—as every major medical association warned. Planned Parenthood's experience illustrates the Department's conclusion that the "2019 rule is not in the best interest of public health."[17] Below, Planned Parenthood underscores just a few of the many harms wrought by this ill-advised change to the decades of success of the Title X program, already set forth in detail in the Proposed Rule.

In short, the 2019 Rule reduced the quantity and quality of care and increased the cost of care to patients across the board, with marginalized populations getting hit the hardest. Much like elsewhere in the health system, people impacted by the 2019 Rule are more likely to be people who reside in rural areas; immigrants; Black, Latino, and Indigenous communities; LGBTQ+ people; and people who live at the intersections of systemic barriers. The Department's proposal to return Title X to its effective pre-2019 state should be swiftly adopted. Additionally, to ensure that the harms from the 2019 Rule are promptly reversed regardless of adoption of the new Proposed Rule, the Department should explicitly revoke the 2019 Rule by agency action distinct from the promulgation of the new regulations.

There are certain aspects of the Proposed Rule that Planned Parenthood recommends the Department alter. *First*, the preamble to the Proposed Rule contains some language suggesting that entities might be permitted to refuse to counsel on abortion, including by making referrals, even when the patient wants and needs that information. Such broad refusal allowances are not permitted by the federal laws on which the Department relies and would perpetuate the very harms the Proposed Rule professes to address by impairing patients' ability to obtain comprehensive medical information and care. *Second*, the Proposed Rule lacks needed protections ensuring that providers that offer abortion services outside of the Title X program can participate in the Title X program. *Third*, the Department should adopt minor modifications to enhance the ability of the Title X network to provide efficient, quality care, including defining and promoting "telehealth."

These comments reflect Planned Parenthood's extensive experience with the Title X program and the consequences of the 2019 Rule. Because Planned Parenthood's challenge to the 2019 Rule involved a lengthy explanation of the lawfulness of the 2000 rule, and because the Proposed Rule largely returns to the 2000 rule, these comments

[16] *Id.* at 19,818.

[17] *Id.* at 19,817.

do not focus on the Proposed Rule's lawfulness, with the exception of the refusal language. Instead, these comments urge the Department to:

- **Revoke the 2019 Rule through agency action distinct from the promulgation of any new regulations.** The harms from the 2019 Rule have been immense and should be reversed as quickly and decisively as possible. As explained above and further below, the 2019 Rule forced many providers, including Planned Parenthood affiliates, out of the Title X program. Those departures have had disastrous, and ongoing, consequences for access to family-planning and related preventive health care, particularly among low-income individuals; Black, Asian American and Pacific Islander (AAPI), Latino, and Indigenous communities; and those in rural or remote locations. Revoking that rule will allow Planned Parenthood and other critical community health care providers to rejoin the Title X program, expanding access to quality, free or low-cost care. That revocation should be a distinct agency action separate from the promulgation of any new regulations to ensure that the Title X program is promptly restored to its extraordinarily successful pre-2019 state.
- **Adopt the Proposed Rule, with small modifications.** In addition to revoking the 2019 Rule, the Proposed Rule will take significant steps toward undoing the harms caused by the 2019 Rule and rebuilding a stronger and more patient-centered Title X network. The Department should adopt the Proposed Rule, with only small modifications, as explained below.
- **Remove the preamble's reference to refusal language, or, at minimum, modify it to match the scope of the federal refusal statutes.** The Proposed Rule's preamble provides that "grantees with conscience objections will not be required to follow the proposed rule's requirements regarding abortion counseling and referral."[18] That exception is broader than authorized by the federal refusal statutes that the Proposed Rule references and would unnecessarily and harmfully restrict patients' access to nondirective options counseling, including referral.
- **Modify the Proposed Rule to include protections that ensure that specialized reproductive health care providers can participate as service providers.** To ensure that Title X grantees and subrecipients are selected based only on the requirements set forth in 42 C.F.R. § 59.5 and are not excluded based on the services they offer outside of the Title X program, including abortion, the Proposed Rule should be modified to expressly provide that grantees and subgrantees may not be excluded from the program for reasons unrelated to their ability to provide quality Title X services.

[18] *Id.* at 19,818.

I. THE DEPARTMENT SHOULD REVOKE THE 2019 RULE AND, SEPARATELY, ADOPT THE PROPOSED RULE

The 2019 Rule has caused immense harm, and the Department should revoke it through a distinct agency action severable from any new regulations that are promulgated in order to restore services as quickly as possible. The 2019 Rule has directly contravened Title X's goal of expanding access to "a broad range of acceptable and effective family planning methods" and related preventive health services.[19] Instead, the 2019 Rule restricted access to care. In addition, the Department should adopt the Proposed Rule—which reverses the most harmful aspects of the 2019 Rule, including the gag and separation requirements; restores providers' ability to participate in Title X without compromising patient service or adherence to ethical practices; and takes important steps to promote health equity. The Proposed Rule would expand access to the high-quality, patient-centered care that Title X is intended to provide.

A. The Harms From The 2019 Rule Have Been Immense

The 2019 Rule's gag requirement infringes the professional and ethical obligations of health care professionals, distorting and invading the patient-provider relationship. Moreover, that rule needlessly requires strict physical separation requirements on any Title X provider engaging in virtually any abortion-related activities *outside* the Title X program, despite the absence of any documented misuse of Title X funds under the 2000 rule and accompanying guidance. The 2019 Rule's separation requirement is extremely burdensome, unnecessary, and harmful to patient care. Indeed, as Planned Parenthood detailed in its comment on the 2019 rulemaking, the physical separation requirement alone would impose an estimated cost of nearly $625,000 per affected service site, with no corresponding benefit and at great harm to the program. As Planned Parenthood and other commenters warned, the previous Administration's prediction that new providers would enter the program was unsupported, baseless, and misguided.[20] Instead, time has only borne out the prediction that the Title X network would be decimated by the rule.

Thus, since the 2019 Rule was implemented, approximately 1,000 service sites have left the Title X program. That includes more than 400 Planned Parenthood health centers. These departures have reduced the network's capacity to provide family-

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[19] 42 U.S.C. § 300(a).

[20] The previous Administration, in claiming that new providers would enter the program, relied only on a single online survey, released by the Christian Medical Association in 2009. 84 Fed. Reg. at 7,781 n.139. Far from a survey of all professionals, the survey in fact was directed at "faith-based healthcare professionals," with the vast majority of the small number of responses coming from members of the Christian and Catholic Medical Associations. The online survey was "completed by 2,298 members of the Christian Medical Association, 400 members of the Catholic Medical Association, 69 members of the Fellowship of Christian Physicians Assistants, 206 members of the Christian Pharmacists Fellowship International, and 8 members of Nurses Christian Fellowship." Freedom2Care & Christian Medical Association, *Two National Polls Reveal Broad Support for Conscience Rights in Health Care* 1 (Apr. 8, 2009).

planning and related preventive health care services by an estimated 46%.[21] Six states (Hawaii, Maine, Oregon, Utah, Vermont, and Washington) now have no Title X service site.[22] And 20 additional states (Alaska, Arizona, California, Connecticut, Delaware, Indiana, Iowa, Illinois, Massachusetts, Maryland, Michigan, Minnesota, Missouri, Montana, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, and Rhode Island) have lost between 25% and 99% of the Title X service sites they had before the 2019 Rule.[23] Yet, research prior to the 2019 Rule showed that Title X service sites are more likely than non-Title X sites to provide a wider variety of reproductive care, such as the most effective long-acting contraceptives, and that specialized reproductive health care providers like Planned Parenthood are the most capable of providing that care. For example, between 80% and 89% of Title X grantees provide highly effective and long-acting contraceptive options such as implants and intra-uterine devices (IUDs).[24] For Planned Parenthood affiliates, that number is 99%.[25] For non-Title X grantees, it is only about 50%.[26] And Planned Parenthood has historically accounted for a large share of publicly funded contraceptive care. In 2015, nearly a third of all patients at publicly funded family planning clinics—about two million contraceptive patients—received care at a Planned Parenthood affiliate. Because of the 2019 Rule, causing a mass exodus of Title X providers, patients have fewer care options and lower quality of care.

This forced exit from Title X could not have come at a worse time for this nation's public health. For example, for the sixth consecutive year, in 2019, reported cases of the sexually transmitted diseases chlamydia, gonorrhea, and syphilis in the U.S. hit an all-time high. And the number of women in need of public support for contraceptive services has increased in recent years by 8% overall and by 12% for those below 250% of federal poverty guidelines.[27] Currently, more than 19 million women of reproductive

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[21] Ruth Dawson, *Trump Administration's Domestic Gag Rule Has Slashed the Title X Network's Capacity by Half*, Guttmacher Institute (Feb. 26, 2020), https://www.guttmacher.org/article/2020/02/trump-administrations-domestic-gag-rule-has-slashed-title-x-networks-capacity-half; Brittni Frederiksen et al., *Current Status of the Title X Network and the Path Forward*, Kaiser Family Foundation (Dec. 21, 2020), https://www.kff.org/womens-health-policy/issue-brief/current-status-of-the-title-x-network-and-the-path-forward/.

[22] Ruth Dawson, *What Federal Policymakers Must Do to Restore and Strengthen a Title X Family Planning Program That Serves All*, Guttmacher Institute (Mar. 8, 2021), at fig.1, https://www.guttmacher.org/gpr/2021/03/what-federal-policymakers-must-do-restore-and-strengthen-title-x-family-planning-program.

[23] *Id.*

[24] Usha Ranji et al., *Financing Family Planning Services for Low-income Women: The Role of Public Programs*, Kaiser Family Foundation (Oct. 25, 2019), at fig. 5, https://www.kff.org/womens-health-policy/issue-brief/financing-family-planning-services-for-low-income-women-the-role-of-public-programs/.

[25] Marta Bornstein et al., *Access to Long-Acting Reversible Contraception Among U.S. Publicly Funded Health Centers*, 97 Contraception 405 (2018), at tbl. 2, https://pubmed.ncbi.nlm.nih.gov/29253581/.

[26] Ranji et al., *supra* note 24.

[27] Jennifer J. Frost et al., *Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Impact, 2016*, Guttmacher Institute (Nov. 13, 2019), at fig. 1, https://www.guttmacher.org/report/publicly-supported-FP-services-US-2016.

age are in need of publicly funded contraception and yet lack reasonable access to a health care center offering a full range of contraceptive options.[28] The pandemic has compounded those problems. In the spring of 2020, 33% of women faced delays or were unable to get contraception or other care because of the COVID-19 pandemic; women of color and women with low incomes were more likely than white women and women with higher incomes to report problems accessing this care. These gaps in care could translate into higher numbers of women experiencing severe health issues requiring Title X care in the near term.

Moreover, without access to Title X funds, providers like Planned Parenthood have been forced to close health centers and/or reduce hours—all with negative consequences for the patients who relied on those centers for care. In particular, some Planned Parenthood health centers that were providing Title X services have closed due to lack of funds—for example, in Connecticut, Ohio, Indiana, and Washington State. Some affiliates have had no choice but to impose new fee structures, which, unlike the Title X scale, require all patients to pay something for each visit. For example, Planned Parenthood's Michigan affiliate reports that, since the loss of Title X funding, patients who are not enrolled in Medicaid are now paying approximately 13% more for services.

With patients being forced to bear higher costs, many of them, particularly lower-income individuals and those without insurance, including in states that have not expanded Medicaid, have had to ration care. Planned Parenthood affiliates, for example, have reported that patients are forgoing recommended tests or lab work due to costs or are choosing less expensive and less effective methods of contraception, such as birth-control pills instead of more expensive IUDs. One affiliate reports that, after the 2019 Rule took effect and prior to the COVID-19 pandemic, pap tests across three states were down nearly 40% from the year prior, tests for STIs approximately 15% lower, and breast exams over 25% lower. Similarly, across all affiliates that have not received state replacement funds, the number of breast exams fell by 20%, contraceptive visits by about 12%, and pap tests by nearly 10% during the period September 2019 through March 2020 (as compared to the prior year). The affiliates serving many parts of the country, including Alaska, Iowa, Indiana, Idaho, Michigan, Minnesota, Nebraska, and Utah report that patients have walked away from or failed to show up for appointments after hearing that they would have to pay out of pocket for services. Affiliates have also reported long-time patients being forced to seek care elsewhere, with a disruption to their continuity of care.

The rising costs of care have hit lower-income and uninsured individuals the hardest, with some affiliates reporting decreases of over 25% in uninsured clients and those at or below the federal poverty line, and 30% decreases in clients self-paying for care. Affiliates have also reported large reductions in the numbers of people of color who are able to access care—one affiliate saw nearly 30% fewer patients who identify as African-American, nearly 10% fewer patients who identify as Asian, and nearly 20% fewer patients who identify as multiracial. And many of these patients, as the

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[28] Power To Decide, *Birth Control Access*, https://powertodecide.org/what-we-do/access/birth-control-access (last accessed May 17, 2021).

Department knows, have nowhere else to go for the free or reduced-cost care they previously received through the Title X program at Planned Parenthood health centers. As the Department properly recognizes and as Planned Parenthood can confirm from decades of experience in the program, so "many individuals depend on the Title X program as their primary source of healthcare" that "this situation creates a widespread public health concern."[29]

Adolescents have also been among the hardest hit. The decrease in Title X service sites has left many adolescents without access to the affordable and confidential care that Title X requires. One affiliate reported that, after the 2019 Rule took effect, visits by adolescents declined by over 20%.

Title X funds have also long supported community outreach and education programs devoted to sexual and reproductive health information and preventative community-based services. The forced exit from Title X resulted in Planned Parenthood affiliates having to scale back or eliminate completely education and outreach programs in many states. For example, one Planned Parenthood affiliate in Ohio was forced to eliminate over 600 sexual education programs, across 10 counties, affecting nearly 9,000 people annually.

Planned Parenthood has always worked to ensure that patients, including those who cannot pay, are not turned away. Planned Parenthood affiliates have done their best to continue providing affordable and high-quality health care, even without Title X funds, but many affiliates will not be able to sustain current levels of care for much longer, unless they can reenter the program swiftly.[30] In fact, Planned Parenthood affiliates have in many instances been able to sustain their level of care to patients only through Herculean efforts to fundraise over the short term. Planned Parenthood knows from experience, moreover, that fundraising revenue cannot replace the stable and predictable funding that Title X provides to health care providers able to participate in the program. Indeed, Planned Parenthood's ability to fundraise since the 2019 Rule took effect has been supported by the fact that the stock market has remained strong during this period. Further, Planned Parenthood recognizes that it is able to raise funds when other providers also forced out of the Title X program might not have the same ability to do so.[31] And the ability of Planned Parenthood and other providers to raise funds depends in large measure on geography—there are more philanthropic resources in some parts of the country than in others. Unfortunately, there is also significant need in parts of the country with fewer resources.

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[29] 86 Fed. Reg. at 19,817.

[30] The Proposed Rule compares Planned Parenthood's two most recent annual financial reports and notes that they showed no decrease in patients served after the 2019 Rule took effect. *Id.* at 19,826. Planned Parenthood clarifies for the Department that the most recent annual report includes affiliate data from affiliate fiscal years that ended in 2019. Because the majority of affiliate fiscal years end in June, the most recent annual report is not fully representative of patient volume after the 2019 Rule took effect.

[31] Indeed the Rule recognizes that focusing on "just one organization" has obvious "limitations." *Id.*

Planned Parenthood's increased fundraising to attempt to replace the Title X funds itself has come at a cost—namely, the administrative burdens and expenses of raising money through charitable solicitations.[32] Further, affiliates report that some of those donations have been one-time grants meant to "bridge the gap" before a return to Title X that will soon run dry. And fundraising dollars are not limitless, so funds that have been used to replace Title X dollars are unavailable for other services that are critical to Planned Parenthood's communities, including planned expansion of services and education programing.

Some Planned Parenthood affiliates have had relief from replacement funds provided by their states, but those replacement funds are not guaranteed year to year and may be at increased risk because of the challenges posed to state governments budgets, which are even more challenging due to the COVID-19 pandemic. Unfortunately, even with these efforts to fundraise and state replacement funds, many affiliates face significant budget deficits, leaving them less resilient especially in light of the pandemic. Planned Parenthood of Southern New England, for example, posted a $2 million loss as of January 2021. And budget gaps are growing. Payment rates for services received are low, as are Medicaid reimbursement rates, and many health centers are at risk of further reductions in staffing, hours, and even closure if unable to regain access to Title X funding. Any future reductions will cause further harm for the patient communities that rely on and trust Planned Parenthood health centers for care.

The piecemeal replacement funding that Planned Parenthood has cobbled together to continue to provide care since the summer of 2019 means that the level of support that patients are receiving for their care differs depending on where they live in the country. Title X was designed in 1970 to ensure that low-income people around the country have access to family planning care. Congress made clear the program is intended for patients who were "forced to do without, or to rely heavily on the least effective nonmedical techniques for fertility control unless they happen to reside in an area where family planning services are made readily available by public health agencies or voluntary agencies."[33] And Congress acknowledged that existing federal, state, and private sources of family planning services were not meeting needs, and that "privately financed programs … were growing so fast that they had outstripped their ability to

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32 The administrative costs involved in raising funds are well recognized in the world of non-profits. See Fundraising Report Card, Cost Per Dollar Raised, What it Means, and How to Stay on Top of It, https://fundraisingreportcard.com/cost-per-dollar-raised-what-it-means-and-how-to-stay-on-top-of-it/. In addition, Planned Parenthood affiliates report that their administrative personnel have had to increase the percent of their time spent fundraising in order to compensate for lost funding—with some forced to spend 85-90% of their time fundraising, as compared to about 50% before 2019. That is time that could be devoted instead to client-centered endeavors. Similarly, affiliates report that their health center staff members are having to help clients navigate the new financial barriers to care, putting an even greater strain on Planned Parenthood staff working to provide the best possible care to patients.

33 S. Rep. No. 91-1004, at 9 (1970).

attract the necessary funds from private sources."[34] By enacting Title X, Congress sought to "provide for more centralized administration, unification of existing programs, and the development of more comprehensive, all-inclusive programs designed to remedy one of the most pressing problems facing all of us today"; it envisioned a federally funded approach to family planning rather than heavy reliance on private fundraising to address this need.[35] It is more than apparent that the 2019 Rule has decimated the program's promise.

B. The Department Should Revoke the 2019 Rule and Adopt The Proposed Rule—Which Takes Important And Necessary Steps To Increase Health Equity, Promote Confidential Care, And Expand Access To A Broad Range Of Comprehensive Family Planning Care

Planned Parenthood strongly supports changes in the Proposed Rule that will help sustain Title X's purpose of ensuring that all people—regardless of age, race, ethnicity, sexual orientation, geography, gender identity, or income—have access to high-quality, comprehensive, and confidential reproductive health care. In particular, the changes outlined below will help improve the ability of the Title X network to meet Title X's goals. But we emphasize first that the 2019 Rule should be revoked as a distinct agency action as quickly as possible.

1. The 2019 Rule should be promptly revoked

Expressly revoking the 2019 Rule would help reverse the grave harms discussed above—thereby avoiding, as the Proposed Rule recognizes, the "possibility of a two-tiered health care system in which those with insurance and full access to health care receive full medical information and referrals, while low-income populations with fewer opportunities for care are relegated to inferior access."[36] This revocation action would return the Title X network to its proven effectiveness under the 2000 regulations, under which Title X providers operated for decades. Planned Parenthood affiliates will seek to reenter the Title X program if they can provide comprehensive information about medical care in accordance with core medical ethics, without regard to patient ability to pay for it, and if can do so without the 2019 Rule's burdensome and unnecessary physical-separation requirement. And because Planned Parenthood affiliates historically have provided care to 40% of the patients in the program,[37] Planned

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[34] Legislative History of the Family Planning Services and Population Research Act of 1970, Pub. L. No. 91-572, 84 Stat. 1504, 115 Cong. Rec. 13,280 (May 21, 1969) (Remarks by Mr. Bush upon introduction of H.R. 11440).

[35] *Id.*, 115 Cong. Rec. 14,255 (May 28, 1969) (Remarks by Mr. Cohelan on H.R. 11551).

[36] 86 Fed. Reg. at 19,817.

[37] Jennifer J. Frost et al., *Publicly Funded Contraceptive Services at U.S. Clinics, 2015*, Guttmacher Institute (Apr. 2017), https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015.

Parenthood's return to the program can quickly help restore the capacity of the Title X network to its pre-2019 levels.

It bears emphasis that even if the 2019 Rule had not visited such harms upon clients in terms of the quality, availability, and cost of care, revoking the 2019 Rule and, separately, adopting the Proposed Rule would still be the right course of action. In clear contrast to the 2019 Rule, the Proposed Rule embraces modern medical and ethical standards and faithfully interprets Title X's mission, focusing on patient-centered family planning care.

2. The Proposed Rule helps promote health equity

Planned Parenthood applauds the Proposed Rule's emphasis on promoting health equity. All people should have equal access to reproductive health care. And yet, due to systemic racism, and economic inequality, the health care system has created unfair burdens for communities of color and people with low incomes. For people of color, the right to bodily autonomy and quality health care has been consistently under attack in this country—leading to huge disparities in sexual and reproductive health outcomes between women of color and white women. These unfair burdens have only been exacerbated during the ongoing COVID-19 pandemic.

Because of racism, homophobia, transphobia, and other systemic barriers that contribute to income inequality, people of color, LGBTQ+ people, and people in rural areas make up a large proportion of people with low incomes. For many of them, safety net family planning centers that specialize in sexual and reproductive health are the sole point of access to health care services. This is the case for four in ten women who obtained contraceptive care at a safety net family planning site.[38] The Title X program has long been a way to address some of those inequities by allowing all patients to access the highest standard of preventive and reproductive health care services. In 2019, for example, 33% of patients at Title X services sites identified as Hispanic, 24% identified as Black, 64% were at or below the federal poverty level, and 41% were uninsured.[39]

Rescinding the 2019 Rule and restoring the decimated Title X network are an important step toward the promise of health equity for low income people, communities of color, and LGBTQ+ people. But the Proposed Rule appropriately recognizes that the Title X network can do more to improve health equity. Approximately a third of Asian- and Hispanic-Americans report that the ability to communicate with physicians poses a

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[38] Jennifer J. Frost et al., *Specialized family planning clinics in the United States: Why Women Choose Them and Their Role in Meeting Women's Health Care Needs*, 22 Women's Health Issues e519 (2012), http://www.whijournal.com/article/S1049-3867(12)00073-4/pdf.

[39] U.S. Dep't of Health & Human Services, Office of Population Affairs, Family Planning Annual Report: 2019 Summary at 14, 25-26 (Sept. 2020), https://opa.hhs.gov/sites/default/files/2020-09/title-x-fpar-2019-national-summary.pdf.

barrier to care.[40] And Black, Indigenous, and Latino patients report less partnership with physicians, less participation in their own medical decisions, and less satisfaction with the care they receive—including feeling that they were treated disrespectfully by health care providers.[41] As the Department has itself recognized in its National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care, culturally and linguistically appropriate care is thus vital in order to begin reducing inequitable disparities in health outcomes.[42] The Proposed Rule takes important steps toward ensuring that the Title X network meets the national standards for CLAS.

In particular, Planned Parenthood supports the Proposed Rule's definition of "Health equity";[43] the requirement in § 59.5(a)(3) that family planning projects must "[p]rovide services in a manner that is client-centered, culturally and linguistically appropriate, inclusive, and trauma informed; protects the dignity of the individual; and ensures equitable and quality service delivery consistent with nationally recognized standards of care";[44] the requirement in § 59.5(b)(3) that projects "[p]rovide for opportunities for community education, participation, and engagement," including to "[p]romote continued participation in the project by diverse persons to whom family planning services may be beneficial to ensure access to equitable, affordable, client-centered, quality family planning services";[45] the requirement in § 59.6 that grantees provide culturally and linguistically appropriate informational and educational materials;[46] and the specification in § 59.7(a)(3) that the Department make funding decisions based in part upon a consideration of a project's "ability … to advance health equity."[47]

Planned Parenthood also supports the transition from using the word "women" to the more inclusive "client." Gender identity should never be a barrier to receiving needed health care.

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40 Cindy Brach & Irene Fraser, *Reducing Disparities through Culturally Competent Health Care: An Analysis of the Business Case*, 10 Qual. Manag. Health Care 15 (2002), https://pubmed.ncbi.nlm.nih.gov/12938253/.

41 Georgetown University Health Policy Institute, *Cultural Competence in Health Care: Is it important for people with chronic conditions?*, https://hpi.georgetown.edu/cultural/ (last visited May 12, 2021).

42 U.S. Dep't of Health & Human Services, Office of Minority Health, National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care, https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf (last visited May 12, 2021).

43 86 Fed. Reg. 19,829 (§ 59.2).

44 *Id.* at 19,830.

45 *Id.* at 19,831.

46 *Id.*

47 *Id.* at 19,832.

3. The Proposed Rule helps to expand access to comprehensive care, including a broad range of contraceptive options

Title X directs that family planning projects "shall offer a broad range of acceptable and effective family planning methods and services."[48] Consistent with the statute, the Department's own 2014 clinical recommendations, Providing Quality Family Planning Services (QFP), which constitute the current national standard for quality clinical family planning care, confirm the importance of making available the full range of FDA-approved contraceptive methods to meet patients' diverse reproductive needs.[49] The QFP were developed through rigorous evaluation of evidence regarding the effectiveness of services. The 2019 Rule, contrary to the QFP, improperly allowed Title X projects to offer no contraceptive methods whatsoever, and Planned Parenthood supports changes in the Proposed Rule that will help ensure that all individuals can access a full range of contraceptive services regardless of their specific provider.

Specifically, Planned Parenthood supports the requirement in § 59.5(a)(1) that projects provide a broad range of medically approved family planning methods, ensuring that projects provide care that is consistent with the QFP. And to ensure that patients have access to the contraceptive methods of their choice, Planned Parenthood also supports the requirement in § 59.5(a)(1) that any organization offering only one method of family planning may participate only if it is part of a project that offers a broad range of methods and further that any service site unable to provide a broad range of methods must be able to refer patients to the method of their choice in a way that does not unduly limit the patient's access to their method of choice.[50] This referral requirement is important, as it appears that under the 2019 Rule, at least one provider refused to distribute or even provide referrals for *any* form of contraceptive services. Specifically, after receiving a Title X grant in 2019, the founder of the Obria Group stated that its clinics "never distributed or referred for contraceptives and have no plans to do so."[51] For Title X to fulfill its purpose of providing access to a broad range of family planning methods, including contraceptives, it is essential that providers not be permitted to refuse to even refer patients for contraceptive services, and must ensure that patients have access to their "method of choice."

Changes to the grant criteria in § 59.7 also will help ensure that the Title X network is able to meet the diverse health care needs of the many clients that it serves. The Title

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48 42 U.S.C. § 300(a).

49 Centers for Disease Control & Prevention, Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs (Apr. 25, 2014), https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm.

50 86 Fed. Reg. at 19,830.

51 Victoria Colliver, *Anti-Abortion Clinics Caught in Tumult Over Trump Family Planning Rules*, Politico (May 3, 2019), https://www.politico.com/story/2019/05/03/anti-abortion-clinics-family-planning-1402415; *see also* Dorothy McLean, *Pro-Life Catholic Medical Group's Title X Application Included Contraceptive Promise*, LifeSite News (Apr. 18, 2019), https://www.lifesitenews.com/news/pro-life-catholic-medical-groups-title-x-application-included-contraceptive-promise.

X statute mandates that the Department make grant awards based on, among other things, “the number of patients to be served” and the applicant’s “capacity to make rapid and effective use of such assistance.”[52] The 2019 Rule added a threshold consideration permitting the Department to deny applications without even considering the statutorily mandated factors.[53] That Rule also emphasizes evaluating an applicant’s “ability to procure a broad range of diverse subrecipients,”[54] a provision that prioritizes nontraditional Title X providers that are less familiar with the program and often have lower capacity to provide a broad range of services, including contraceptive services. Eliminating these provisions, as the Proposed Rule does, will ensure that Title X grant decisions are made so as to maximize the ability of the Title X network to quickly and effectively provide the comprehensive care that the statute requires.

4. The Proposed Rule will further the program’s historically strong protections for patient confidentiality for adolescents

Planned Parenthood applauds the Department’s proposal to return to the 2000 rules, with some specific improvements to protect client confidentiality. Specifically, the ability to receive confidential care is important to many adolescents,[55] and, without it, adolescents receive less contraceptive and related preventive health care. For example, 15- to 17-year-olds who report confidentiality-related concerns are significantly less likely to receive contraceptive services than those who report no confidentiality-related concerns.[56] The 2019 Rule undermined confidentiality and trust among adolescents by requiring Title X providers to force adolescent patients to share unnecessary details about their sexual activities and to include their parents in their reproductive health care decisions. The Rule required providers to “conduct a preliminary screening of any minor who presents with a sexually transmitted disease (STD) [or] pregnancy … in order to rule out victimization of a minor,” regardless of whether there is any suspicion of abuse.[57] That requirement has undermined patient

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[52] 42 U.S.C. § 300(b).

[53] *See* 84 Fed. Reg. at 7788 (§ 59.7(b)).

[54] *Id.* (§ 59.7(c)(2)).

[55] Kate Coleman-Minahan et al., *Availability of Confidential Services for Teens Declined After the 2011-2013 Change to Publicly Funded Family Planning Programs in Texas*, 66 J. Adolescent Health 719, 721 (2020), https://www.jahonline.org/article/S1054-139X(19)30918-8/fulltext (describing interview responses from health care providers explaining that confidentiality is essential to the provision of reproductive-related care to adolescents). As stated by one respondent in the study, “[i]f you can’t offer confidentiality, you don’t have an adolescent program.” *Id.*

[56] Liza Fuentes et al., Adolescents’ and Young Adults’ Reports of Barriers to Confidential Health Care and Receipt of Contraceptive Services, 62 J. Adolescent Health 36, 38, 42-43 (2018), https://www.jahonline.org/article/S1054-139X(17)30508-6/abstract (20% of 15-year-olds and 14% of 17-year-olds reported that they would not go for sexual or reproductive health care because their parents might find out); Kinsey Hasstedt, *Ensuring Adolescents’ Ability to Obtain Confidential Family Planning Services in Title X*, Guttmacher Institute (Nov. 15, 2018), https://www.guttmacher.org/gpr/2018/11/ensuring-adolescents-ability-obtain-confidential-family-planning-services-title-x.

[57] 84 Fed. Reg. at 7790 (§ 59.17(b)(1)(iv)).

trust to the detriment of public health. The Rule also required providers not only to encourage adolescent patients to include their families in deciding to seek family planning services but also forced them to document "the specific actions taken" to encourage such familial involvement.[58] The requirement is inconsistent with the Title X statute, which requires encouraging family involvement "[t]o the extent practical,"[59] and is unnecessarily burdensome for providers. Title X providers always rely on their considerable expertise, training, and experience in assisting adolescents to involve their families in decisions about family planning services and other key health care matters when realistic and appropriate. And research shows that 7 out of 10 adolescents ages 15-17 report having discussed at least one topic related to sexual and reproductive health with a parent or guardian.[60] But for those adolescents who are at risk of harm from talking with their families about matters related to reproductive health, the ability to obtain confidential care without pressure is essential. This is particularly true for adolescents without trusted adults, including those experiencing homelessness, those in the foster care system, those facing interpersonal violence, or those who identify as LGBTQ+.[61] The proposed revisions will help ensure that confidentiality remains paramount in Title X.

II. THE DEPARTMENT SHOULD REMOVE THE PREAMBLE'S REFUSAL LANGUAGE OR, AT MINIMUM, MODIFY IT TO COMPORT WITH FEDERAL LAW AND TITLE X'S PURPOSE

As the Department has acknowledged in the preamble to the Proposed Rule, provisions of federal law allow certain entities to refuse to provide certain health care services and information under specific circumstances. These federal laws cannot be altered by regulation, and it is therefore unnecessary for the Department to address them in either the preamble to its final rule or the final rule itself.[62] To the extent the Department continues to reference these statutes, however, it should modify the preamble's refusal language to match what is actually permitted by the federal refusal statutes that it cites.

Specifically, citing subsection (d) of the Church Amendment[63] and the Weldon Amendment,[64] the Proposed Rule's preamble provides that objecting grantees "will not be required to follow the proposed rule's requirements regarding abortion counseling

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58 *Id.* at 7787 (§ 59.2).

59 42 U.S.C. § 300(a).

60 Hasstedt, *supra* note 56.

61 *See id.*

62 *See* Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws, 76 Fed. Reg. 9968, 9973 (Feb. 23, 2011) (recognizing both that "[h]ealth care entities must continue to comply with the long-established requirements of the statutes … governing Departmental programs" and that the refusal "laws and the other federal statutes have operated side by side often for many decades").

63 42 U.S.C. § 300a–7(d).

64 Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, Div. H, sec. 507(d) (2020), https://www.congress.gov/bill/116th-congress/house-bill/133/text.

and referral."[65] It further states that, "[u]nder these [appropriations] statutes, objecting providers or Title X grantees are not required to counsel or refer for abortions."[66] The scope of the preamble's current refusal language is contrary to the laws on which it purports to rely and therefore creates confusion that threatens to restrict patients' ability to obtain complete information and referrals, for two reasons.

First, the Proposed Rule's preamble elides key distinctions between the refusal statutes' application to entity providers and individual employees. *Second*, it both misstates and overstates the scope of those laws. Indeed, to Planned Parenthood's knowledge, the Department has never taken the position that those refusal laws allow entities providing Title X services—as opposed to individual providers—to refuse to counsel on abortion, including by making referrals, which is unsurprising given that the plain language of the statutes does not authorize such broad refusals. Although, as noted, the final rule cannot alter the scope of the federal refusal statutes, if the Department includes refusal language in the preamble to the promulgated rule, it must match the terms of the federal refusal statutes upon which it relies in application and scope.

The Church Amendment provision upon which the Proposed Rule relies, subsection (d), only refers to *individuals*; it states that "[n]o *individual* shall be required" to perform or assist in the performance of certain activities.[67] As the Supreme Court has stated, where a statute "does not define the term 'individual,'" the word is presumed to refer only to natural persons, not "organization[s]" or entities.[68] Therefore, by its terms (and underscored by its title), this provision does not grant any rights to entities at all, regardless of whether they receive Title X grants or subgrants. This cited section provides no authority for the preamble's statement that objecting "Title X *grantees* are not required to counsel or refer for abortions."[69]

Unlike the Church Amendment's subsection (d), the Weldon Amendment covers entities as well as individuals. Its scope, however, is narrow. The Weldon Amendment provides:

> None of the funds made available in this Act may be made available to a Federal agency or program, or to a state or local government, if such agency, program, or government subjects any institutional or individual health care entity to

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65 86 Fed. Reg. at 19,817-18. The Proposed Rule does not mention the Coats-Snowe Amendment, 42 U.S.C. § 238n, another refusal statute that does not implicate Title X.

66 *Id.* at 19,817.

67 42 U.S.C. § 300a–7(d) (emphasis added). Indeed, that section is titled "Individual rights respecting certain requirements contrary to religious beliefs or moral convictions."

68 *Mohamad v. Palestinian Auth.*, 566 U.S. 449, 454-455 (2012).

69 86 Fed. Reg. at 19,817 (emphasis added).

> *discrimination* on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.[70]

The amendment's scope is limited in three important ways.

First, the Weldon Amendment regulates the behavior of a limited group of actors: "Federal agenc[ies] or program[s], or … state or local government[s]."[71] The Department of Justice has explained, on behalf of the United States, that the mere receipt of federal funds does not mean that an organization, such as a recipient of Title X funds, is a federal agency or program covered by the amendment.[72] Therefore, the mere fact that a nongovernmental organization may accept Title X funds does not mean that the organization is subject to the Weldon Amendment.

Second, the Amendment's prohibition on "discrimination" does not prevent the limited group of governmental actors to which it applies from adopting and applying neutral program requirements. As an example, consider an entity that runs a nutritional education project. If that entity also provided pregnancy counseling that does not include abortion referral and applied for a grant under a nutritional education program, the Weldon Amendment might prohibit a state government from denying that grant based on the entity's refusal to refer for abortion—a service entirely separate from the funding and program at issue. But the Weldon Amendment does not prohibit the Department from neutrally applying Title X's program rules to require referral for all pregnancy options, upon request—as is required by Title X. That would not be "discrimination" against entities that do not refer for abortions; it would simply be identifying the scope of the program that the government chooses to support.[73]

Third, the amendment only prohibits "discrimination on the basis that [a] health care entity does not provide, pay for, provide coverage of, or *refer for* abortions."[74] Referral for abortions is but one part of options counseling. Accordingly, by providing that entities can refuse to refer for abortion, the text of the Amendment does not suggest that Title X grantees may refuse to provide all counseling related to abortion. But the preamble's language currently states, incorrectly, that "objecting … Title X grantees are not required to counsel … for abortions."[75]

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70 Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, Div. H, sec. 507(d)(1) (2020), https://www.congress.gov/bill/116th-congress/house-bill/133/text (emphasis added).

71 *Id.*

72 Def. Mem. in Opp. to Pl.'s Motion for Prelim. Inj. at 2, 28-30, *NFPRHA v. Ashcroft*, No. 04-2148 (D.D.C. Dec. 24, 2004), Dkt. 9.

73 *See, e.g.*, *Agency for Int'l Dev. v. All. For Open Soc'y Int'l, Inc.*, 570 U.S. 205, 213-214 (2013).

74 Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, Div. H, sec. 507(d)(1) (2020), https://www.congress.gov/bill/116th-congress/house-bill/133/text (emphasis added).

75 86 Fed. Reg. at 19,817.

Read properly in accordance with their text, as described above, the Church and Weldon Amendments do not conflict with Title X's mission. Title X aims to provide comprehensive, non-directive family-planning services to low-income people. As the Proposed Rule recognizes, one key aspect of these services is nondirective options counseling, including referrals. For example, the Proposed Rule emphasizes the necessity of facilitating clients' access to a full range of options by requiring that "Title X service sites that are unable to provide clients with access to a broad range of … family planning methods and services, must be able to provide a referral to the client's method of choice."[76] Similarly, the QFP provides that "[r]eferral to appropriate providers of follow-up care should be made at the request of the client" and "[e]very effort should be made to expedite and follow through on all referrals."[77] Construing the Weldon Amendment to require government bodies to fund entities that refuse to permit their employees or volunteers to refer patients for abortions would decrease patients' access to information and services that they seek.[78] Health care entities that refuse to refer for abortion serve as roadblocks in patients' time-sensitive searches for abortion care.[79] The government is not required to fund entities that seek to disregard the Department's regulations or QFP recommendations by refusing to refer for abortion.

For all these reasons, Planned Parenthood recommends that the Department delete all language discussing the federal refusal laws from the Proposed Rule's preamble. The Rule cannot alter those laws, and the preamble's language is likely to create more confusion than clarity, potentially harming patients' access to information and care they seek. If the Department intends to address these refusal laws, however, it should modify the preamble's language to accurately reflect the text and scope of the statutory

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[76] *Id.* at 19,830 (§ 59.5(a)(1)).

[77] Centers for Disease Control & Prevention, Providing Quality Family Planning Services Recommendations of CDC and the U.S. Office of Population Affairs (Apr. 25, 2014), https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf; *see also* American Medical Association, Code of Medical Ethics Opinion 2.1.1 Informed Consent, https://www.ama-assn.org/delivering-care/informed-consent (last visited May 13, 2021); *see also* Farr A. Curlin et al., *Religion, Conscience, and Controversial Clinical Practices*, 356 N. Engl. J. Med. 593, 597 (2007) https://pubmed.ncbi.nlm.nih.gov/17287479/ (most physicians surveyed believed that physicians with a moral or religious objection to a procedure are obligated to present patients with all options and refer a patient requesting that procedure to another physician who does not object to it).

[78] Megan L. Kavanaugh et al., *"It's not something you talk about really": Information Barriers Encountered by Women Who Travel Long Distances for Abortion Care*, 100 Contraception 79-84 (2019), https://www.sciencedirect.com/science/article/pii/S001078241930126X (finding that "health care providers play a crucial role in ensuring pregnant patients' right to informed consent within reproductive health care delivery").

[79] *See id.* at 81-82 (some gynecologists and other providers acting as "gatekeepers" who steer patients away from abortion and refuse to provide information about how to obtain an abortion); *see also* Luciana Hebert et al., *Variation in Pregnancy Options Counseling and Referrals, And Reported Proximity to Abortion Services, Among Publicly Funded Family Planning Facilities*, 48(2) Perspect. Sex Reprod. Health 65-71 (2016), https://pubmed.ncbi.nlm.nih.gov/27116392/ (providers were significantly more likely to refer for adoption than abortion, and health departments and community health centers were significantly less likely to refer to abortion and provide a list of abortion providers than comprehensive reproductive health centers).

provisions on which it relies. That approach has the added benefit of advancing the goals of the Proposed Rule—namely, ensuring patients' access to comprehensive, patient-centered care.

III. THE FINAL RULE SHOULD EXPRESSLY STATE THAT PROVIDERS MAY NOT BE EXCLUDED FOR REASONS UNRELATED TO THEIR QUALIFICATIONS TO EFFECTIVELY PROVIDE TITLE X SERVICES

We agree with the Department that "state restrictions on subrecipient eligibility unrelated to the ability to deliver Title X services undermine the mission of the program to ensure widely available access to services by the most qualified providers."[80] The success of the Title X program depends on the participation of high-quality, comprehensive, patient-centered providers. The program suffers—and, with it, the ability to provide care to those in need—if high-quality providers can be excluded for reasons wholly unrelated to their qualifications to effectively provide Title X services. We welcome the Department's invitation to comment on ways to ensure the program does not exclude providers based on factors unrelated to their qualifications to provide the required services and effectively serve individuals in need.

Such protections are urgently needed. Twenty states currently restrict providers that perform abortions and/or those that are affiliated with an abortion provider from receiving family-planning-related public funds from the state—considerations that are unrelated to a provider's ability to provide Title X services. Ten of those states specifically restrict providers that perform abortions, are affiliated with an abortion provider, provide abortion-related counseling, or even focus on reproductive health from receiving Title X funds from the state.[81]

Excluding providers focused on reproductive health care from Title X funding decreases the capacity and quality of the Title X network. Specialized providers often have a greater capacity to provide reproductive-health focused care. Before being forced out the Title X network, for instance, Planned Parenthood alone served over 40% of patients obtaining contraceptive care from Title X sites—despite representing only 13% of Title X-funded clinics.[82] This is because the average Planned Parenthood health center can serve *10 times* the number of contraceptive clients as can the average federally qualified health center (FQHC); the average Planned Parenthood health center serves nearly 3,000 contraceptive clients per year while the average FQHC serves only

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[80] 86 Fed. Reg. at 19,817.

[81] Guttmacher Institute, *State Family Planning Funding Restrictions* (last updated May 1, 2021), https://www.guttmacher.org/state-policy/explore/state-family-planning-funding-restrictions; Candice Hare, *State funding for abortions ban signed into law; Planned Parenthood reacts*, KMVT (May 11, 2021), https://www.kmvt.com/2021/05/12/state-funding-for-abortions-ban-signed-into-law-planned-parenthood-reacts/; LegiScan, *Montana House Bill 620*, https://legiscan.com/MT/bill/HB620/2021 (last accessed May 17, 2021).

[82] Jennifer J. Frost et al., *Publicly Funded Contraceptive Services at U.S. Clinics, 2015*, Guttmacher Institute (Apr. 2017), https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015.

about 300.[83] As a provider focused on reproductive health, Planned Parenthood can offer shorter wait times for initial contraceptive visits, more on-site contraceptive methods, including more highly effective long-acting methods, and faster initiation of new contraceptive methods, including quick-start and delayed pelvic exam protocols for new oral contraceptive users and same-day insertion of long-acting methods.[84] Providers not focused specifically on reproductive health simply cannot provide reproductive health care as broadly or effectively.

Accordingly, it is critical that providers focused on reproductive health, like Planned Parenthood, are not arbitrarily excluded from the Title X network for reasons unrelated to their ability to effectively provide Title X services. Such exclusions are incongruous with the goal of providing patient-centered sexual and reproductive health care to people with low incomes, as they disproportionately prevent or otherwise bar people with low incomes from seeing high-quality providers they trust for access to comprehensive care. To that end, Planned Parenthood proposes the following changes to protect providers from arbitrary discrimination:

1. Add a new subsection (14) to section 59.5(a) requiring that Title X projects "Provide that, if family planning services are provided by subgrant, contract or other similar arrangements, no service provider that would otherwise be eligible to apply to provide services under this subpart is excluded, limited, or otherwise restricted from participation in the project, based on any factor unrelated to its qualification to provide the required services and effectively serve individuals in need in the service area."

2. Add language to section 59.7(a) clarifying that "Funding decisions will be made based solely on the ability of a project applicant, whether the applicant proposes to provide the project's services itself or in reliance upon other entities, to provide the required services and best serve individuals in need throughout the anticipated service area."

3. Add section 59.7(d) to require that "(d) If an applicant proposes to rely on other entities to provide services under the project, no grant shall be made unless the applicant provides assurance satisfactory to the Secretary that it will meet the requirement established in 59.5(a)(14) of this subpart."

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83 Kinsey Hasstedt, *Federally Qualified Health Centers: Vital Sources of Care, No Substitute for the Family Planning Safety Net*, 20 Guttmacher Policy Review 67, 68 (2017), https://www.guttmacher.org/sites/default/files/article_files/gpr2006717_0.pdf.

84 Mia R. Zolna & Jennifer J. Frost, *Publicly Funded Family Planning Clinics in 2015: Patterns and Trends in Service Delivery Practices and Protocols*, Guttmacher Institute (Nov. 2016), https://www.guttmacher.org/report/publicly-funded-family-planning-clinic-survey-2015; *see also* Kinsey Hasstedt, *Understanding Planned Parenthood's Critical Role in the Nation's Family Planning Safety Net*, Guttmacher Institute (Jan. 12, 2017), https://www.guttmacher.org/gpr/2017/01/understanding-planned-parenthoods-critical-role-nations-family-planning-safety-net.

4. Add section 59.13 "Prohibition on the use of certain criteria in the selection process for Federal awards and subawards. (a) No federal agency, grantee, subrecipient, or other entity shall, in the course of administering or carrying out any program or activity under Title X of the Act, act in a manner which has the effect of excluding, limiting, or restricting the participation of any entity that would otherwise be eligible to apply for funds under Title X of the Act, on the basis of any factor unrelated to its qualifications to effectively carry out the program or activity. Prohibited actions under this subsection include but are not limited to excluding from participation in Title X based on non-Title X health services offered or other activities providers conduct with non-federal funds, or because they are a certain type of provider. (b) The Secretary shall monitor and enforce the requirements in this section, including but not limited to requiring recipients of Federal funds under Title X of the Act to maintain and submit records regarding the criteria used in the decisions of the recipient or any sub-recipients to recruit and retain qualified entities, including providers of health care or other services. Within thirty days of identifying noncompliance by any recipient or subrecipient, the Secretary shall take appropriate action to remedy the noncompliance, including immediate redirection of project funds from the recipient or subrecipient to a suitable, qualified alternative entity that will administer the grant funds consistent with this section while minimizing the impact of any interruption of services in the affected service area. In the event that a recipient or subrecipient relinquishes its grant funding, whether in part or in full, for noncompliance, the Secretary shall take appropriate action within sixty days of notice of relinquishment to redirect or otherwise administer the grant funds consistent with this section while minimizing the impact of any interruption of services in the affected service area, including through the approval of a sole source replacement grant to a suitable, qualified alternative entity."

These additional provisions will ensure that Title X funds are allocated to maximize the integrity and effectiveness of the Title X program. Selecting high-quality providers of family planning and related preventive care is essential to achieving Title X's objectives. When otherwise eligible providers that are optimally suited to meet the aims of the program are denied participation for reasons extrinsic to their capabilities to perform Title X required services, federal health care resources are poorly and inefficiently distributed to individuals in need.[85]

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[85] Including this language would be consistent with the Congressional Review Act (CRA). The CRA provides that, if Congress disapproves of a rule pursuant to the CRA, "a new rule that is substantially the same … may not be issued." 5 U.S.C. § 801(b)(2). The proposed language is not substantially the same as any rule disapproved by Congress. Congress did overturn a 2016 rule, *see* Act of Apr. 13, 2017, Pub. L. No. 115-23, 131 Stat. 89 (2017), adding language to subsection 59.3 providing that "No recipient making subawards for the provision of services as part of its Title X project may prohibit an entity from participating for reasons other than its ability to provide Title X services." Compliance With Title X Requirements by Project Recipients in Selecting Subrecipients, 81 Fed. Reg. 91,852, 91,860 (Dec. 19, 2016). But the language proposed is not "substantially the same" as that rule because it modifies different subsections of the regulation and applies more broadly to address not only conduct by grantees against subrecipients but also conduct by the Department against grantees. Additionally, because the

IV. THE FINAL RULE SHOULD ADOPT MINOR MODIFICATIONS TO ENHANCE THE ABILITY OF THE TITLE X NETWORK TO PROVIDE EFFICIENT, QUALITY CARE

A. The Final Rule Should Define And Promote "Telehealth"

Planned Parenthood applauds the Department's recognition in the preamble that enhancing the Title X program should include "family planning services provided using telemedicine."[86] Planned Parenthood encourages the Department to ensure that telehealth, more broadly, may be used to deliver care in this program. Telehealth is the use of a variety of technologies to deliver health care and education services between two locations.[87]

The importance of telehealth has grown in recent years, particularly in the context of the COVID-19 pandemic. Once able to return to the program, Planned Parenthood will be able to provide significant additional telehealth capacity to the program. Forty-seven Planned Parenthood affiliates (96% of all affiliates) provided telehealth services in 2020 across 395,868 visits, allowing Planned Parenthood to provide health care during the pandemic to the patients who rely on us the most—including people of color, people with low-incomes, LGBTQ people, and immigrant communities. To protect increased access to a wide range of remote care, the Department should expressly name in regulation and define "telehealth" as follows:

- Amend section 59.5(b)(1) to state that family planning projects must "Provide for clinical and other qualifying services related to family planning (including consultation by a healthcare provider, family planning counseling and education, examination, prescription, and continuing supervision, laboratory examination, contraceptive supplies), in person or via telehealth, including audio-only modalities, regardless of the patient's or provider's setting, and necessary referral to other medical facilities when medically indicated, and provide for the effective usage of contraceptive devices and practices."

B. The Final Rule Should Permit The Provision Of Services Under the Direction of Appropriate Advanced Practice Clinicians

Planned Parenthood supports changes in the Proposed Rule that will more broadly foster a robust Title X network of providers capable of meeting the diverse reproductive

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Proposed Rule already contains numerous other provisions, it should not be considered to be "substantially the same" as the 2016 rule, which included only the one provision barring certain conduct against providers. The CRA pertains only to rules in their entirety and cannot be used to invalidate only certain provisions of a rule. *See* Maeve P. Carey & Christopher M. Davis, Cong. Research Serv., R43992, The Congressional Review Act (CRA): Frequently Asked Questions 5 (Jan. 14, 2020), https://fas.org/sgp/crs/misc/R43992.pdf.

[86] 86 Fed. Reg. 19,818.

[87] The use of the term "telehealth" recognizes that a broad range of both clinical and non-clinical remote health care services, including contraceptive counseling and STD testing and treatment, can be provided remotely.

health care needs of those it serves. For example, the Proposed Rule properly recognizes that many Title X services are provided by health care providers who are not physicians by the proposed revision to section 59.5(b)(1),[88] which protects the critical role that physician assistants, nurse practitioners, nurse midwives, registered nurses, and health educators all play in providing a full range of comprehensive reproductive health care and education. Elevating the role of these non-physician health care providers and educators, moreover, fosters diversity among providers. Physician assistants, nurse practitioners, nurse midwives, registered nurses, and health educators are more likely than physicians to be Black, Indigenous, and People of Color—racial and ethnic groups that are both persistently underrepresented in health care professions and more reflective of the clients served through the Title X program.[89]

Planned Parenthood urges the Department to further recognize the important roles and abilities of these non-physician health care providers in ensuring that clients' reproductive health care needs are met. It therefore recommends that the Department:

- Amend section 59.5(b)(6) to allow services to be provided "under the direction of an advanced practice clinician, if the services offered are within their scope of practice and if allowable under state law."

C. The Final Rule Should Ensure that Title X Grantees Are Able to Focus on Providing Client-Centered Care, Without Burdensome, Unnecessary Requirements.

Planned Parenthood applauds the Department for proposing a requirement that each project take "reasonable measures to verify client income, without burdening clients from low-income families."[90] Planned Parenthood agrees the proposed addition is essential to ensure that grantee income verification practices are aligned with the program's mission of ensuring care for patients with low incomes, and shares the Department's goal of seeking to improve "accessibility and affordability of services for low-income clients consistently" throughout that program.[91] But income verification through means other than patient-self report is not always possible, and in any event, can be overly burdensome and delay access to care. Therefore, Planned Parenthood asks the Department to confirm in the final rule that Title X projects may rely solely on patient self-report in assessing income, as is consistent with past practice of the program.

Planned Parenthood, moreover, applauds the Department for proposing to scale back the reporting burdens on grantees imposed by the 2019 Rule's "transparency" provision,

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[88] 86 Fed. Reg. at 19,831 (§ 59.5(b)(1)).

[89] Edward Salsberg et al., *Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce*, JAMA Network Open (Mar. 31, 2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2777977.

[90] 86 Fed. Reg. at 19,830 (§ 59.5(a)(9)).

[91] *Id.* at 19,819.

recognizing in particular the burdens imposed by reporting detailed information about each subrecipient and referral agency. But Planned Parenthood urges the Department to go further in reducing those burdens. In particular, the proposal suggests that this provision is needed as part of "subrecipient monitoring and reporting,"[92] but then fails to explain why such monitoring requires grantees to report the extent of "collaboration" with "referral agencies, and any individuals providing referral services."[93] Not only is the term "collaboration" vague, but requiring grantees to describe the "extent of collaboration" with every agency or individual to which the project might refer clients, regardless of the type of care referred for, will divert project resources away from providing care. Providers like Planned Parenthood work to ensure that patients have every referral they need, including for such things as behavioral health or care for high blood pressure, which may range outside of the scope of the services provided in the Title X program. Reporting the "extent of collaboration" with each referral organization or individual is extremely burdensome, particularly the larger the geographic area covered by the grant. Accordingly, Planned Parenthood would propose ending 59.5(a)(13)(ii) after the word "subrecipients."

D. The Final Rule Should Delete The Reference To 45 C.F.R. part 87 ("Equal Treatment for Faith-Based Organizations").

In section 59.12, titled "What other HHS regulations apply to grants under this subpart?", the Proposed Rule states that the "Department proposed a technical correction to § 59.12 to update the regulations that apply to 42 CFR part 59, subpart A. The proposal includes a reference to 45 CFR part 87 ('Equal Treatment for Faith-based Organizations') on the list of regulations that apply to the Title X family planning services program."[94]

The Equal Treatment for Faith-Based Organizations rule, however, only applies to "HHS social service programs," of which Title X is not one.[95] The preamble to the rule specifically states that the "Title X program has its own regulations at 42 CFR part 59," and "the Title X regulations would apply to how that program handles … referral matters."[96] It further explains that "[t]his final rule does not change how the provisions of the Title X regulation govern matters concerning the non-directive counseling rider and referrals in the Title X program, especially since the Title X regulations do not identify part 87 as applicable to Title X grants."[97] It also notes that "[n]othing in the rule

[92] *Id.* at 19,820.

[93] *Id.* at 19,831 (§ 59.5(a)(13)(ii)).

[94] *Id.* at 19,820.

[95] 45 C.F.R. § 87.2.

[96] Equal Participation of Faith-Based Organizations in the Federal Agencies' Programs and Activities, 85 Fed. Reg. 82,037, 82,117 (Dec. 17, 2020).

[97] *Id.*

addresses the provision of health care per se by health care providers, or provides health care providers with enhanced powers to refuse patient care."[98]

The Equal Treatment for Faith-Based Organizations rule explicitly disclaims an application to 42 C.F.R. part 59, explaining that Title X has its own governing regulations that the rule does not affect. Planned Parenthood therefore recommends that, to avoid unnecessary regulatory confusion, the Department remove this new proposed reference to the Equal Treatment for Faith-Based Organizations rule from the final rule.

CONCLUSION

Planned Parenthood strongly supports the revocation of the 2019 Rule and adoption of the Proposed Rule, which promises to correct course in the wake of the ill-advised and disruptive 2019 Rule that upended the Title X program—harming patients, providers, and the Title X program as a whole. While we recommend that the Department make the several discrete revisions to the Proposed Rule highlighted above, Planned Parenthood commends the Proposed Rule's commitment to nondirective counseling on all medical options, its refusal to impose unnecessary and wasteful separation requirements, and its broad respect for Title X's mission, and looks forward to returning to the program after the finalization of the Proposed Rule.

Respectfully,

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98 *Id.*