May 17, 2021

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

VIA ELECTRONIC SUBMISSION

Re: Comments on "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services" (RIN: 0937-AA11)

The Center for Reproductive Rights respectfully submits the following comment on the Notice of Proposed Rulemaking ("the proposed rule") on Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services, published by the Department of Health and Human Services ("HHS" or "the Department") on April 15, 2021. We commend the Department of Health and Human Services' Office of Population Affairs ("OPA") for this proposal to reverse the 2019 Title X regulations and readopt the 2000 regulations with key revisions.

Founded in 1992, the Center for Reproductive Rights uses the power of law to advance reproductive rights as fundamental human rights worldwide. Our litigation and advocacy over the past 26 years have expanded access to reproductive health care around the nation and the world. We have played a key role in securing legal victories in the United States, Latin America, Sub-Saharan Africa, Asia, and Eastern Europe on issues including access to life-saving obstetrics care, contraception, abortion services, and comprehensive sexuality information. We envision a world where every person participates with dignity as an equal member of society, regardless of gender; where individuals are free to decide whether or when to have children and whether or when to get married; where access to quality reproductive health care is guaranteed; and where every person can make these decisions free from coercion or discrimination.

We commend OPA for a proposed rule that is critical to restoring and improving the Title X program after the 2019 Final Rule "Compliance with Statutory Program Integrity Requirements"[1] (the "2019 Final Rule") devastated the Title X provider network and undermined the purpose of the program. We urge the Department to act swiftly to finalize and implement the rule with a 30-day implementation period to ensure that qualified providers who were forced out of the program by the 2019 Final Rule will be able to promptly rejoin the program and resume serving patients as soon as possible.

1. Rescinding the 2019 Final Rule is Necessary and Urgent

We welcome the Department's proposal to eliminate the 2019 Final Rule in its entirety by readopting the 2000 regulations, with key revisions. The Title X family planning program is a critical source of family planning and related preventive care for low-income, uninsured, and

[1] 84 Fed. Reg. 7,714 (Mar. 4, 2019).

young people across the country, and an important pathway toward fulfillment of the United States' human rights obligations.[2] Under the 2019 Final Rule, the Title X program has been unable to fulfill this purpose, and the rule has had a rapid and devastating impact on the program. As the proposed rule notes, the Title X program lost more than 1,000 health centers overall.[3] Those health centers represented approximately one quarter of all Title X-funded sites in 2019.[4] Nearly two years later, six states continue to have no Title X-funded provider network (Hawaii, Maine, Oregon, Utah, Vermont, and Washington),[5] and an additional six states have a very limited Title X-funded network (Alaska, Connecticut, Massachusetts, Minnesota, New Hampshire, and New York).[6] As a result, at least 1.5 million patients lost access to Title X-funded services.[7] The previous administration's already dubious claim that the 2019 Final Rule would cause new applicants to apply for Title X funding and result in "more clients being served"[8] has been conclusively disproven. OPA has been unable to find new grantees to fill the gaps the 2019 Final Rule created, and the number of clients served by the Title X program dropped substantially.[9] This precipitous decline in Title X patients has concerning implications for broader access to care. In a 2016 study, six in ten women seeking contraceptive services at a Title X-funded health center reported that to be their only source of medical care in the past year.[10]

---

[2] The Title X program furthers U.S. compliance with its international human rights treaty obligations to ensure equality in access to adequate health care. International human rights bodies and experts have repeatedly noted concern over disparities in access to health care in the U.S., including sexual and reproductive health care. In 1994, the U.S. ratified the International Convention on the Elimination of All Forms of Racial Discrimination (CERD), agreeing to "undertake to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of… [t]he right to public health [and] medical care." Convention on the Elimination of All Forms of Racial Discrimination art. 5(e)(iv), opened for signature Dec. 21, 1965, S. Exec. Doc. C, 95-2 (1978), 660 U.N.T.S. 195. During the CERD Committee's most recent (2014) review of U.S. compliance with the Convention, the Committee called on the U.S. to "[e]liminate racial disparities in the field of sexual and reproductive health." U.N. Comm. on the Elimination of Racial Discrimination, Concluding Observations on the Combined Seventh to Ninth Periodic Reports of the United States of America, ¶ 15(b), U.N. Doc. CERD/C/USA/CO/7-9 (Sep. 25, 2014). United Nations independent experts have expressed similar concerns. In 2016, the UN Working Group on discrimination against women reported on an official visit to the U.S., noting with concern that "an increasing number of states are targeting women's health providers for exclusion from key federal health programmes, including the Title X Family Planning Program." U.N. Working Group on discrimination against women and girls, Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America, ¶ 69, U.N. Doc. A/HRC/32/44/Add.2. (Aug. 4, 2016). The Working Group's recommendations to the U.S. government included "(a) [i]ncreasing funding of clinics under the Title X Family Planning Program in order to expand coverage for low-income women who lack insurance so they can access preventive care, including sexual and reproductive health services, and to reduce maternal mortality" and "(b) [p]reventing politically motivated actions to exclude women's health providers from federally supported public health programmes." *Id.* at ¶ 95.

[3] "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Servs.," 86 Fed. Reg. 19,812, 19,815 (Apr. 15, 2021).

[4] Mia Zolna et al., *Estimating the impact of changes in the Title X network on patient capacity*, GUTTMACHER INST., 2 (Feb. 5, 2020), https://www.guttmacher.org/sites/default/files/article_files/estimating_the_impact_of_changes_in_the_title_x_network_on_patient_capacity_2.pdf.

[5] Zolna et al., n.59, at 2.

[6] 86 Fed. Reg. at 19,815 (Apr. 15, 2021).

[7] *Title X: Key Facts About Title X*, NAT'L FAMILY PLANNING & REPROD. HEALTH ASS'N, https://www.nationalfamilyplanning.org/title-x_title-x-key-facts.

[8] 84 Fed. Reg. at 7,723 (Mar. 4, 2019).

[9] OPA released two competitive FOAs for "areas of high need" on May 29, 2020, intending to provide approximately $18 million through an estimated 10 grants to provide services in areas left without any Title X-funded services. *See* Grants Notice, U.S. Dep't of Health and Human Servs., *PA-FPH-20-001, FY2020 Title X Services Grants: Providing Publicly-Funded Family Planning Services in Areas of High Need* (May 29, 2020), https://www.grants.gov/web/grants/view-opportunity.html?oppId=323353; Grants Notice, HHS, *PA-FPH-20-002, FY2020 Title X Service Grants: Providing Publicly-Funded Family Planning Services in Areas of High Need—Maryland Service Area Only* (May 29, 2020), https://www.grants.gov/web/grants/view-opportunity.html?oppId=327358. The FOAs yielded only five grantees, four of which were 2019 grantees with current projects and none of which would be providing services in the six states that lost their entire Title X-funded provider network. *See* Press Release, Off. of. Population Affairs, *OPA Awards $8.5 Million in Grants to Family Planning Services in Unserved & Underserved Areas* (Sept. 18, 2020), https://opa.hhs.gov/about/news/grant-award-announcements/opa-awards-85-million-grants-family-planning-services-unserved. OPA was able to fund only $8.6 million in grants under the FOA, with the remaining funding given as supplemental funding to the existing grantees. *Id.*

[10] Megan L. Kavanaugh et al., *Use of Health Insurance Among Clients Seeking Contraceptive Services at Title X-Funded Facilities in 2016*, 50 PERPSECT. ON SEXUAL AND REPRO. HEALTH 101 (2018), https://www.guttmacher.org/journals/psrh/2018/06/use-health-insurance-among-clients-seeking-contraceptive-services-title-x.

The Center fully supports the Department's proposal to eliminate the harmful 2019 Final Rule. Further, we applaud the Department's efforts to strengthen the program and ensure access to equitable, affordable, client-centered, quality family planning services for all clients, especially low-income clients, through key revisions to the 2000 regulations, and we suggest making the following adjustments to the final rule to further these efforts.

2. The Final Rule Should Clarify Key Definitions to Maximize Equity and Inclusivity

We commend the Department for its inclusion of the following definitions in § 59.2: adolescent-friendly health services"; "client-centered care"; "culturally and linguistically appropriate services"; "health equity"; "inclusivity"; "quality health care"; and "trauma-informed." These definitions are central to furthering the mission of the Title X program. As the proposed rule notes, "[a]dvancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequity is a priority for OPA and the Title X program."[11] To further the program's mission to ensure access to equitable, client-centered, and inclusive family planning services, we recommend that the Department make clarifications to the definitions for "health equity" and "inclusivity" as follows:

a. "Health Equity"

The proposed rule defines "health equity" as "[w]hen every person has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances."[12] We recommend that the Department expand the umbrella term "socially determined circumstances"[13] to "other circumstances that are socially, economically, demographically, or geographically determined."[14] We further recommend adding an explicit acknowledgment of how systemic and structural racism impact health risks, outcomes, opportunities, and the social determinants of health.

Whether or not individuals and communities have an equal "opportunity to attain their full health potential" depends on both access to quality health care and on conditions in the environments in which they live. These conditions—the social determinants of health—are in turn shaped by structural racism and other forms of discrimination. While the preamble cites in a footnote to the CDC's National Center for Chronic Disease Prevention and Health Promotion's guidance on health equity, which discusses social determinants of health,[15] the existing definition of health equity in the proposed regulatory text lacks specificity. We advise the Department to clarify the scope and meaning of health equity by including a statement acknowledging that health equity encompasses the social determinants of health, and that structural discrimination drives inequities in these underlying conditions.

---

[11] 86 Fed. Reg. at 19,817 (Apr. 15, 2021).
[12] *Id.*
[13] *Id.*
[14] Refining the definition in this way adds clarity and brings the definition into closer alignment with the human rights informed definition of health equity promoted by the World Health Organization. *See Equity*, WORLD HEALTH ORG., https://www.who.int/healthsystems/topics/equity/en/.
[15] *Health Equity*, CTR. FOR DISEASE CONTROL AND PREVENTION (2020), https://www.cdc.gov/chronicdisease/healthequity/index.htm.

Additionally, we urge the Department to specifically acknowledge systemic and structural racism as key drivers of health inequities. Systemic racism harms health by exposing individuals and communities of color to stress and discrimination and it exacerbates inequities in other social determinants of health such as housing, employment, and education.[16] The American Medical Association has recognized that "primary drivers of racial health inequity are systemic and structural racism"[17] and has recently adopted a policy to "recognize racism, in its systemic, cultural, interpersonal and other forms, as a serious threat to public health, to the advancement of health equity and a barrier to appropriate medical care."[18] Similarly, the CDC has recognized racism as a serious threat to public health.[19] Given systemic and structural racism's profound impact on health equity, we strongly recommend that the Department explicitly acknowledge the importance of addressing racism as a critical part of Title X's mission to further health equity.

Acknowledging the substantial impact of racism on health equity is particularly important given the reproductive coercion and violations of bodily autonomy that people of color have historically faced and continue to experience, particularly with respect to family planning. Racial discrimination within and beyond the health care system undermines access to quality care and makes it more difficult for people of color to trust and rely on the health care system to meet their needs. To improve health equity,[20] family planning projects and providers must understand and combat the role of racism in health, ensuring that all patients receive the high quality, respectful care they deserve. As the Department elevates health equity as an important goal of Title X in the proposed rule, we urge HHS to acknowledge and reckon with structural and systemic racism as an integral part of that work.

b. "Inclusivity"

The NPRM proposes to define "inclusivity" as:

> *[Ensuring] that all people are fully included and can actively participate in and benefit from family planning, including, but not limited to, individuals who belong to underserved communities, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of*

[16] *See, e.g., Racism and Health*, AM. PUB. HEALTH ASS'N, https://www.apha.org/topics-and-issues/health-equity/racism-and-health ("Racism is a driving force of the social determinants of health (like housing, education and employment) and is a barrier to health equity."); *Advancing Health Equity by Addressing the Social Determinants of Health in Family Medicine (Position Paper)*, AM. ACAD. OF FAMILY PHYSICIANS (2019), https://www.aafp.org/about/policies/all/social-determinants-health-family-medicine.html ("SDoH, especially poverty, structural racism, and discrimination, are the primary drivers of health inequities.").

[17] Kevin B. O'Reilly, *AMA: Racism is a threat to public health*, AM. MED. ASS'N (2020), https://www.ama-assn.org/delivering-care/health-equity/ama-racism-threat-public-health.

[18] *Id.*

[19] *Racism is a Serious Threat to the Public's Health*, CTR. FOR DISEASE CONTROL AND PREVENTION (2021), https://www.cdc.gov/healthequity/racism-disparities/index.html.

[20] *See, e.g.*, Jo Jones et al., *Current Contraceptive Use in the United States, 2006-2010, and Changes in Patterns of Use Since 1995*, 60 NAT'L HEALTH STATISTICS REPORTS 1 (Oct. 18, 2012), http://www.cdc.gov/nchs/data/nhsr/nhsr060.pdf (Black women use contraception at lower rates and have higher breast cancer mortality rates than women of other racial and ethnic backgrounds.); Jacqueline Corcoran et al., *Cervical Cancer Screening Interventions for US Latinas: A Systematic Review*, 37 HEALTH AND SOCIAL WORK 197-205 (2012), https://pubmed.ncbi.nlm.nih.gov/23301433/; *Health Disparities in HIV/AIDS, Viral Hepatitis, STDs, and TB, Hispanics/Latinos*, CTR. FOR DISEASE CONTROL AND PREVENTION, (Feb. 1, 2017), https://www.cdc.gov/nchhstp/healthdisparities/hispanics.html (Latinas experience cervical cancer at twice the rate of white women and also have higher rates of sexually transmitted infections.); *Reproductive Health: Teen Pregnancy, Social Determinants and Eliminating Disparities in Teen Pregnancy*, CTR. FOR DISEASE CONTROL AND PREVENTION (Oct. 15, 2019), https://www.cdc.gov/teenpregnancy/about/social-determinants-disparities-teen-pregnancy.htm (Latina youth experience pregnancies at about twice the rate of their white counterparts.); Kimberly Daniels et al., *Contraceptive Methods Women Have Ever Used: United States, 1982-2010*, 62 NATIONAL HEALTH STATISTIC REPORT 1-15 (Feb. 14, 2013) (Asian American and Pacific Islander women use highly effective contraceptive methods at lower rates than women of other races and instead rely on inexpensive, less effective methods.)

religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.

We urge the Department to explicitly include in this definition the intersex community, which faces high levels of discrimination in health care settings and denials of care once their atypical anatomy is known.[21] Studies have shown that up to 80 percent of intersex patients have changed their care based on discomfort with their medical providers.[22] Intersex individuals make up 1.7 percent of the world population,[23] and advocates have identified health care discrimination as the most pressing area of need.[24] Listing the intersex community in this definition would help ensure that the Title X program provides inclusive, client-centered care to all patients and does not perpetuate ongoing stigma and discriminatory and inappropriate care for those born with variations in sex characteristics.

3. Strengthening Family Planning Project Requirements

We appreciate the Department's proposal to update the requirements that must be met by a family planning project to include a requirement that service sites unable to provide a broad range of acceptable and effective medically approved family planning methods and services must be able to provide a referral to the client's method of choice and "must not unduly limit the client's access to their method of choice."[25] We recommend expanding on this definition to clarify that, as recommended by the CDC and OPA's Quality Family Planning (QFP) Guidelines, such service sites must provide clients with medically accurate information. This requirement would ensure that a service site that objects to a certain family planning method does not effectively deny care to a patient by withholding critical information required to access the care that is best suited to a client's needs.

Additionally, we strongly support the nondiscrimination obligations in § 59.5 (a)(4) as a critical step towards a more equitable Title X program. We recommend that the Department change the provision as follows:

> Provide services ~~without regard of~~ free from discrimination on the basis of religion, race, color, national origin, disability, age, or sex, including on the basis of sexual orientation, gender identity, sex stereotyping, sex characteristics (including intersex traits), pregnancy, (including number of pregnancies, false pregnancy, termination of pregnancy, or recovery therefrom), childbirth or related medical conditions, or marital status.

This language would clarify that the obligations are grounded in legal frameworks addressing nondiscrimination and would provide clearer expectations for compliance by family planning projects.

---

[21] *Providing Ethical and Compassionate Health Care to Intersex Patients: Intersex-Affirming Hospital Policies*, INTERACT & LAMBDA LEGAL (2018), https://www.lambdalegal.org/sites/default/files/publications/downloads/resource20180731hospital-policies-intersex.pdf.
[22] *Id*.
[23] *Fact Sheet: Intersex*, UNITED NATIONS FOR LGBT EQUAL. (2017), https://www.unfe.org/wp-content/uploads/2017/05/UNFE-Intersex.pdf.
[24] INTERACT, DISCRIMINATION BASED ON INTERSEX TRAITS UNDER BOSTOCK V. CLAYTON COUNTY AND OTHER LAWS 1 (March 2021).
[25] 86 Fed. Reg. at 19,830 (Apr. 15, 2021).

4. Increasing Emphasis on Health Equity in the Funding Criteria

We commend the inclusion of a criterion requiring the Department to consider the ability of an applicant to advance health equity. This criterion will be key to achieving the Title X program's mission. To address the Department's invitation for comment on "ways in which it can ensure that Title X projects do not undermine the program's mission by excluding otherwise qualified providers as subrecipients,"[26] we propose that the Department take this criterion one step further by clarifying that the Department must consider whether an applicant has a policy that excludes certain otherwise qualified providers based on criteria unrelated to their ability to provide services and whether such an exclusion impacts the applicant's ability to further health equity. We recommend that the Department give significant weight to this criterion, given its critical impact on the mission of Title X.

The intent of the Title X program is to help individuals—with a priority for low-income individuals—achieve their family planning goals and further health equity. Title X funding is therefore provided to public and nonprofit entities to "assist in the establishment and operation of voluntary family planning projects" that offer a broad range of effective family planning methods and services.[27] As noted in the proposed rule, "[P]roviders with a reproductive health focus often provide a broader range of contraceptive methods on-site and therefore may reduce additional barriers to accessing services."[28] Moreover, "[a]dvancing health equity is critical to the mission of the Title X program."[29]

Title X providers are essential in the fight to achieve health equity. Publicly funded family planning clinics are critically important resources for the 24% of U.S. residents living in rural areas, including 19 million women.[30] Even before the 2019 Final Rule went into effect, rural areas already experienced a significant shortage of reproductive health providers.[31] Title X clinics are also a critical source of care for low-income communities of color.[32] Decades of racism, sexism and other social and economic barriers have contributed to stark health disparities for women of color, who are more than half of the patients in the Title X program. Title X clinics are also an important source of care for LGBTQ+ people, who are disproportionately represented in the number of Americans living in poverty and homelessness.

---

[26] *Id.* at 19,817.
[27] 42 U.S.C. § 300.
[28] 86 Fed. Reg. at 19,817 (Apr. 15, 2021).
[29] *Id.* at 19,820.
[30] Sharon A. Dobie et al., *Family Planning Service Provision in Rural Areas: A Survey in Washington State*, FAMILY PLANNING PERSPECT. (1998), https://pdfs.semanticscholar.org/09af/d6874486e371e214d3adb67df9fc438356eb.pdf; *see* U.S. DEP'T OF HEALTH AND HUMAN SERVS., HEALTH RES. AND SERVS. ADMIN., MATERNAL AND CHILD HEALTH BUREAU, WOMEN'S HEALTH USA 2013 (2013), https://mchb.hrsa.gov/whusa13/population-characteristics/p/rural-urban-women.html; *see generally* U.S. DEP'T OF HEALTH AND HUMAN SERVS., AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, TELEHEALTH: MAPPING THE EVIDENCE FOR PATIENT OUTCOMES FROM SYSTEMATIC REVIEWS, TECHNICAL BRIEF NO. 26 (June 2016), https://mchb.hrsa.gov/whusa13/population-characteristics/p/rural-urban-women.html.
[31] Annalisa Merelli, *America is running out of OB/GYNs*, QUARTZ (2018), https://qz.com/1315458/the-link-between-medicaid-and-americas-shortage-of-ob-gyns/; Kevin J. Bennett et al., *Rural Women's Health*, NATIONAL RURAL HEALTH ASSOCIATION (2013), https://www.ruralhealthweb.org/getattachment/Advocate/Policy-Documents/RuralWomensHealth-(1).pdf.aspx.
[32] Sixty-four percent of Title X patients have incomes at or below the federal poverty level, earning less than $11,880 in 2016. Title X patients are disproportionately Black and Hispanic or Latino. Twenty-one percent of Title X patients self-identify as Black and thirty-two percent as Hispanic or Latino, as compared twelve and eighteen percent of the nation, respectively. *See, e.g.*, *Title X: An Introduction to the Nation's Family Planning Program, Policy Brief*, NAT'L FAMILY PLANNING & REPROD. HEALTH ASS'N (2017), https://www.nationalfamilyplanning.org/file/Title-X-101-November-2017-final.pdf; C.I. Fowler et al., *Family Planning Annual Report: 2016 National Summary*, RTI INTERNATIONAL (2017), https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf.

Despite the clear need for providers that effectively serve communities facing structural barriers to care, tiering and other state-level policies often exclude the very providers that are the most qualified and best-equipped to help Title X patients achieve their family planning goals and further health equity. At least 15 states currently have laws on the books that, where funds flow through the state government, could negatively impact the Title X service delivery network.[33]

To best achieve the program's goals, Title X has historically funded a diverse network of service delivery providers—including state, county, and local health departments, as well as hospitals, family planning councils, Planned Parenthood affiliates, federally qualified health centers, and other private non-profit organizations. These networks vary widely across communities because they are specifically established to provide the most effective care to their unique patient populations. It is therefore imperative that HHS "ensure that Title X projects do not undermine the program's mission by excluding otherwise qualified providers as subrecipients."[34]

To this end, we propose that the Department clarify that an applicant's policy of excluding certain qualified providers from Title X funding based on criteria unrelated to their ability to provide Title X services will weigh against them in the Title X application process and that the Department will favor applicants that ensure all qualified providers are fully eligible for subgrants and prioritize health equity throughout the subgranting process.

5. Modernizing the Title X Regulations

The proposed rule makes an important update in § 59.5(b)(1) recognizing that medical services in many Title X-funded health centers can be and are provided by health care providers who are not physicians. In fact, the preamble in the proposed rule specifically mentions physician assistants and nurse practitioners as the types of health care providers that provide consultation in Title X settings.[35] However, it is important to note that "consultation by a [health care] provider" is not and should not be limited only to the examples cited by HHS, as these Clinical Services Providers (CSPs) represent only one facet of health care providers in Title X settings.[36] In 2019, 23% of family planning encounters fell under the primary responsibility of other service providers, including registered nurses practicing within a standard scope of practice, licensed practical nurses, health educators, and social workers.[37] We encourage the Department to elevate the critical role these health care professionals play in the Title X program.

We also commend the Department for its emphasis on inclusivity in the proposed rule and the transition the proposed rule makes to using the more inclusive word "client" instead of "women" in the Title X regulations. This change better reflects the diverse population of patients served by the Title X program. Gender identity should never be a barrier to receiving the care someone needs, and all people who are can become pregnant, including queer, transgender, and nonbinary people, may have a need for family planning care, as may their partners.

---

[33] *State Family Planning Funding Restrictions*, GUTTMACHER INST. (2021), https://www.guttmacher.org/state-policy/explore/state-family-planning-funding-restrictions#.
[34] 86 Fed. Reg. at 19,817 (Apr. 15, 2021).
[35] 86 Fed. Reg. at 19,820 (Apr. 15, 2021).
[36] *Id.* at 19831.
[37] C. FOWLER ET AL., FAMILY PLANNING ANNUAL REPORT: 2019 NATIONAL SUMMARY (2020), https://opa.hhs.gov/sites/default/files/2020-09/title-x-fpar-2019-national-summary.pdf.

6. Protecting Patient Privacy

We welcome the proposed rule's addition of language codifying a longstanding practice that had been included in the 2014 Title X Program Requirements that reasonable efforts must be made to "collect charges without jeopardizing client confidentiality,"[38] along with a new requirement that clients be informed of "any potential for disclosure of their confidential health information to policyholders where the policyholder is someone other than the client."[39] Family planning services address some of the most sensitive and personal issues in health care and therefore require strong confidentiality protections. Patients seeking family planning services encompass a broad spectrum of patient populations. Certain groups, including adolescents and young adults, and people at risk of domestic or intimate partner violence, have special privacy concerns that require particularly strong patient privacy protections.

The Department is right to recognize the potential for harm from varied state and local laws regarding the accessibility of client information to insurance policyholders that are not the client. As more and more patients have access to insurance, the potential risks of disclosure of sensitive information have increased. These proposed additions to the Title X regulations will help to ensure that patient privacy protections remain paramount in Title X.

7. Applicability of Religious Refusal Statutes

The preamble acknowledges that certain federal statutes allow providers to deny care based on religious objections. However, the preamble overstates the scope of these laws. Moreover, because the Department is not proposing to alter its interpretation of these statutes, it is unnecessary for the Department to address them in either the preamble to its final rule or the final rule itself.[40] To the extent the Department continues to reference these statutes, however, it should accurately reflect the scope of the federal refusal statutes to avoid confusion and eliminate potential denials of care.

Specifically, citing subsection (d) of the Church amendment[41] and the Weldon amendment,[42] the proposed rule's preamble provides that objecting grantees "will not be required to follow the proposed rule's requirements regarding abortion counseling and referral."[43] It further states that, "[u]nder these [appropriations] statutes, objecting providers or Title X grantees are not required to counsel or refer for abortions."[44] This interpretation is contrary to the underlying statutes and creates confusion that threatens to restrict patients' ability to obtain complete information and referrals, for two reasons: The proposed rule's preamble omits key differences between the

[38] 86 Fed. Reg. at 19,820 (Apr. 15, 2021).
[39] *Id.* at 19,832.
[40] *See* Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws, 76 Fed. Reg. 9968, 9973 (Feb. 23, 2011) (Recognizing both that "[h]ealth care entities must continue to comply with the long-established requirements of the statutes … governing Departmental programs" and that the refusal "laws and the other federal statutes have operated side by side often for many decades").
[41] 42 U.S.C. § 300a–7(d).
[42] Consolidated Appropriations Act, 2021, Public Law 116–260, Div. H, sec. 507(d) (2020), https://www.congress.gov/bill/116th-congress/house-bill/133/text.
[43] 86 Fed. Reg. at 19,817-18. The Proposed Rule does not mention the Coats-Snowe amendment, 42 U.S.C. § 238n, another refusal statute that does not implicate Title X.
[44] *Id.* at 19,817.

statutes' application to entity grantees and individual employees; and, it both misstates and overstates the scope of these laws.

The Church amendment provision upon which the proposed rule relies, subsection (d), only refers to *individuals* who shall not be required to perform or assist in the performance of certain activities.[45] As the Supreme Court has stated, where a statute "does not define the term 'individual,'" the word is presumed to refer only to natural persons, not "organization[s]" or entities.[46] Therefore, by its terms (and underscored by its title) this provision does not grant any rights to entities at all, regardless of whether they receive Title X grants or subgrants. This cited section provides no authority for the preamble's statement that objecting "Title X *grantees* are not required to counsel or refer for abortions."[47] Moreover, the Church amendment is limited to health services and does not encompass the provision of information such as counseling or a referral. Unlike the Church amendment's subsection (d), the Weldon amendment covers entities as well as individuals. Its scope, however, is narrow,[48] and is limited in three important ways. First, the Weldon amendment regulates the behavior of a limited group of actors: "Federal agenc[ies] or program[s], or … state or local government[s]."[49] Therefore, the mere fact that a nongovernmental organization may accept Title X funds does not mean that the organization is subject to the Weldon amendment. [50]

Second, the Weldon amendment's prohibition on discrimination does not prevent the limited group of governmental actors to which it applies from adopting and applying neutral program requirements. And Title X's program rules—which merely recognize that beneficiaries of a family planning program are best served by receiving referral for all pregnancy options, upon request—are plainly neutral program requirements. Thus, this provision would not be "discrimination" against entities that do not refer for abortions; it would simply identify the scope of the program that the government chooses to support.[51]

Third, the Weldon amendment only prohibits "discrimination on the basis that [a] health care entity does not provide, pay for, provide coverage of, or *refer for* abortions."[52] Referral for abortions is only one part of options counseling. Accordingly, the text of the amendment does not suggest that Title X grantees may refuse to provide *all* counseling related to abortion. But the preamble's language currently states, incorrectly, that "objecting … Title X grantees are not required to counsel … for abortions."[53]

As the proposed rule recognizes, a key requirement of Title X's statutory mandate is that services must include nondirective options counseling, including referrals.[54] Thus, interpreting the

---

[45] 42 U.S.C. § 300a–7(d) (emphasis added). Indeed, that section is titled "Individual rights respecting certain requirements contrary to religious beliefs or moral convictions."
[46] *Mohamad v. Palestinian Auth.*, 566 U.S. 449, 454-455 (2012).
[47] 86 Fed. Reg. at 19,817 (Apr. 15, 2021) (emphasis added).
[48] The Weldon amendment provides: None of the funds made available in this Act may be made available to a Federal agency or program, or to a state or local government, if such agency, program, or government subjects any institutional or individual health care entity to *discrimination* on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions. Consolidated Appropriations Act, 2021, Pub. L. 116-260, Div. H, sec. 507(d)(1) (2020), https://www.congress.gov/bill/116th-congress/house-bill/133/text (emphasis added).
[49] *Id.*
[50] Def. Mem. in Opp. to Pl.'s Motion for Prelim. Inj. at 2, 28-30, *NFPRHA v. Ashcroft*, No. 04-2148 (D.D.C. Dec. 24, 2004), Dkt. 9.
[51] *See, e.g., Agency for Int'l Dev. v. All. For Open Soc'y Int'l, Inc.*, 570 U.S. 205, 213-214 (2013).
[52] Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, Div. H, sec. 507(d)(1) (2020), https://www.congress.gov/bill/116th-congress/house-bill/133/text (emphasis added).
[53] 86 Fed. Reg. at 19,817 (Apr. 15, 2021).
[54] *See, e.g., id.* at 19,830 (Sec. 59.5(a)(5)(ii)).

Weldon amendment to require an option for grantees to avoid providing nondirective counseling would directly contravene Title X's nondirective counseling mandate. Interpreting the Weldon amendment in this manner would gut the nondirective counseling requirement of any meaning and would decrease patients' access to information and services that they need.[55] It is a key principle of statutory construction that, whenever possible, statutes should be construed in a manner that reconciles their meaning and gives force to all statutes involved. Accordingly, the Weldon amendment cannot be interpreted to require the government to fund entities that disregard the Department's QFP recommendations by refusing to refer for abortion, as doing so would directly contravene Title X's nondirective options counseling mandate.

We urge the Department to delete all language discussing the federal refusal laws from the proposed rule's preamble to avoid confusion and denials of care and information. If the Department intends to address these refusal laws, however, it should modify the preamble's language to accurately reflect the text and scope of the statutory provisions on which it relies.

8. Applicability of Other HHS Regulations

The proposed rule also proposes making a "technical correction" to § 59.12 to include 45 CFR part 87, the ''Equal Treatment for Faith-based Organizations'' rule (faith-based organizations rule) in the list of regulations that apply to Title X.[56] But the faith-based organizations rule, by its own terms, only applies to grants awarded in "HHS social service programs" insofar as it applies to HHS grant programs.[57] While the proposed rule notes that Title X projects must "provide for social services related to family planning,"[58] Title X is a health service program, not a social service program. As such, 45 CFR part 87 does not rightfully apply, and should therefore not be included in the final rule.

9. Conclusion

For 50 years, the Title X family planning program has been a critical underpinning of the public health safety-net infrastructure that serves millions of low-income people each year. We welcome the Department's proposal to reverse the 2019 Title X regulations and readopt the 2020 regulations with key revisions to further the mission of the Title X program.

We appreciate the opportunity to comment on this proposed rule. If you require any additional information about the issues raised in this letter, please contact Katherine Gillespie, Acting Director, Federal Policy and Advocacy, at kgillespie@reprorights.org.

Signed,

The Center for Reproductive Rights

[55] Megan L. Kavanaugh et al., *"It's not something you talk about really": Information Barriers Encountered by Women Who Travel Long Distances for Abortion Care*, 100 CONTRACEPTION 79-84 (2019), https://www.sciencedirect.com/science/article/pii/S001078241930126X.
[56] 86 Fed. Reg. at 19820 (Apr. 15, 2021)
[57] Equal Participation of Faith-Based Orgs. in Fed. Agencies' Programs and Activities, 85 Fed. Reg. 82,037, 82,117 (Dec. 17, 2020).
[58] 86 Fed. Reg. at 19831 (Apr. 15, 2021).