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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

STATE OF CALIFORNIA, BY AND THROUGH ATTORNEY GENERAL XAVIER BECERRA,

Plaintiff,

v.

ALEX AZAR, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; DOES 1-100,

Defendants.

DECLARATION OF KATHRYN KOST IN SUPPORT OF A MOTION FOR A PRELIMINARY INJUNCTION

Date:	April 18, 2019
Time:	12:30 p.m.
Dept:	Courtroom 5, 17th Floor
Judge:	The Honorable Edward M. Chen
Trial Date:	Not set
Action Filed:	March 4, 2019

I, Kathryn Kost, declare as follows:

1. I am Acting Vice President of Domestic Research at the Guttmacher Institute, where I have worked in a full-time or consulting capacity since 1989.

2. I hold a B.A. in sociology from Reed College and a Ph.D. in sociology, specializing in demography, from Princeton University.

3. The Guttmacher Institute is a private, independent, nonprofit, nonpartisan corporation that advances sexual and reproductive health and rights through an interrelated program of research, policy analysis, and public education. The Institute's overarching goal is to ensure quality sexual and reproductive health for all people worldwide by conducting research according to the highest standards of methodological rigor and promoting evidence-based policies. It produces a wide range of resources on topics pertaining to sexual and reproductive health and publishes two peer-reviewed journals.

4. The information and analysis Guttmacher generates on reproductive health and rights issues are widely used and cited by researchers, policymakers, the media and advocates across the ideological spectrum. Guttmacher began as the Center for Family Planning Development in the late 1960s and contributed research to Congress in its creation of Title X. In the early 2010s, Guttmacher experts were among those selected to participate in the Centers for Disease Control and Prevention (CDC) and the Office of Population Affairs' (OPA) development of the national standards of care for family planning services. The Department of Health and Human Services (HHS) frequently invokes Guttmacher research, including in the context of Title X.[1,2]

5. Over the course of more than 30 years, I have designed, executed, analyzed, and supervised numerous quantitative and qualitative research studies in the field of reproductive

[1] U.S. Department of Health and Human Services (HHS), Compliance with statutory program integrity requirements, *Federal Register*, 2019, 84(42):7714–7791, https://www.federalregister.gov/documents/2019/03/04/2019-03461/compliance-with-statutory-program-integrity-requirements.

[2] Healthy People 2020, Family planning, objectives, 2018, https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning/objectives.

health care, including those on contraceptive use and failure, unintended pregnancy, maternal and child health, and analysis of trends in key demographic and reproductive health measures. My peer-reviewed research has been published in dozens of articles, including first-authored work in *Demography*, *Perspectives on Sexual and Reproductive Health*, *Contraception*, *Family Planning Perspectives*, *Studies in Family Planning* and other public health, medical and demographic journals. My education, training, responsibilities and publications are set forth in greater detail in my curriculum vitae, a true and correct copy of which is attached as Exhibit A. I submit this declaration as an expert on reproductive health care, family planning, and unintended pregnancy, and the impact on individuals, families, and public health from access to contraception and related care, or interference with that care, in the United States.

6. I understand that this lawsuit involves a challenge to the federal government's newly issued regulations regarding the Title X family planning program (the "New Rule," published at 84 Fed. Reg. 7714). In addition to my own expertise on family planning topics, including for example, on demographic trends in unintended pregnancy and disparities in its incidence, and on contraception, including access to it as well as its use, efficacy, and importance for the prevention of unintended pregnancy, in my role as Acting Vice President of Domestic Research at Guttmacher, I lead a team of researchers whose specialties include publicly funded family planning programs.

7. As discussed in more detail below, research over many decades establishes that Title X projects have been extremely effective in expanding access to modern contraceptive technologies, including the most effective methods, for patients with limited economic means. As a result, Title X projects have helped significantly diminish the rate of unintended pregnancies in the United States. Research also shows that Title X providers are especially effective in gaining patients' trust, treating particularly marginalized populations, offering a broad range of effective options for patients' personal, voluntary decision-making, and helping individuals take control of their own reproductive plans and lives. Since its inception, the Title X program has provided high-quality family planning care to low-income individuals, improved public health, and saved public expense at all levels of government.

8. In my expert opinion, the New Rule, if implemented, would force the Title X program in counterproductive directions that are contrary to evidence-based family planning research and that would significantly undermine the individual and public health benefits of Title X in multiple ways.

9. The New Rule would immediately harm the quality of care provided in Title X-funded health centers; deprive patients of non-directive pregnancy options counseling, including referrals; compromise Title X patients' ability to obtain timely, acceptable and effective contraceptive methods; and increase (rather than continue to help diminish) individuals' risk of unintended pregnancy.

10. In addition, many of the high-quality, experienced providers that have been the hallmark of Title X care for years would be pushed from the program. The departure of these providers from the network, without similarly effective providers to take their place, would result in a reduction in patients served and further hamstring the Title X program.

11. Ultimately, the New Rule would fundamentally subvert the Title X program's purpose of helping to close the gap in contraceptive access between individuals and couples with more resources and those with less, ensuring that low-income individuals can count on receiving the highest standard of family planning care. The evidence-based clinical recommendations that guide the delivery of Title X set the bar for what high-quality family planning care should look like: services that are comprehensive, timely, affordable, voluntary, confidential and respectful of all who seek them. The New Rule would effectively transform Title X from the gold standard of family planning care to a program that prioritizes providers' religious or moral beliefs over patient-centered care—with the government's imprimatur. This would erode the nearly 50-year legacy of Title X–funded sites serving as trusted providers of evidenced-based, high-quality, ethical medical care.

12. The negative consequences of the New Rule would impact not only current and future patients, but also their children and families, public health, government budgets, and the nation's health care infrastructure.

I. THE TITLE X PROGRAM REDUCES SYSTEMIC GAPS IN ACCESS TO HIGH-QUALITY FAMILY PLANNING SERVICES.

A. Title X Expands Access to Wanted Family Planning Services Among Low-Income Individuals

13. The Title X Family Planning Program is the nation's only federal program devoted exclusively to providing family planning services.[3]

14. At President Richard Nixon's urging and with strong bipartisan support, Congress established the Title X program in 1970 to make modern contraceptive options and the clinical care they required just as accessible to low-income women as they were to more affluent women.[4] Studies in the 1960s showed that women with low incomes wanted the same number of children as more affluent women, yet had more children than they desired because they lacked access to modern contraceptives.[5]

15. Title X helps low-income individuals maintain reproductive health; avoid pregnancies they do not want; and determine the number, timing, and spacing of their children, all of which contribute to the health and social and economic well-being of patients, their families and communities. In addition to providing access to the most advanced contraceptive methods, comprehensive counseling and information, and related medical services, Title X providers also offer basic clinical infertility services (infertility counseling and screening), as well as pregnancy testing and nondirective counseling on all pregnancy options, including referral upon request regarding prenatal care, adoption, and abortion.[6] Title X funding can also support clinical services addressing other aspects of patients' sexual and reproductive health, including STI testing,

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[3] 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/catalog/12585/a-review-of-the-hhs-family-planning-program-mission-management.

[4] 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.

[5] Ryder NB and Westoff CF, *Reproduction in the United States*, Princeton, NJ: Princeton University Press, 1971.

[6] Office of Population Affairs (OPA), HHS, *Program Requirements for Title X Funded Family Planning Projects*, Washington, DC: OPA, 2014, https://www.hhs.gov/opa/sites/default/files/Title-X-2014-Program-Requirements.pdf.

counseling and treatment, cervical and breast cancer screening and prevention, and screening for high blood pressure, diabetes and depression, or other preconception issues.[7,8]

16. For any health services outside a provider's scope of care, Title X program regulations and guidelines require referrals to and coordination with other health care providers, social service agencies, and other resources, including but not limited to those that are publicly funded.[9,10]

17. Since the program's inception, Title X funds have been prohibited from use in programs where abortion is a method of family planning.[11] Title X providers, however, are explicitly required to offer patients who are pregnant factual, nondirective information and counseling, including referrals, on all pregnancy options, including abortion, that the patient wishes to consider.[12,13]

B. The Title X Program Requires the Provision of High-Quality Family Planning Care

18. The principles of high-quality, ethical care defined in the Title X statute, regulations and program guidelines apply to all women, men and adolescents served by a Title X project.[14]

19. A central tenet of Title X family planning care is that it is voluntary and non-coercive. This is critical, because history has shown that family planning programs can and have been abused as a tool of social control: Deliberate campaigns have been waged, for example, to

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[7] Ibid.

[8] 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.

[9] OPA, HHS, *Program Requirements for Title X Funded Family Planning Projects*, Washington, DC: OPA, 2014, https://www.hhs.gov/opa/sites/default/files/Title-X-2014-Program-Requirements.pdf.

[10] 42 CFR 59.5.

[11] 42 USC 300.

[12] P.L. 115-141, Mar. 23, 2018.

[13] 42 CFR 59.5.

[14] 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/catalog/12585/a-review-of-the-hhs-family-planning-program-mission-management.

limit the fertility of women of color, low-income women, incarcerated women, and women with disabilities.[15]

20. Title X's authorizing statute requires that projects offer clients a broad range of contraceptive methods from which they can choose. This protection helps ensure that individuals seeking contraceptive care are not coerced into using any method they do not want, and to help ensure individuals can in fact obtain the methods that will work best for them. The statute also expressly prohibits conditioning individuals' participation in other publicly funded programs on the acceptance of family planning services.[16]

21. Voluntary decision-making necessarily depends on access to information. Title X standards promote informed decision-making by offering neutral and complete factual counseling, with regard to contraceptives, pregnancy, and other Title X clinical care.

22. In addition to this foundational principle, Title X care is also governed by standards published by OPA, which administers the Title X program, and the CDC, under the title: "Providing Quality Family Planning Services" ("the QFP").[17] The QFP resulted from an exhaustive, multi-year process involving numerous panels of experts from around the country. They were tasked with developing national, evidence-based clinical recommendations intended to serve as the national standard of care for all providers of family planning services, whether publicly funded or not.[18] The QFP is periodically updated by CDC and OPA, including as recently as December 2017.

23. The Title X Family Planning Guidelines, through which HHS implements the Title X program, require Title X grantees to adhere to the QFP.[19]

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[15] 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.

[16] 42 USC 300.

[17] 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.

[18] Godfrey EM et al., Developing federal clinical care recommendations for women, *American Journal of Preventive Medicine*, 2015, 49(2):S6–S13.

[19] OPA, HHS, Program Requirements for Title X Funded Family Planning Projects,

24. The QFP recommends offering a full range of Food and Drug Administration (FDA)-approved contraceptive methods and counseling that highlights methods' effectiveness in helping to prevent pregnancy, further explaining that: "Contraceptive counseling is … a process that enables clients to make and follow through on decisions about their contraceptive use."[20] The selected contraceptive method(s) are preferably provided to the patient onsite and in multiple cycles (if applicable), the patient should be able to start their chosen methods immediately (unless medically contraindicated), and clinicians should assist patients in their decision-making through patient-centered planning and counseling discussions.[21]

25. The QFP also sets the standard of care for pregnancy testing and counseling, which are core family planning services supported by Title X. Indeed, 100% of Title X sites offer pregnancy testing.[22] The QFP specifically instructs that "[positive pregnancy] test results should be presented to the client, followed by a discussion of options and appropriate referrals. Options counseling should be provided in accordance with the recommendations from professional medical associations, such as ACOG and AAP."[23] Both ACOG and AAP are explicit in their recommendations that all pregnant individuals, including adolescents, be provided with factual, nondirective pregnancy options counseling that includes information on and timely referral for abortion services.[24][25]

Washington, DC: OPA, 2014, https://www.hhs.gov/opa/sites/default/files/Title-X-2014-Program-Requirements.pdf, see p.5.

[20] 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.

[21] Ibid.

[22] 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.

[23] 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.

[24] American College of Obstetricians and Gynecologists (ACOG), *Guidelines for Women's Health Care: A Resource Manual*, fourth ed., Washington, DC: ACOG, 2014.

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

26. Leading professional medical associations, including those referenced by the QFP, state unequivocally that it is unethical to withhold relevant information about options from patients or mislead patients as to their options, when patients indicate a desire for information.[26,27]

27. The QFP further stresses that "every effort should be made to expedite" referrals for pregnant patients and that initial prenatal counseling is to be provided only for "clients who are considering or choose to continue the pregnancy."[28]

28. Taken together, these provisions of the QFP ensure that patients are able to make informed decisions about and truly consent to their own health care.[29]

C. Title X Patients Reflect the Program's Priorities

29. In 2017, Title X-funded providers served approximately 4.0 million individual family planning patients, providing 6.6 million family planning visits.[30] These numbers demonstrate that many patients visit their Title X provider multiple times in a given year.

30. Consistent with the program's prioritization of low-income individuals, in 2017, 90% (3.6 million) of Title X patients had household incomes that qualified them for either free or reduced-cost services under Title X:[31] Sixty-seven percent (2.7 million) had family incomes at or below 100% of the federal poverty level, and 23% (932,000) had incomes ranging from 101% to

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[26] ACOG, Guidelines for Women's Health Care: A Resource Manual, fourth ed., Washington, DC: ACOG, 2014.

[27] American Academy of Physician Assistants (AAPA), Guidelines for Ethical Conduct for the PA Profession, 2013, https://www.aapa.org/wp-content/uploads/2017/02/16-EthicalConduct.pdf.

[28] 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.

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

[30] Fowler CI et al., *Title X Family Planning Annual Report: 2017 National Summary*, Research Triangle Park, NC: RTI International, 2018, https://www.hhs.gov/opa/title-x-family-planning/fp-annual-report/index.html.

[31] Ibid.

250% of that threshold.[32] In 2017, the federal poverty level was $12,060 for a single-person household, and $20,420 for a household of three.[33]

31. In 2017, 42% (1.7 million) of Title X patients were uninsured, 38% (1.5 million) had some form of public health insurance (reflecting household incomes low enough to qualify for public coverage), and 19% (760,000) had private health insurance.[34] Although increases in health insurance coverage in recent years suggest somewhat greater overall access to health care for Title X patients, the proportion of uninsured Title X patients is still more than triple the national proportion among all women of reproductive age (12%).[35] Furthermore, some 17% of insured patients are not in a position to use their insurance to pay for the clinic visit.[36] The most common reasons given by insured clients for not using their coverage were that the services they were going to receive were not covered under their plan (31%) or that someone might find out about their visit if they did so (28%).[37]

32. In 2017, 47% of Title X patients (1.9 million) were aged 20 to 29, 35% (1.4 million) were 30 or older, and 17% (693,724) were younger than 20.[38] This shows that while the greatest proportion of Title X patients are young adults in their 20s, Title X providers serve individuals of all reproductive ages.

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[32] Ibid.

[33] 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.

[34] Fowler CI et al., *Title X Family Planning Annual Report: 2017 National Summary*, Research Triangle Park, NC: RTI International, 2018, https://www.hhs.gov/opa/title-x-family-planning/fp-annual-report/index.html.

[35] Guttmacher Institute, Gains in insurance coverage for reproductive-age women at a crossroads, *News in Context*, Dec. 4, 2018, https://www.guttmacher.org/article/2018/12/gains-insurance-coverage-reproductive-age-women-crossroads.

[36] 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):101–109, https://www.guttmacher.org/journals/psrh/2018/06/use-health-insurance-among-clients-seeking-contraceptive-services-title-x.

[37] Ibid.

[38] Fowler CI et al., *Title X Family Planning Annual Report: 2017 National Summary*, Research Triangle Park, NC: RTI International, 2018, https://www.hhs.gov/opa/title-x-family-planning/fp-annual-report/index.html.

33. In 2017, 31% (1.2 million) of Title X patients self-identified with at least one of the Office of Management and Budget's nonwhite race categories: Black or African American, Asian, Native Hawaiian or Pacific Islander, American Indian or Alaska Native, or more than one race. Thirty-three percent (1.3 million) of Title X patients identified as Hispanic or Latino.[39]

34. In 2017, 14% (553,241) of Title X patients reported having limited English language proficiency.[40]

II. TITLE X-SUPPORTED SERVICES YIELD ENORMOUS BENEFITS TO INDIVIDUALS, FAMILIES AND PUBLIC HEALTH

A. Title X-Supported Contraceptive Care Helps Individuals Avoid Pregnancies They Do Not Want, and Time and Space Wanted Pregnancies

35. In 2015, the most recent year for which these numbers are available, the contraceptive care delivered by Title X-supported providers helped women avoid an estimated 822,000 unintended pregnancies, which would have resulted in an estimated 387,000 births and 278,000 abortions.[41,42] Without the contraceptive care provided by these Title X-funded health centers that year, the U.S. rates of unintended pregnancy and abortion would have been 31% higher, and the adolescent unintended pregnancy rate would have been 44% higher.[43]

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[39] Ibid.

[40] Ibid.

[41] 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.

[42] The numbers of pregnancies, births and abortions prevented by contraceptive services provided by Title X-supported sites are derived by first estimating the number of pregnancies that would occur over one year among women using the mix of contraceptive methods found among all patients receiving contraceptive care. This is compared to the number of pregnancies that would occur among a hypothetical group of similar women who do not have access to publicly funded services. This methodology relies on updated information on contraceptive failure rates for different methods, use of national survey data to construct the hypothetical cohort, and a number of adjustments that align the results with actual numbers of pregnancies occurring to women using contraceptive methods. For more detailed methodology, see:

Frost JJ et al., *Contraceptive Needs and Services, 2010: Methodological Appendix*, New York: Guttmacher Institute, 2013, https://www.guttmacher.org/sites/default/files/report_downloads/contraceptive-needs-methodology_0.pdf; 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):667–720, https://onlinelibrary.wiley.com/doi/epdf/10.1111/1468-0009.12080.

[43] Frost JJ, et al., *Publicly Funded Contraceptive Services at U.S. Clinics, 2015*, New

36. This impact comes from Title X's expansion of low-income individuals' ability to freely choose from among a broad range of acceptable and effective contraceptive methods, along with related counseling and clinical services.[44]

37. The ability to obtain contraceptive methods that best meet an individual's needs helps that person feel satisfied with their chosen methods, and women who are satisfied with their current contraceptive methods are more likely to use them consistently and correctly.[45] For example, only 35% of satisfied oral contraceptive users have skipped at least one pill in the past three months, compared with 48% of dissatisfied users.[46]

38. Consistent and correct contraceptive use increases individuals' likelihood of successfully avoiding unintended pregnancies: The women at risk for unintended pregnancy (those who are sexually active and able to become pregnant but are not pregnant and do not want to become pregnant) who consistently and correctly use a contraceptive method account for only 5% of unintended pregnancies.[47]

39. True choice in contraceptive methods is also important because U.S. women and couples rely on a broad mix of contraceptive methods and sometimes use two or more methods at

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York: Guttmacher Institute, 2017, https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015.

[44] 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.

[45] Frost JJ and Darroch JE, Factors associated with contraceptive choice and inconsistent method use, United States, 2004, *Perspectives on Sexual and Reproductive Health*, 2008, 40(2):94–104, https://www.ncbi.nlm.nih.gov/pubmed/18577142.

[46] Ibid.

[47] 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.

once.[48,49] Furthermore, most individual women rely on multiple methods over the course of their reproductive lives, with 86% having used three or more methods by their early 40s.[50]

40. The ability to make an informed choice from a broad range of method options is also important to ensuring individuals can obtain and use the contraceptive methods that best fulfill their own needs and priorities, which may include not only preventing pregnancy, but also managing potential side effects, drug or hormonal interactions, perceived risk of HIV and other STIs, and many other considerations.[51]

41. Offering patients a wide choice of contraceptive methods—or the choice to use no method at all—is also essential to guarding against reproductive coercion, and requires considerable resources and provider expertise, which Title X expressly facilitates.[52]

42. Title X sites facilitate choice by providing a greater number of contraceptive method options to their patients, as compared to other publicly funded health centers that do not receive Title X support and provide contraceptive care to at least 10 women each year[53] —70% of

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[48] Kavanaugh ML and Jerman J, Contraceptive method use in the United States: trends and characteristics between 2008, 2012 and 2014, *Contraception*, 2017, 97(1):14-21, https://www.guttmacher.org/article/2017/10/contraceptive-method-use-united-states-trends-and-characteristics-between-2008-2012.

[49] Kavanaugh ML and Jerman J, Concurrent multiple methods of contraception in the United States, poster presented at the North American Forum on Family Planning, Atlanta, Oct. 14–16, 2017.

[50] Daniels K, Mosher WD and Jones J, Contraceptive methods women have ever used: United States, 1982–2010, *National Health Statistics Reports*, 2013, No. 62, https://www.cdc.gov/nchs/products/nhsr.htm.

[51] Lessard LN et al., Contraceptive features preferred by women at high risk of unintended pregnancy, *Perspectives on Sexual and Reproductive Health*, 2012, 44(2):194–200, https://www.guttmacher.org/journals/psrh/2012/09/contraceptive-features-preferred-women-high-risk-unintended-pregnancy.

[52] 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.

[53] Together, these sites are also referred to as "safety-net family planning centers." This group includes health centers that offer contraceptive care to the general public and use public funds (e.g., federal, state or local funding though programs such as Title X, Medicaid or the federally qualified health center program) to provide free or reduced-fee services to at least some clients. Sites must serve at least 10 contraceptive clients per year to be counted among this group. These sites are operated by a diverse range of provider agencies, including public health departments, Planned Parenthood affiliates, hospitals, federally qualified health centers and other

which are operated by federally qualified health centers (FQHCs).[54] *See infra*, Section D. Seventy-two percent of Title X sites offer a full range of FDA-approved reversible contraceptive methods, compared to 49% of non-Title X sites.[55] Title X-supported centers offer a choice of 12 methods, on average, and 85% offer at least one long-acting reversible method, such as the IUD or contraceptive implant.[56]

43. Title X-supported centers are also more likely than non-Title X providers to offer contraceptives on site rather than give a prescription that women must fill at a pharmacy or a referral to another provider for insertion of an IUD or implant. Seventy-two percent of Title X–funded centers provide oral contraceptive supplies and refills on site, compared with only 40% of sites not funded by the program.[57] Similarly, among Title X sites, 41% offer same-day insertion of IUDs or implants, compared to 27% of non-Title X sites.[58] Minimizing the number of trips a woman must make to obtain her contraceptive methods makes it easier for her to successfully use those methods, especially for those who juggle the demands of school, family and work, or who rely on public or perhaps a borrowed mode of transportation—all common complicating factors in patients' lives.

44. Among the 3.1 million sexually active female patients at risk of unintended pregnancy who visited a Title X site in 2017, 70% (2.2 million) left their last visit with a contraceptive method deemed either most or moderately effective at preventing pregnancy.[59] This

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independent organizations.

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

[55] 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.

[56] Ibid.

[57] Ibid.

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

[59] Fowler CI et al., *Title X Family Planning Annual Report: 2017 National Summary*, Research Triangle Park, NC: RTI International, 2018, https://www.hhs.gov/opa/title-x-family-planning/fp-annual-report/index.html.

is unsurprising, given that an important feature for most individuals seeking contraceptive care is how well a method works to prevent pregnancy.[60] "Most effective" methods include vasectomy, female sterilization, implant, or IUD, and "moderately effective" methods include injectable contraception, vaginal ring, contraceptive patch, pills, diaphragm, or cervical cap.[61] These methods require a prescription or services provided by a medical professional. In contrast, the contraceptive methods that can be purchased over the counter at a neighborhood drugstore for a comparatively low cost—male condoms and spermicide—are far less effective at preventing pregnancy than methods that require a prescription or a visit to a health care provider, which have higher up-front and ongoing costs.[62]

45. While long-acting reversible contraceptives ("LARC"), such as implants and IUDs are very effective, they are also costly.[63] Without any third-party payer to help defray the expense, the total cost to the patient of initiating one of these methods generally exceeds $1,000.[64] Oral contraceptives, which are nearly twice as effective as condoms in practice, require a prescription and have ongoing monthly costs.[65] Many methods would cost a patient at least $50 per month, or upwards of $600 per year.[66]

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[60] Lessard LN et al., Contraceptive features preferred by women at high risk of unintended pregnancy, *Perspectives on Sexual and Reproductive Health*, 2012, 44(2):194–200, https://www.guttmacher.org/journals/psrh/2012/09/contraceptive-features-preferred-women-high-risk-unintended-pregnancy.

[61] Fowler CI et al., *Title X Family Planning Annual Report: 2017 National Summary*, Research Triangle Park, NC: RTI International, 2018, https://www.hhs.gov/opa/title-x-family-planning/fp-annual-report/index.html.

[62] Hatcher RA et al., C*ontraceptive Technology*, 21st ed., New York: Ayer Company Publishers, Inc., 2018.

[63] Ibid.

[64] Eisenberg D, McNicholas C and Peipert JF, Cost as a barrier to long-acting reversible contraceptive (LARC) use in adolescents, *Journal of Adolescent Health*, 2013, 52(4):S59–S63, http://www.jahonline.org/article/S1054-139X(13)00054-2/fulltext.

[65] Sundaram A et al., Contraceptive failure in the United States: Estimates from the 2006-2010 National Survey of Family Growth, *Perspectives on Sexual and Reproductive Health*, 2017, 49(1):7-16, https://www.guttmacher.org/journals/psrh/2017/02/contraceptive-failure-united-states-estimates-2006-2010-national-survey-family.

[66] Planned Parenthood, How do I get birth control pills? No date, https://www.plannedparenthood.org/learn/birth-control/birth-control-pill/how-do-i-get-birth-control-pills.

46. Title X providers work hard to ensure that women are able to start their method at the same time that they request it. For example, Title X–supported centers are particularly likely to use the so-called "quick start" protocol (87% of them did so in 2015, as compared to only 66% of all publicly funded health centers delivering contraceptive care not supported by Title X), under which clients who choose to use oral contraceptives begin taking them immediately, rather than waiting until a certain point in their menstrual cycles, as some providers require.[67]

47. Title X–supported centers are also particularly likely to prescribe contraception without requiring a pelvic exam (88%, as compared to only 76% of non-Title X supported clinics),[68] a practice in line with evidence-based guidelines issued by the World Health Organization[69] and the American College of Obstetricians and Gynecologists.[70]

48. Title X support also helps clinicians to obtain the necessary training and spend the needed time during a patient visit to provide in-depth contraceptive counseling and explore options with clients.[71] On the whole, clinicians at Title X-supported sites spend more time with patients during initial contraceptive visits than do clinicians at non-Title X sites—especially those clients with specific needs, such as those who are younger, have limited English proficiency or have other complex medical or personal issues.[72]

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[67] 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.

[68] Ibid.

[69] World Health Organization (WHO), *Selected Practice Recommendations for Contraceptive Use*, 3rd ed., Geneva: WHO, 2016, https://www.who.int/reproductivehealth/publications/family_planning/SPR-3/en/.

[70] ACOG, The utility and indications for routine pelvic examinations, Committee Opinion No. 754, *Obstetrics & Gynecology*, 2018, 132:e174–180, https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/The-Utility-of-and-Indications-for-Routine-Pelvic-Examination.

[71] 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.

[72] Frost JJ et al., *Variation in Service Delivery Practices Among Clinics Providing Publicly Funded Family Planning Services in 2010*, New York: Guttmacher Institute, 2012, https://www.guttmacher.org/report/variation-service-delivery-practices-among-clinics-providing-publicly-funded-family-planning.

B. Title X-Supported Care Helps Prevent Preterm or Low-Birth-Weight Births and Other Negative Health Outcomes

49. The contraceptive services provided at Title X family planning visits also help prevent poor birth outcomes. In 2010 (the most recent year for which these estimates are available), the contraceptive services provided by Title X-supported providers helped individuals and couples to avert an estimated 87,000 preterm or low-birth-weight births.[73,74]

50. Contraceptive use enables women to plan their pregnancies, and women who plan generally recognize their pregnancies earlier on, in turn allowing women more time to engage in behaviors that promote healthy pregnancies, such as taking prenatal vitamins, and reducing or stopping smoking and drinking.[75]

51. Moreover, by enabling women to plan their pregnancies, contraceptive use can decrease individuals' risk for pregnancy-related morbidity and mortality.[76] The risk of such adverse outcomes is particularly high for individuals who are near the end of their reproductive years and for those with medical conditions that may be exacerbated by pregnancy.[77] Although reversible contraceptives—like virtually all medications and medical devices—are not without

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[73] 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):667–720, https://onlinelibrary.wiley.com/doi/epdf/10.1111/1468-0009.12080.

[74] The numbers of preterm or low-birth-weight births that are prevented among women obtaining contraceptive services from Title X sites are derived by first estimating the overall number of births that are prevented, and then using national data to estimate the proportion of unintended births to women with the same characteristics as those going to clinics that are preterm or low-birth-weight. For more detailed methodology, see: 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):667–720, https://onlinelibrary.wiley.com/doi/epdf/10.1111/1468-0009.12080.

[75] Kost K and Lindberg L, Pregnancy intentions, maternal behaviors and infant health: investigating relationships with new measures and propensity score analysis, *Demography*, 2015, 52(1):83–111, https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/kost-lindberg-demography_s13524-014-0359-9.pdf.

[76] Kavanaugh ML and Anderson RM, *Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Center*s, New York: Guttmacher Institute, 2013, https://www.guttmacher.org/report/contraception-and-beyond-health-benefits-services-provided-family-planning-centers.

[77] Berg C et al., Pregnancy-related mortality in the United States, 1998 to 2005, *Obstetrics & Gynecology*, 2010, 116(6):1302–1309.

risk, the likelihood of serious health risks is lower than that for pregnancy or childbirth, which can be an important consideration for individual patients.[78][79]

C. Title X-Supported Services Contribute to the Prevention, Early Detection and Treatment of STIs

52. Title X-supported STI testing and screening also yields considerable benefits for individuals' and their partners' sexual and reproductive health. Testing for chlamydia, gonorrhea and/or HIV are conducted routinely as part of family planning visits.[80] Chlamydia and gonorrhea testing can help prevent additional health problems, such as pelvic inflammatory disease, ectopic pregnancy and infertility.[81,82,83] Testing can do so directly, by detecting an infection early and facilitating treatment, and indirectly, because treating an infection prevents its spread to a client's current sexual partners and to any future partners they may have.[84]

53. Similarly, HIV testing and early detection help facilitate treatment and reduce transmission of the virus to partners, because they may lead to less risky behavior after a positive test result and to reduced infectivity after entry into treatment.[85]

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[78] Speidel JJ et al., Pregnancy: not a disease but still a health risk, *Contraception*, 2013, 88(4):481–484.

[79] Harlap S, Kost K and Forrest JD, *Preventing Pregnancy, Protecting Health*: *A New Look at Birth Control in the United States*, New York: Guttmacher Institute, 1991.

[80] 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.

[81] Kavanaugh ML and Anderson RM, *Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers*, New York: Guttmacher Institute, 2013, https://www.guttmacher.org/report/contraception-and-beyond-health-benefits-services-provided-family-planning-centers.

[82] Centers for Disease Control and Prevention (CDC), Chlamydia- CDC Fact Sheet, *Fact Sheet*, Atlanta: CDC, 2017, https://www.cdc.gov/std/chlamydia/stdfact-chlamydia.htm.

[83] CDC, Gonorrhea- CDC Fact Sheet, *Fact Sheet*, Atlanta: CDC, 2017, https://www.cdc.gov/std/gonorrhea/stdfact-gonorrhea.htm.

[84] Workowski KA and Bolan GA, Sexually transmitted diseases treatment guidelines, 2015, *Morbidity and Mortality Weekly Report*, 2015, Vol. 64, No. 3, https://www.cdc.gov/std/tg2015/default.htm.

[85] Marks G et al., Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the United States implications for HIV prevention programs, *Journal of Acquired Immune Deficiency Syndromes*, 2005, 39(4):446–453.

54. In 2017, Title X providers tested 61% (939,300) of female patients under age 25 for chlamydia, and they performed 2.4 million gonorrhea tests (6.1 tests per 10 patients), 1.2 million confidential HIV tests (3.0 tests per 10 patients), and 709,000 syphilis tests (1.8 tests per 10 patients).[86] Of the confidential HIV tests performed, 2,200 (1.8 per 1,000 tests performed) were positive.[87]

55. In 2010 (the most recent year for which these data are available), the STI testing, screening and related services provided by Title X-supported providers helped to avert an estimated 63,000 STIs.[88]

D. Title X-Supported Services Contribute to the Prevention and Early Detection of Cervical Cancer

56. Title X funding and services also support the provision of services intended to aid in the prevention and early detection of cervical cancer as part of routine family planning care, namely Pap tests, human papillomavirus (HPV) testing and HPV vaccinations.[89] Pap tests—now often performed in conjunction with HPV tests in accordance with clinical recommendations—help to detect abnormal cervical cells and cases of precancer, which allows for early treatment that prevents cervical cancer cases and deaths.[90,91] HPV vaccinations help protect clients against the viral strains of HPV most commonly linked to cervical cancer; they also provide some

[86] Fowler CI et al., *Title X Family Planning Annual Report: 2017 National Summary*, Research Triangle Park, NC: RTI International, 2018, https://www.hhs.gov/opa/title-x-family-planning/fp-annual-report/index.html.

[87] Ibid.

[88] 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):667–720, https://onlinelibrary.wiley.com/doi/epdf/10.1111/1468-0009.12080.

[89] Fowler CI et al., *Title X Family Planning Annual Report: 2017 National Summary*, Research Triangle Park, NC: RTI International, 2018, https://www.hhs.gov/opa/title-x-family-planning/fp-annual-report/index.html.

[90] Sonfield A, Beyond preventing unplanned pregnancy: the broader benefits of publicly funded family planning services, *Guttmacher Policy Review*, 2014, 17(4):2–6, https://www.guttmacher.org/gpr/2014/12/beyond-preventing-unplanned-pregnancy-broader-benefits-publicly-funded-family-planning.

[91] CDC, Gynecological cancers: what should I know about screening, 2018, https://www.cdc.gov/cancer/cervical/basic_info/screening.htm.

protection against HPV-attributable cancers of the vulva, vagina, anus, rectum, and oropharynx.[92,93]

57. In 2017, Title X-supported sites provided Pap tests to screen for cervical cancer to 18% (649,300) of female patients. Fourteen percent of those Pap tests yielded indeterminate or abnormal results, prompting further evaluation and possible treatment.[94]

58. In 2010 (the most recent year for which these data are available), the cervical cancer prevention services provided by Title X-supported providers helped to prevent an estimated 2,000 cases of cervical cancer.[95]

E. Title X Provides a Gateway to Health Coverage and Care

59. For 60% of Title X patients, that Title X-supported provider was their sole source of medical care in the last year, making these providers critical sources of care in their own right.[96] However, Title X providers have also long served as entry points to the broader health care system for many individuals, as the high-quality, low-cost, confidential services they offer enable many people to walk through Title X providers' doors when they would not be willing or able to walk through others.[97]

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[92] Sonfield A, Beyond preventing unplanned pregnancy: the broader benefits of publicly funded family planning services, *Guttmacher Policy Review*, 2014, 17(4):2–6, https://www.guttmacher.org/gpr/2014/12/beyond-preventing-unplanned-pregnancy-broader-benefits-publicly-funded-family-planning.

[93] CDC, Human papillomavirus: why is HPV vaccine important, 2017, https://www.cdc.gov/hpv/hcp/hpv-important.html.

[94] Fowler CI et al., *Title X Family Planning Annual Report: 2017 National Summary*, Research Triangle Park, NC: RTI International, 2018, https://www.hhs.gov/opa/title-x-family-planning/fp-annual-report/index.html.

[95] 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):667–720, https://onlinelibrary.wiley.com/doi/epdf/10.1111/1468-0009.12080.

[96] 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):101–109, https://www.guttmacher.org/journals/psrh/2018/06/use-health-insurance-among-clients-seeking-contraceptive-services-title-x.

[97] Gold RB, The role of family planning centers as gateways to health coverage and care, *Guttmacher Policy Review*, 2011, 14(2):15–19, https://www.guttmacher.org/gpr/2011/06/role-family-planning-centers-gateways-health-coverage-and-care.

60. Title X sites have long engaged in outreach and enrollment assistance efforts helping eligible people obtain comprehensive health insurance coverage, particularly since the ACA's implementation.[98]

61. Title X providers' referral relationships help ensure that individuals who need them can obtain services and supports outside their family planning visit. Ninety-nine percent of sites have formal or informal referral relationships with other providers; 97% refer to other public providers, including FQHCs and other community clinics offering primary care, and 90% refer to private providers, including ob-gyns and private physicians or group practices.[99] Sixty-two percent of Title X sites refer patients to social service agencies, and nearly half to home visiting programs or services.

F. Title X-Supported Services Help Individuals to Achieve Their Educational, Workforce and Economic Goals

62. By enabling individuals and couples to more reliably time and space pregnancies, the Title X program promotes individuals' continued educational and professional advancement, contributing to the enhanced economic stability of individuals and their families. In a 2011 national survey of more than 2,000 women obtaining family planning care from Title X sites focused on reproductive health care, women reported that over the course of their lives, contraception had enabled them to take better care of themselves or their families (63%), support themselves financially (56%), complete their education (51%), or get or keep a job (50%).[100]

63. When asked why they were seeking contraceptive services at that moment, women provided similar answers, including not being able to afford to care for a baby or another baby at that time (65%), not being ready to have children (63%), feeling that contraception gives them

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[98] Hasstedt K, Building it is not enough: family planning providers poised for key role in helping people obtain coverage under the Affordable Care Act, *Guttmacher Policy Review*, 2014, 17(4):7–13, https://www.guttmacher.org/gpr/2014/12/building-it-not-enough-family-planning-providers-poised-key-role-helping-people-obtain.

[99] 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.

[100] Frost JJ and Lindberg LD, Reasons for using contraception: perspectives of U.S. women seeking care at specialized family planning clinics, *Contraception*, 2013, 87(4):465–472.

better control over their life (60%) and wanting to wait to have a baby until life is more stable (60%).[101]

64. Economic analyses have found positive associations between women's ability to obtain and use oral contraceptives and their ability to obtain higher levels of education, participate in the labor force and obtain higher-paying jobs, in turn contributing to a narrowing of the gender-based wage gap.[102]

65. Given its connections to so many central aspects of people's lives, it makes sense that the ability to determine for oneself whether and when to have children is also related to an individual's mental health and happiness. Individuals and couples who experience an unintended pregnancy that ends in birth are particularly likely to experience depression, anxiety and a decreased perception of happiness.[103]

G. Title X Investment Yields Considerable Public Savings

66. In addition to promoting positive health and other outcomes for individuals, couples and families, and the broader public, Title X-supported services also yield considerable savings of government expenditures. Title X-supported services—including contraceptive care, STI testing, and cervical cancer testing and prevention—save approximately $7 for every public dollar invested.[104] This amounted to an estimated $8.1 billion in gross federal and state government savings in 2010 (the most recent year for which these data are available), by avoiding public expenditures that would have otherwise been made for medical care associated with unintended pregnancies, STIs and cervical cancer. The federal and state governments realized an

[101] Ibid.

[102] Sonfield A et al., *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children*, New York: Guttmacher Institute, 2013, https://www.guttmacher.org/sites/default/files/report_pdf/social-economic-benefits.pdf.

[103] Gipson JD, Koenig MA and Hindin MJ, The effects of unintended pregnancy on infant, child, and parental health: a review of the literature, *Studies in Family Planning*, 2008, 39(1):18–38.

[104] 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):667–720, https://onlinelibrary.wiley.com/doi/epdf/10.1111/1468-0009.12080.

estimated $7 billion in net savings that year, after subtracting the cost of delivering Title X-supported services.[105]

III. TITLE X FUNDS SUPPORT A NATIONWIDE NETWORK OF HEALTH CENTERS THAT ARE CRITICAL, TRUSTED SOURCES OF HIGH-QUALITY CARE FOR THEIR PATIENTS

67. The Title X program's ability to serve four million patients each year[106] and advance the extensive individual, familial and societal benefits articulated above depends on the participation of health care providers with the expertise, staff and resources necessary to deliver a truly broad range of contraceptive options and counseling, and related clinical services, to considerable numbers of patients.

68. In 2017, Title X funds supported a network of over 1,000 provider organizations, including both non-profit and public entities, which operated 3,858 service sites.[107]

69. In 2015, among Title X-supported centers, sites operated by Planned Parenthood represented 13% of sites and served 41% of all contraceptive patients; those operated by state or local health departments represented 48% of sites and served 28% of patients; sites operated by federally qualified health centers (FQHCs) accounted for 26% of sites and served 19% of patients; and other independent agencies operated 9% of all sites and served 7% of patients.[108] Seventy-two percent of Title X sites focus on the provision of reproductive health services,[109] 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%).[110]

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[105] Ibid.

[106] Fowler CI et al., *Title X Family Planning Annual Report: 2017 National Summary*, Research Triangle Park, NC: RTI International, 2018, https://www.hhs.gov/opa/title-x-family-planning/fp-annual-report/index.html.

[107] Ibid.

[108] 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.

[109] 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.

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

70. Reproductive health-focused sites serve a considerable majority of Title X patients. These 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.[111] (Patients served by the small number of reproductive health–focused sites that FQHCs report operating are not included in this estimate.)

71. Many women prefer to obtain contraceptive services from reproductive health–focused health centers over primary care–focused sites in their communities: Six in 10 women obtaining services at a reproductive health-focused provider report having made a visit to another provider in the last year, but chose the specialized provider for their contraceptive care; the remaining four in 10 of these women report that the reproductive health–focused provider was their only source of care in the last year, despite having other options in their communities.[112]

72. Leading reasons patients provided for preferring to visit reproductive–health focused sites over other, non-specialized sites include: "The staff here treat me respectfully" (84%), "Services here are confidential" (82%), and "The staff here know about women's health" (80%).[113]

IV. THE NEW RULE WOULD IMMEDIATELY HARM PATIENTS AND PUBLIC HEALTH BY IMPOSING SUBSTANDARD CARE AND DISRUPTING THE TITLE X SAFETY NET OF PROVIDERS

73. The New Rule would immediately impose substandard care on those who rely on Title X-funded providers by eliminating the requirement that Title X sites all offer nondirective pregnancy options counseling to patients who are pregnant and forbidding abortion referrals except in the case of medical emergency. This change deprives patients of information and referrals regarding all options, including abortion, if they are pregnant and is contrary to the QFP and medical ethics. Additionally, the New Rule would allow providers to deprive patients of full

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family-planning-clinic-survey-2015.

[111] Ibid.

[112] 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.

[113] Ibid.

information or provide them with misleading information, inhibit informed decision-making, and delay patients from obtaining the care they may desire.

74. In addition, the New Rule would require that all pregnant patients be referred for prenatal care, regardless of their wishes. Furthermore, while not mandatory, clinicians would be allowed to provide information on "maintaining the health of the mother and unborn child," even when it is not requested by the patient, in direct violation of Title X's central tenet that all services are voluntarily received and free from coercion.

75. The New Rule would also curtail contraceptive options for Title X clients by deemphasizing the provision of modern, medically approved contraceptive methods, diverting funds away from core family planning services, and encouraging a shift toward "non-traditional" providers that are permitted to offer a single or limited method(s) of contraception.

76. In addition to the direct, immediate impacts on patient care and public health, the New Rule would also create a massive disruption in the Title X network of providers that would compound the harms to patient and public health. The New Rule would put Title X grantees and the providers now participating in the Title X program in the untenable bind of choosing between two bad options: Either (1) agreeing to provide care that does not adhere to medical or ethical standards, because they want to continue providing at least some Title X–supported services for their low-income patients, or (2) deciding that they must exit the program because they are unwilling to comply with the New Rule's requirements for substandard care, and do so mid-grant, when the New Rule goes into effect. Title X grantees and providers may also be forced to exit the program because the New Rule would impose significant new costs and hurdles that are not tenable and would interfere with Title X's effectiveness even if they could be feasibly implemented—including new "financial and physical" separation requirements that also impose considerable limits on providers' use of funding for infrastructure.

77. Many current providers would feel compelled to choose the second option and leave the Title X program in the middle of the current funding cycle. The New Rule erroneously assumes that there would be sufficient available capacity and willingness among other health care providers—particularly, among primary care providers, such as FQHCs—to take their place. The

inevitable result would be a considerable disruption in the current Title X network and gaps in capacity.

78. The departure of providers would be acutely felt in areas of the country that do not have another safety-net family planning center. Twenty-one percent of Title X sites are in counties that do not have another safety-net family planning center.[114] Moreover, in one-fifth of all 3,142 U.S. counties, a Title X site is the only safety-net family planning center. If any of these sites were to no longer participate in Title X as a consequence of this rule, it would make it exceedingly difficult for low-income individuals in those areas to obtain high-quality, affordable family planning care.

79. Furthermore, the New Rule does not address the inevitable difficulty OPA would face in finding new, comparably qualified providers to fill this gap during its next funding cycle. HHS offers only a single letter submitted in response to the Proposed Rule as evidence of the existence of providers that might be able to fill the gap.[115] The letter and, in turn, HHS rely on 2009 and 2011 online surveys of "faith-based medical professionals" to suggest individual practitioners would increasingly participate in Title X under the New Rule, helping to fill the gap in service delivery. However, the evidence presented in the letter does not support HHS' conclusion. These surveys asked health care providers broadly about the importance of "conscience protections" to their ability to practice medicine, but did not assess providers' interest in participating in Title X or delivering family planning services specifically. Moreover, the letter and HHS offer no estimates of how many providers might newly participate, or their capacity to serve large numbers of contraceptive patients—critical considerations in contemplating the loss of current Title X providers that each serve thousands of patients each year. In fact, the letter suggests that faith-based organizations are unlikely to seek federal funding

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

[115] Imbody J, Comments re: RIN 0937-ZA00 Compliance with Statutory Program Integrity Requirements, July 31, 2018, https://www.regulations.gov/document?D=HHS-OS-2018-0008-69125.

without extensive grants training and restructuring of the grants process, activities that are not part of the new rule and that would take many years to implement, leaving huge gaps in service delivery for many years to come. The comment letter further asserts that FQHCs could fill the gap in Title X service delivery, an unrealistic suggestion addressed extensively in Section D, below.

80. Even if some new resources or new providers could be found, there would still be significant short-term and potentially long-term harms as patients are inevitably left without the high-quality, affordable Title X–supported care they rely on for months or longer.

81. The New Rule, if implemented, would thus trigger a downward spiral within the Title X program that harms patients, providers, grantees and public health right away and in a growing fashion from the effective date, and that current data and conditions indicate would be very hard to stop or reverse. Some patients would be effectively excluded from the program and others would receive inadequate care.

82. Taken together, and without any intervention, these changes would inevitably increase some people's risks for unintended pregnancy, undetected and untreated STIs, and cervical cancer, among other health effects.

83. Moreover, as soon as the New Rule takes effect, all current Title X grantees, sub-recipients and individual providers would be forced to choose between compromising national standards of care and central ethical requirements, or exiting the Title X program.

A. The New Rule Would Involve Providers in and Subject Patients to Directive, Involuntary Pregnancy Counseling that Misleads and Denies Wanted Abortion Referral

84. If the New Rule is allowed to take effect as planned, patients would immediately be treated with substandard care following positive pregnancy tests, in the form of falsely limited pregnancy options counseling, misleading responses or outright denials to requests for abortion referrals, and forced referrals for prenatal care, regardless of the patient's wishes or medical needs. Pregnant patients could only be referred for abortion services in the event of a medical emergency, and would be denied referral if abortion was "only" medically indicated.

85. The New Rule would eliminate the long-standing guarantee that all pregnant patients at Title X-funded sites be offered unbiased, factual, and comprehensive counseling—including referrals upon request. Such nondirective counseling is necessary to ensuring patients are able to make informed, voluntary decisions about their own health care. These changes not only violate congressional directives,[116] but also the federal government's own standard of care as articulated in the QFP, described above.[117] Moreover, they also ignore bedrock principles of medical ethics.[118,119,120,121]

86. The New Rule would also unnecessarily limit pregnancy options counseling to physicians and "advanced practice providers" with "at least a graduate level degree." This definition excludes highly trained providers who also play an important role in delivering counseling in Title X settings, such as registered nurses, public health nurses, health educators and clinical social workers.[122] Although Guttmacher does not have data specific to clinicians offering pregnancy options counseling, data from 2010 show that 65% of Title X sites and 64% of all safety-net family planning centers focused on reproductive health rely on trained health educators, registered nurses and other qualified providers (excluding physicians and advanced practice clinicians) to counsel patients in selecting contraceptive methods.[123] Given the critical

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[116] P.L. 115-141, Mar. 23, 2018.

[117] 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.

[118] ACOG, *Guidelines for Women's Health Care: A Resource Manual*, fourth ed., Washington, DC: ACOG, 2014.

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

[120] AAPA, Guidelines for Ethical Conduct for the PA Profession, 2013, https://www.aapa.org/wp-content/uploads/2017/02/16-EthicalConduct.pdf.

[121] 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.

[122] Fowler CI et al., *Title X Family Planning Annual Report: 2017 National Summary*, Research Triangle Park, NC: RTI International, 2018, https://www.hhs.gov/opa/title-x-family-planning/fp-annual-report/index.html.

[123] Frost JJ et al., *Variation in Service Delivery Practices Among Clinics Providing Publicly Funded Family Planning Services in 2010*, New York: Guttmacher Institute, 2012,

role these clinicians play in contraceptive counseling, needlessly excluding them from pregnancy options counseling stands to harm patients' experiences and service delivery.

87. Regarding the substance of permissible pregnancy options counseling, the New Rule would allow physicians and advance practice practitioners to deliver counseling that excludes information on abortion, rendering that counseling far from "nondirective." Even more directive, those clinicians would be forced to provide information about prenatal care, even when the patient does not request or actively does not want such information, and required to discuss a prenatal or adoption option with a patient that only wishes to discuss abortion.

88. The New Rule would effectively require clinicians to deny abortion referrals entirely. Providers would have the option of offering pregnant patients an intentionally misleading provider list that must include only "licensed, qualified comprehensive primary health care providers (including providers of prenatal care)." At best, that list would provide incomplete and confusing information as "some, but not the majority" of sites could also offer abortion, though neither the list nor clinic staff would be permitted to identify those sites as abortion providers. At worst, patients requesting abortion could be given a referral list without any abortion providers, without the patient's knowledge or understanding that the referral list was in no way responsive to their request.

89. Additionally, there is also no guarantee that any comprehensive primary care sites offering abortion would be available in patients' communities to even include on the list, and the rule bars clinicians from telling patients about other, specialized abortion providers. For example, in 2018, in eight states (Kentucky, Louisiana, Mississippi, Missouri, South Dakota, North Dakota, West Virginia and Wyoming), the only providers known to offer abortions in the state are specialized abortion providers, including Planned Parenthood clinics and independent providers.[124] There are no comprehensive primary care sites that are known to offer abortion

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https://www.guttmacher.org/sites/default/files/report_pdf/clinic-survey-2010.pdf.

[124] Abortion Care Network, *Communities Need Clinics: Independent Abortion Care Providers and the Future of Abortion Access in the United States*, Minneapolis: Abortion Care Network, 2018, https://www.abortioncarenetwork.org/wp-content/uploads/2019/01/communities-need-clinics-FINAL-2018.pdf.

services in these states, making it effectively impossible to put any abortion providers on the misleading referral list permissible under the New Rule. Moreover, there are likely similar situations in many areas of many other states, because there are no known primary care providers that also offer abortion, or perhaps only private practice physicians who offer abortion care only to their established patients. As a result, under the New Rule, Title X patients in these states and areas would not even be able to obtain obscured referral information from their Title X provider.

90. All of these restrictive options would harm and confuse all patients, but may be particularly problematic for adolescents, those with limited English proficiency, or other especially marginalized populations.

91. Beyond denying abortion referrals to patients who request them, the New Rule mandates that all pregnant patients at Title X sites be referred for prenatal care, regardless of the patient's wishes. Moreover, though not required, pregnant patients may be provided prenatal counseling, may be referred to social services or adoption agencies, and may be given "information about maintaining the health of the mother and unborn child"—again, all regardless of the patient's wishes. These provisions are coercive not only in requiring or allowing for services to be provided even for women who do not want them, but also because they force all patients toward the particular pregnancy outcome of childbirth, regardless of the patient's own wishes and in violation of the voluntary, patient-centered foundations of Title X care.[125,126,127,128]

92. Restricting pregnancy options counseling, including abortion referrals, and directing pregnant patients only toward childbirth would ultimately threaten their health and well-

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[125] 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.

[126] 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.

[127] AAPA, Guidelines for Ethical Conduct for the PA Profession, 2013, https://www.aapa.org/wp-content/uploads/2017/02/16-EthicalConduct.pdf.

[128] 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.

being in a number of ways. First, limiting information and referrals only to those related to carrying a pregnancy to term would misleadingly deprive patients of broader information about relative risks and suggests that pregnancy and childbirth are a woman's safest options. In fact, pregnancy and delivery pose decidedly greater medical and health risks than abortion.[129]

93. Second, denying a woman information about and access to her full range of options once she knows that she is pregnant would interfere with her ability to obtain additional services in a timely manner. For women who choose to terminate a pregnancy, abortion is particularly safe when obtained in the first trimester of pregnancy and risks increase with any delay.[130] Moreover, it often becomes more difficult for a woman to obtain an abortion as pregnancy progresses due to a lack of providers and increased cost.[131,132,133]

94. Third, denying Title X patients' access to information concerning their ability to obtain abortions would especially jeopardize the health and well-being of patients with certain medical conditions. Multiple professional medical associations have asserted that the inability to make a fully informed decision on how to proceed with a pregnancy would be especially harmful for women with severe diabetes, heart conditions, HIV/AIDS and estrogen-dependent tumors—all conditions that could be exacerbated by continuing a pregnancy.[134] Yet the New Rule would

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[129] Raymond EG and Grimes DA, The comparative safety of legal induced abortion and childbirth in the United States, *Obstetrics & Gynecology*, 2012, 119(2):215–219.

[130] Weitz TA et al., Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives, and physician assistants under a California legal waiver, *American Journal of Public Health*, 2013, 103(3):454–461, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3673521/.

[131] Jerman J and Jones RK, Secondary measures of access to abortion services in the United States, 2011 and 2012: gestational age limits, cost, and harassment, *Women's Health Issues*, 2014, 24(4):419– 424, https://www.guttmacher.org/article/2014/07/secondary-measures-access-abortion-services-united-states-2011-and-2012-gestational.

[132] Jones RK, Upadhyay UD and Weitz TA, At what cost? Payment for abortion care by U.S. women, *Women's Health Issues*, 2013, 23(3):e173–e178, https://www.guttmacher.org/article/2013/05/what-cost-payment-abortion-care-us-women.

[133] Jerman J et al., Barriers to abortion care and their consequences for patients traveling for services: qualitative findings from two states, *Perspectives on Sexual and Reproductive Health*, 2017, 49(2):95–102, https://www.guttmacher.org/journals/psrh/2017/04/barriers-abortion-care-and-their-consequences-patients-traveling-services.

[134] Letter from American Academy of Nurse Practitioners et al. to Deputy Assistant

forbid direct referrals to abortion providers for a patient with these types of conditions, even if the patient so desires.

95. Finally, forcing clinicians to deny patients the full scope of information and referral would interfere in the provider-patient relationship and reinforce what experts have described as "the historical imbalance of power in gender relations and in the physician-patient relationship…and the intersection of gender bias with race and class bias" that are particularly present in obstetrics and gynecology, and in reproductive health care broadly.[135] Forcing providers to sabotage rapport they have built with patients may cause those patients to retreat from seeking health care; 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.[136,137]

B. The New Rule Would Diminish Contraceptive Choice and Access for Title X Patients

96. Another way in which the New Rule would directly impede patient care is by curtailing contraceptive options for Title X clients by: (1) deemphasizing the provision of modern, medically approved contraceptive methods; and (2) reshaping the Title X network to favor "diverse" providers, including those that offer only a single method or limited methods of contraception.

97. The New Rule deemphasizes the provision of modern methods of contraception in several ways. First, it would remove the requirement that the range of family planning methods

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Secretary for Population Affairs, HHS, Nov. 1, 1987.

[135] 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.

[136] 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.

[137] Center for Reproductive Rights (CRR), National Latina Institute for Reproductive Justice and SisterSong Women of Color Reproductive Justice Collective, *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.

offered by a Title X project must be "medically approved" methods. As stated above, in 2017, 70% (2.2 million) of the 3.1 million sexually active female Title X patients at risk of unintended pregnancy left their last visit with a method deemed either most or moderately effective at preventing pregnancy, all of which require a prescription or services provided by a medical professional.[138] Notably, just 15,300 female Title X patients (less than 0.5%) chose some fertility awareness-based method in 2017.[139]

98. Second, the New Rule would also distort the 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, this requirement has meant that projects must provide a broad range of contraceptive options, in addition to other care or services. Now, a Title X project could apparently satisfy this requirement by providing only a limited choice of modern contraceptive care so long as they offer a seemingly broad range of "methods and services" overall. For instance, it appears that the rule would allow a Title X project to include abstinence-only-until-marriage counseling, and natural family planning or other fertility awareness–based methods together with just a few other contraceptive options, to represent a "broad range" of "methods and services."

99. Third, the New Rule would open the door for Title X funds to go to entities that commonly do not have any medical staff and are not able or willing to provide many or all modern methods of contraception; such sites would not be required to provide information or referrals about other methods. Entities such as antiabortion counseling centers and abstinence-only programs approach "family planning" in a way that would undermine Title X's core tenets of ensuring patients' contraceptive choices are broad, voluntary and free from coercion. Shifting Title X dollars to such entities would harm patients and jeopardize the documented benefits of Title X as identified above.

[138] Fowler CI et al., *Title X Family Planning Annual Report: 2017 National Summary*, Research Triangle Park, NC: RTI International, 2018, https://www.hhs.gov/opa/title-x-family-planning/fp-annual-report/index.html.

[139] Ibid.

100. Moreover, the administration twists what it means to ensure patients have a meaningfully broad range of contraceptive options. Individuals' ability to obtain the methods that are best for them and successfully avoid pregnancy depends not just on having a provider nearby, but also on the range of options available at those sites. Seventy-four percent of reproductive health–focused providers offer a full range of contraceptive methods onsite;[140] directing Title X funds away from such providers and toward ideologically motivated single-method sites would sharply diminish patients' access to a broad range of options. And while the rule clarifies that contraceptive methods are expected to be provided as part of a Title X project, a project may stretch across an entire state and dozens of widely separated sites.

101. Collectively, the provisions of the New Rule would interfere with Title X patients' ability to learn about, obtain and use their preferred method of contraception. This would fundamentally undermine the program's long history as the gold standard of family planning care, and its congressionally defined purpose: "to assist in making comprehensive voluntary family planning services readily available to all persons desiring such services."[141] Without intervention, the New Rule would result in some individuals' increased risk of unintended pregnancy and the consequent harms that follow, as described above.

C. The New Rule's Additional, More Onerous Separation Requirements, And Other Mandates Would Also Force Many Providers Out of the Program, and Create Dislocation and Disruption That Would Start Immediately and Build

102. The New Rule would modify the long-standing requirement that Title X funds be used solely for Title X purposes and separately accounted for in detail by all Title X projects by imposing a series of additional, more onerous, "financial and physical" separation requirements. These separation requirements would create new, significant obstacles for many current Title X providers to remain in the program. This includes not only the approximately one in 10 sites that offer abortions outside their Title X projects and using non–Title X funds,[142] but also any

[140] 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.

[141] P.L. 91-572, Dec. 24, 1970.

[142] Zolna MR, special tabulations from the Guttmacher Institute's 2015 Publicly Funded

provider engaging in any of the wide range of services that fall under the administration's construct of prohibited abortion-related activities, including abortion referral. These providers would be forced to either exit the program, alter the scope of services they provide in their communities, or incur substantial new costs in an attempt to separate their services in a manner that HHS deems acceptable.

103. The latter scenario would require providers to lease or purchase new office space, find and hire new staff, procure exam tables, medical equipment, and office systems. In light of the New Rule's infrastructure spending prohibitions, it is not clear whether any or how much of a provider's Title X's funds could be used to satisfy the separation requirements. These costs would have to come directly out of providers' coffers and would leave ever fewer dollars available for actually providing family planning care. The costs to completely separate one health center into two standalone clinics, with different staff and systems, are costs that could quickly swamp providers and make their participation in Title X financially irrational and practically infeasible.

104. Incurring such extensive costs would be impractical for many Title X providers whose resources are already stretched thin trying to meet the demand for services in their communities. Title X providers must accept all patients, regardless of their ability to pay, and sites routinely struggle with inadequate reimbursement from public and private third-party payers. For instance, a 2016 Guttmacher Institute analysis found that Medicaid reimbursement for family planning services provided by Title X clinics typically covers less than half the actual cost of delivering these services.[143] This makes Title X grants themselves a main source of funding that safety-net providers would rely on for the type of infrastructure investments necessary under the New Rule's separation requirements. Plus, Title X funding nationwide is already insufficient because it has been flat for years.[144]

Family Planning Clinic Survey, https://www.guttmacher.org/report/publicly-funded-family-planning-clinic-survey-2015.

[143] Sonfield A et al., *Assessing the Gap Between the Cost of Care for Title X Family Planning Providers and Reimbursement from Medicaid and Private Insurance*, New York: Guttmacher Institute, 2016, https://www.guttmacher.org/report/assessing-gap-between-cost-care-title-x-family-planning-providers-and-reimbursement-medicaid.

[144] OPA, HHS, Funding history, 2018, https://www.hhs.gov/opa/title-x-family-

105. 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 also subject to the separation requirements, as are any activities that may assist patients in obtaining abortions, including referral. Separating these activities to meet HHS's requirements may further constrain providers' willingness and ability to participate in Title X, as many may determine that participation would either too significantly limit their activities or impose too great a financial burden.

106. Moreover, given the extensive degree to which separation between Title X–funded activities and the wide range of prohibited abortion-related activities would be required, the rule might impose onerous separation requirements not just to individual health centers offering abortion or abortion-related services, but also to agencies operating multiple health centers where only a subset of sites do so. As such, entire agencies may determine the New Rule's demands would compromise their services or their finances too significantly to remain in the program, demonstrating the rule's potential to impact the Title X provider network as a whole.

107. Notably, to justify its extensive financial and physical separation requirements, HHS leans heavily on Guttmacher publications on Title X as supposed proof that Title X funds support the physical "infrastructure" of sites that also provide abortions—and thereby fund abortions themselves.[145] This framing is inaccurate and misleading. The cited Guttmacher analyses unambiguously refer to the basic and underlying infrastructure of the family planning safety net—the systems and activities directly necessary to providers' ability to deliver high-quality family planning services to those who need them. Such expenditures are wholly appropriate uses of Title X funds, as detailed by a 2009 panel convened by the Institute of

planning/about-title-x-grants/funding-history/index.html.

[145] HHS, Compliance with statutory program integrity requirements, *Federal Register*, 2019, 84(42):7714–7791, https://www.federalregister.gov/documents/2019/03/04/2019-03461/compliance-with-statutory-program-integrity-requirements. See p.7773–7774.

Medicine to provide an independent evaluation of the Title X program, and fund the Title X project–nothing else.[146,147]

108. Additionally, the rule's impact would extend beyond sites that offer abortion or engage in any of the New Rule's prohibited abortion-related activities. For instance, the rule's restrictions on abortion referral and requirement of prenatal care referral regardless of the patient's wishes are antithetical to ethical and professional standards on voluntary decision-making and would harm the patient-provider relationship. Many current providers consider these requirements unethical, and may therefore feel compelled to leave the Title X network.

109. Already, at least four states with Title X grants and all Planned Parenthood grantees or sub-recipients have made clear to HHS that they would be forced by the New Rule to exit the Title X program, if they should go into effect.[148]

110. Planned Parenthood health centers serve 41% of women who rely on Title X sites for contraceptive care.[149] 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—if they were to stay in the program, which the rule's expected impact indicates many may not—would have to increase their client caseloads by 70%, on average.[150] The impact would also be more severe in some locations: 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.

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[146] 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.

[147] Ibid.

[148] Planned Parenthood Federation of America, Comments re: RIN 0937-ZA00 Compliance with Statutory Program Integrity Requirements, July 31, 2018.

[149] 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.

[150] 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.

Furthermore, Planned Parenthood is the only Title X provider in 38 counties in the country, out of the 415 counties in which the organization operates.

111. Finally, findings from a nationally representative 2016 survey of women obtaining services at Title X–funded health centers reinforce the gap that would be left by Planned Parenthood's exit: Twenty-six percent of clients at Planned Parenthood sites reported that it was the only place they could get the services they need.[151]

112. All of these scenarios would result in considerable disruptions to the Title X provider network, and there is no evidence that the remaining providers would be able to compensate for these losses. Indeed, available evidence only underscores the challenges that remaining providers would face in accommodating massive increases in their contraceptive patient populations. *See infra*, Section D. Therefore, if the New Rule goes into effect and providers are forced to leave the network, it would lead to significant, broad-based harm because it would be more difficult for the patients who rely on Title X to obtain any, much less high-quality, family planning care.

D. Primary Care–Focused Sites Would Not Be Able to Absorb the Displaced Patient Population

113. While primary care–focused sites and federally qualified health centers (FQHCs) specifically have become an increasingly integral part of the Title X provider network in some areas,[152] these providers could not serve the entire existing Title X population. As discussed above, reproductive health-focused sites serve a considerable majority of Title X patients—seven in 10 women who rely on Title X for contraceptive care.[153]

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[151] 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):101–109, https://www.guttmacher.org/journals/psrh/2018/06/use-health-insurance-among-clients-seeking-contraceptive-services-title-x.

[152] 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.

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

114. FQHCs currently account for the majority (52%) of primary care–focused sites in the Title X network.[154] If FQHCs that offer contraceptive care were asked to serve all of the women who rely on many different types of providers for Title X–supported contraceptive care, these FQHCs would have to at least double their contraceptive client caseloads in 41 states, and at least triple them in 27 states.[155,156] Nationwide, this would add up to an additional 3.1 million contraceptive clients that FQHCs would need to serve. 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%.[157] 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.

115. Additionally, in 33% of the just over 2,000 counties that have a Title X provider, there is no FQHC site providing contraceptive services.[158] In another 47% of counties with a Title X site, 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

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

[155] 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.

[156] Only six in 10 FQHCs nationwide 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.

[157] 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/.

[158] 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.

counties where FQHC sites would have to at least double their capacity, or where there is *no* FQHC site providing contraceptive care.

116. The inability of FQHCs to absorb the volume of displaced patients from even any short-term disruption to the Title X network is salient because the New Rule would attempt to shift the program's emphasis away from centers focused on reproductive health and toward FQHCs and other primary care–focused providers. Specifically, the New Rule would require that Title X providers "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."

117. Not only would the rule seek to shift patients' contraceptive care to providers that cannot realistically be expected to serve huge influxes of Title X patients, but it would also deny many Title X patients access to the reproductive health–focused providers they trust. Reproductive health-focused providers are particularly likely to offer their patients a broad range of contraceptive methods in a timely manner, and to implement protocols that help patients start their chosen methods quickly.[159] As a consequence, the primary care provider provision of the rule would make it more difficult for marginalized patient populations to obtain high-quality, low-cost family planning care, if they can access care at all, given capacity constraints and areas without such a provider.

118. Finally, the New Rule is unnecessary to promote referral and linkages between Title X and primary care. Existing 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."[160] Moreover, Title X providers screen for numerous health issues (such as high blood pressure, diabetes and depression) and customarily establish referral

[159] 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.

[160] 42 CFR 59.5.

arrangements both to and from other providers.[161] According to a recent Guttmacher Institute analysis, 99% of Title X–funded providers reported making referrals of some kind to other providers: 97% reported referring patients to other public providers and 90% reported referring patients to private providers.[162]

E. Data from State-Administered Programs Show Excluding Providers Offering Abortion-Related Services Has Reduced Family Planning Patients Served and Highlights Some of the Harms That Would Result from Provider Network Disruption

119. Policies enacted in Texas and Iowa demonstrate the impact of excluding providers that directly offer abortion or are affiliated with abortion providers from publicly funded programs. In order to exclude abortion providers and affiliates, including Planned Parenthood health centers and others, from their respective programs, both states opted to forgo federal Medicaid funding to cover family planning services for people otherwise ineligible for Medicaid (a "Medicaid family planning expansion") in favor of entirely state-administered family planning programs. Excluding providers that offer abortion or are affiliated with a site that does from these publicly funded programs mirror what the New Rule, in part, would do to Title X. Officials in both Texas and Iowa suggested that other providers would replace those excluded, and that residents' care would not be affected.[163,164] However, these changes resulted in widespread disruption of their programs' provider networks, leading to diminished access to contraceptive services and ongoing difficulty for individuals finding alternative providers.

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[161] 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.

[162] 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.

[163] Poppe R, Abbott requests federal Medicaid exemption for Texas Healthy Women Program, *Texas Public Radio*, Jan. 24, 2018, http://www.tpr.org/post/abbott-requests-federal-medicaid-exemption-texas-healthy-women-program.

[164] Petroski W, Planned Parenthood to close four Iowa clinics after legislative defunding, *Des Moines Register*, May 18, 2017, https://www.desmoinesregister.com/story/news/2017/05/18/planned-parenthood-close-four-iowa-clinics-after-legislative-defunding/330284001/.

120. After Texas made a series of changes to its family planning program starting in 2011—which included disqualifying agencies providing abortion—the reach and effectiveness of the state's program drastically declined. The state reported a nearly 15% decrease in enrollees statewide between 2011 and 2015.[165] The state further reported that claims and prescriptions for contraceptive methods declined 41% over the same four-year period.[166,167]

121. Analyses conducted by the Austin-based Center for Public Policy Priorities (CPPP) offer a more comprehensive view: Between 2011 and 2016, program enrollment declined by 26% and the proportion of women getting health care services in the program declined by nearly 40%.[168] CPPP further reports substantial declines (41%) in the number of women accessing contraceptives through the program, as well as in utilization of highly effective contraceptive methods, including long acting reversible contraception (35% reduction) and injectable contraception (31% reduction).[169]

122. In 2017, then-governor of Iowa Terry Branstad signed an appropriations bill that imposed similar restrictions on the state's Medicaid family planning expansion.[170] Recent data provided by the state showed the new, state-administered program covered a total of only 970 family planning services from April through June of 2018, a 73% decline from the 3,637 services

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[165] Texas Health and Human Services Commission, *Final Report of the Former Texas Women's Health Program: Fiscal Year 2015 Savings and Performance*, Austin: Texas Health and Human Services, 2017, https://hhs.texas.gov/reports/2017/03/former-texas-womens-health-program-fiscal-year-2015-savings-performance.

[166] Ibid.

[167] Texas' 2017 program evaluation notes an increase in client enrollment in the program from the previous year, but does not provide consistent data on enrollment and contraceptive service delivery that would enable comparisons to 2011, when the policy went into effect. See: THHC, *Final Report of the Former Texas Women's Health Program: Fiscal Year 2015 Savings and Performance*, Austin: THHS, 2017, https://hhs.texas.gov/reports/2017/03/former-texas-womens-health-program-fiscal-year-2015-savings-performance.

[168] Center for Public Policy Priorities, Comments on the Draft Healthy Texas Women Section 1115 Demonstration Waiver Application, June 12, 2017, https://forabettertexas.org/images/CPPP_comments_on_HTW_draft_waiver_application.pdf.

[169] Ibid.

[170] Petroski W, Planned Parenthood to close four Iowa clinics after legislative defunding, *Des Moines Register*, May 18, 2017, https://www.desmoinesregister.com/story/news/2017/05/18/planned-parenthood-close-four-iowa-clinics-after-legislative-defunding/330284001/.

covered in April through June of 2017, the last three months of the previous family planning program, when abortion providers and affiliates were still included in the program.[171] Furthermore, the number of patients enrolled in the program fell by more than half, with enrollment dropping from 8,570 in June 2017, the last month of the previous program, to 4,177 in June 2018.[172]

F. Summary of the New Rule's Negative Impacts on Patients, Public Health and Government Costs

123. If the New Rule is allowed to take effect, Title X patients would face substandard care and a compromised network of providers. The rule would diminish access to modern, medically approved family planning services and counseling, and unbiased, comprehensive information on the full range of pregnancy options for low-income individuals. For current and prospective Title X patients who would be given fewer contraceptive choices or deterred from seeking Title X–supported care, this would mean an increased risk of unintended pregnancies, low-birth-weight or preterm births, STIs and cervical cancer. For the pregnant patients who decide on or want information about abortion, this would mean an increased risk of delayed care and medical complications. As risks increase for individual patients, on aggregate the Title X population at large would experience these harms and public health would suffer.

124. The New Rule would also likely push a number of high-quality health care providers dedicated to the provision of a full package of family planning services out of Title X, because of mandated compromises to providers' professional and ethical standards, and untenable operational requirements. Title X funds would instead be made available to entities focusing on efforts that deviate from the program's core purpose. This disruption of a well-established program would further compromise the considerable benefits to individuals and overall public health that Title X–supported providers have demonstrably delivered for decades.

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[171] Leys T and Rodriguez B, State family planning services decline 73 percent in fiscal year as $2.5M goes unspent, *Des Moines Register*, Oct. 18, 2018, https://www.desmoinesregister.com/story/news/health/2018/10/18/iowa-health-care-family-planning-contraception-services-planned-parenthood-abortion-medicaid/1660873002/.

[172] Ibid.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct and that this declaration was executed on March 21, 2019 in Washington DC.

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