NATIONAL CENTER FOR LESBIAN RIGHTS

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May 17, 2021

Office of Population Affairs
Office of the Assistant Secretary for Health
US Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

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

The National Center for Lesbian Rights (NCLR) and the other undersigned organizations representing the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community are pleased to provide comments on the notice of proposed rulemaking (NPRM), "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services," RIN 0937-AA11 ("proposed rule"). NCLR and our partners strongly support revoking the 2019 Title X regulations,[1] which undermined the program through improper interference with patient care, and reinstating the 2000 regulations with revisions. Once finalized, the proposed rule would return the Title X family planning program to its proper focus on "making comprehensive voluntary family planning services readily available to all persons desiring such services."[2] Furthermore, because of the need to reverse the devastating impact of the 2019 Title X regulations on the program's provider network and its patients, we encourage HHS to finalize the proposed rule as quickly as possible.

NCLR is a non-profit, public interest law firm that litigates precedent-setting cases at the trial and appellate court levels; advocates for equitable public policies affecting the LGBTQ community; provides free legal assistance to LGBTQ people and their legal advocates; and conducts community education on LGBTQ issues. NCLR has been advancing the civil and human rights of LGBTQ people and their families across the United States through litigation, legislation, policy, and public education since it was founded in 1977. NCLR serves thousands of LGBTQ people and their families throughout the United States each year, including LGBTQ parents, seniors, immigrants, athletes, and youth. We also seek to empower individuals and communities to assert their own legal rights and to increase public support for LGBTQ equality through community and public education. NCLR was founded more than four decades ago to champion the rights of lesbian parents, and protecting the fundamental right to make personal decisions around family formation remains core to our mission today.

[1] "Compliance With Statutory Program Integrity Requirements," 84 Fed. Reg. 7714 (March 24, 2019).
[2] Public Law 91-572 ("The Family Planning Services and Population Research Act of 1970"), sec. 2(1).

Our comments on the new proposed rule address the following:

- Undoing the harm of the 2019 rule and restoring the Title X program and its network;
- Promoting health equity and reducing health disparities;
- Promoting the standard of care; and
- Modernizing the regulations to ensure the continued success of the program.

I. The Proposed Rule Will Help Undo the Harm of the 2019 Rule and Restore the Title X Network and Program

In our comments opposing the 2019 rule, as well as in the amicus briefs[3] we filed supporting challenges to that rule, we noted our concern that if that rule were implemented, it would reduce the availability of culturally competent providers who serve LGBTQ people seeking not only family planning services but STI screenings and other essential care. We warned that this would affect many people within the LGBTQ community, including lesbian and bisexual women, as well as transgender, nonbinary, and gender nonconforming individuals who can become pregnant and need affordable access to birth control,[4] treatment for STIs to preserve future fertility, and other reproductive health options.[5] Title X sites also perform screenings for interpersonal violence and conduct Pap tests and breast exams, all of which are critical to the health—and indeed the lives—of LGBTQ people.

In addition, in recent years, many reproductive health care providers have filled a critical gap in the provision of health care to the LGBTQ community. These clinics have created welcoming spaces and health care services designed to serve LGBTQ people, who otherwise face pervasive discrimination in the health care system. They have created nondiscriminatory environments for LGBTQ people to receive care, from general wellness services to more specific services for transgender patients, including hormone therapy. These clinics are particularly well-suited to provide LGBTQ care because of their expertise in providing services that are still stigmatized, such as abortion, contraception, and screening and treatment for STIs. These providers recognize that LGBTQ people face bias in the health care system and need competent, affirming services from practitioners who understand the harmful effects of stigma. Comprehensive

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[3] *See*, *e.g.*, *Mayor and City Council of Baltimore v. Azar*, No. 19-1614, Brief of Amici Curiae National Center for Lesbian Rights et al, 2019 WL 3714651 (C.A. 4).

[4] CDC, Abortion Surveillance - United States, 2018, Table 5, 67 Morbidity and Mortality Weekly Report No SS-13 1-45 (Nov. 27, 2020); Brittany Charlton, et. al., *Sexual Orientation Differences in Pregnancy and Abortion Across the Lifecourse,* 30-2 Women's Health Issues 65 (2020) (bisexual participants were three times as likely as heterosexuals to have had an abortion); Caroline Sten Hartnett et. al., *Congruence across sexual orientation dimensions and risk for unintended pregnancy among adult U.S. women*, 27 Women's Health Issues 145 (2017) (unintended pregnancies are equally as common, if not more common, for sexual minority women as for heterosexual women).

[5] *See generally Queering Reproductive Justice: A Toolkit,* NAT'L LGBTQ TASK FORCE (Mar. 2017), https://www.thetaskforce.org/wp-content/uploads/2017/03/Queering-Reproductive-Justice-A-Toolkit-FINAL.pdf [https://perma.cc/P6WR-SYUE].

reproductive health care providers occupy a critical niche within the health care system precisely because they provide services that many will not; this forms an important component of the cultural competency that they bring to LGBTQ health care.

Given the reality of limited health care access and alienation from the health care system, LGBTQ individuals may suffer from health care conditions that go undiagnosed and untreated for months or even years. Title X sites with LGBTQ-specific programming can serve as a critical entry point into the health care system for LGBTQ people. While a patient might come seeking a specific service like hormone therapy, the health care practitioner can also identify other health issues that might otherwise go unaddressed, such as high blood pressure or depression. Many patients of Title X sites have no other source of health care, particularly if they have incomes below the poverty line. This holds true for LGBTQ patients as well, who are disproportionately low-income.[6]

Unfortunately, the 2019 rule *was* finalized and the results were as anticipated. When the 2019 rule was implemented in August 2019, grantees immediately began to withdraw from Title X rather than comply with that rule's onerous and unethical requirements. Overall, as the current NPRM notes, the Title X program lost more than 1,000 health centers.[7] Those health centers represented approximately one quarter of all Title X-funded sites in 2019.[8] Nearly two years later, six states continue to have no Title X-funded provider network[9] and an additional six states have a very limited Title X-funded network.[10] The significant damage to the Title X provider network resulted in at least 1.5 million patients losing access to Title X-funded services.[11] Despite the prior administration's assertion that its rule would inspire new applicants to apply for Title X funding and result in "more clients being served,"[12] the Office of

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[6] *See* National LGBTQ Antipoverty Action Network, "Poverty at the End of the Rainbow," 2020, available at https://nclr.turtl.co/story/poverty-at-the-end-of-the-rainbow/page/1; *LGBT Proportion of Population: United States*, WILLIAMS INST. ON SEXUAL ORIENTATION AND GENDER IDENTITY LAW AND PUBLIC POLICY, UCLA SCHOOL OF LAW (Jan. 2019), https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT#density [https://perma.cc/6EVM-6EGT] (interactive map providing aggregated and disaggregated data and statistics); Lourdes A. Hunter et al., *Intersecting Injustice: A National Call to Action*, SOCIAL JUSTICE SEXUALITY PROJECT, GRADUATE CENTER, CITY UNIV. OF NEW YORK 11 (Mar. 2018), https://static1.squarespace.com/static/5a00c5f2a803bbe2eb0ff14e/t/5aca6f45758d46742a5b8f78/1523216213447/FINAL+PovertyReport_HighRes.pdf [https://perma.cc/YW6P-VPZR] ("LGBTQ people—especially LGBTQ people of color and transgender and gender nonconforming people—are more likely to be living at or near the poverty level.").

[7] "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services," 86 Fed. Reg. 19812, 1981 (April 15, 2021).

[8] 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; *see also Title X Family Planning Directory*, n.5.

[9] Zolna et al., n.59, at 2 (Hawaii, Maine, Oregon, Utah, Vermont, and Washington).

[10] 86 Fed. Reg. at 19815 (Alaska, Connecticut, Massachusetts, Minnesota, New Hampshire, and New York).

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

[12] 84 Fed. Reg. at 7723.

Population Affairs (OPA) has been unable to find new grantees to fill the gaps the prior rule created, including in the six states that lost all Title X-funded services, and the program has served far fewer clients, rather than more.[13]

As HHS rightly highlights in the proposed rule, federal data shows the rapid and devastating impact of the current operative rule on access to critical family planning and sexual health services. Title X saw 844,083 fewer patients in 2019 compared to 2018 (3.1 million vs. 3.9 million). That dramatic 21% drop in patients occurred with the rule in effect for less than half of the year. This decrease meant that providers were able to offer 280,000 fewer cancer screenings, 1.3 million fewer sexually transmitted disease screenings, and 278,000 fewer confidential HIV tests. Additionally, hundreds of thousands of people lost access to contraceptive care due to the rule. The preliminary numbers for 2020 as shared in the proposed rule are even worse – only an estimated 1.5 million people received Title X-supported services in 2020, a loss of 2.5 million people from the network in just two years.[14] 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.[15] Thus, this kind of precipitous decline in patients receiving services through the Title X program has concerning implications for broader access to care.

The 2019 Title X rule severely undermined this bedrock public health program that has provided high quality, affordable family planning and sexual health care to millions for 50 years. NCLR and the undersigned strongly support the revocation of the 2019 rule, and reinstatement of the 2000 regulations with revisions, so that the Title X program can return its focus to its patients and communities.

II. The Proposed Rule Will Promote Health Equity and Help Reduce Health Disparities

Our organizations strongly support the administration's emphasis on health equity in the proposed rule. The statutory requirements that Title X-funded health centers give priority to

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[13] 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, HHS, *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, OPA, *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.*

[14] 86 Fed. Reg. at 19815.

[15] Kavanaugh ML, Zolna MR and Burke KL, 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.

people with low incomes, and provide care regardless of ability to pay, ensure that the Title X program is well-positioned to advance health equity for the patients it serves. The onerous requirements of the 2019 rule diverted attention and resources from this important work and undermined Title X's mission to provide equitable, affordable, client-centered, quality family planning and sexual health services.

Our opposition to the 2019 rule was grounded in the reality that LGBTQ people are a health disparity population,[16] as LGBTQ people of all ages face widespread discrimination in health care on the basis of their sexual orientation and gender identity.[17] The Department's own Healthy People 2020 Initiative recognizes that "LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights."[18] This treatment surfaces in a wide variety of contexts, including physical and mental health care services.[19] LGBTQ people of color are particularly vulnerable to discrimination, which often results in their having either significantly reduced access or no access at all to health care.[20]

When LGBTQ patients are turned away or refused treatment, it is much harder—and sometimes simply not possible—for them to find a viable alternative. In one study, nearly one in five LGBTQ people, including 31 percent of transgender people, said that it would be very difficult or impossible to get the health care they need at another hospital if they were turned away. That rate was substantially higher for LGBTQ people living in non-metropolitan areas, with 41 percent reporting that it would be very difficult or impossible to find an alternative provider.[21] For these patients, being turned away by a medical provider is not just an inconvenience. It often means being entirely denied care with nowhere else to go.

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[16] Director's Message, "Sexual and Gender Minorities Formally Designated as a Health Disparity Population for Research Purposes," Oct. 6, 2016, https://www.nimhd.nih.gov/about/directors-corner/messages/message_10-06-16.html.

[17] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care,* CTR. FOR AM. PROGRESS (Jan. 18, 2018, 9:00 a.m.), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/ [https://perma.cc/D6D2-DSFF]; S. E. James et al., *Report of the 2015 U.S. Transgender Survey*, NAT'L CTR. FOR TRANSGENDER EQUALITY 5 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf [https://perma.cc/8GDT-3ZAJ] (surveying 27,715 respondents from all fifty states); *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV*, LAMBDA LEGAL 5 (2010), https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf [https://perma.cc/G27B-7A68] (4,916 total respondents).

[18] *Lesbian, Gay, Bisexual, and Transgender Health*, U.S. DEPT. HEALTH & HUMAN SERV., https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health (last visited July 24, 2019) [https://perma.cc/4WUD-5ARV].

[19] *See* Ryan Thoreson, *All We Want Is Equality: Religious Exemptions and Discrimination against LGBT People in the United States*, HUMAN RIGHTS WATCH 18–19 (Feb. 2018), https://www.hrw.org/sites/default/files/report_pdf/lgbt0218_web_1.pdf [https://perma.cc/7HP6-8QFS].

[20] *See generally* Ning Hsieh & Matt Ruther, *Despite Increased Insurance Coverage, Nonwhite Sexual Minorities Still Experience Disparities In Access To Care*, 36 HEALTH AFFAIRS 1786 (Oct. 2017), *available at* https://www.ncbi.nlm.nih.gov/pubmed/28971924 [https://perma.cc/4FTV-7A92].

[21] Mirza & Rooney, *supra* note 17.

Health care disparities in general are often more pronounced in rural areas in the United States, and this is further compounded for LGBTQ individuals. In rural areas, if care is restricted, there may be no other resources for health and life-preserving medical care. Since 2010, 83 rural hospitals have closed.[22] Medically underserved areas already exist in every state, with over 75 percent of chief executive officers of rural hospitals reporting physician shortages.[23] Many rural communities already experience a wide array of shortages in mental health, dental health, and primary care health professional coverage.[24] The 2019 rule left individuals in rural communities with even less access to care that is close, affordable, and high quality, leaving many LGBTQ individuals in rural communities with no health care options at all.

LGBTQ youth are at particular risk. Due to pressures to prove they are heterosexual, lesbian and bisexual youth are at higher risk of experiencing unintended pregnancies than are heterosexual youth.[25] Access to family planning is therefore essential for this group of young people. A lack of connection to competent, nondiscriminatory health care resources also isolates LGBTQ youth, making them more susceptible to self-destructive behavior patterns.[26] Isolation often continues into adulthood, when LGBTQ populations are more likely to experience depression and engage in high-risk behaviors as a result.[27] Decimating the main culturally-competent network of health care providers that serves this population was thus a particularly pernicious outcome of the 2019 rule. We applaud HHS for turning the page on that dark chapter and moving to restore the Title X network so that it can continue to provide essential care to populations in need.

We support the addition of new definitions in the Title X regulations, including for health equity and inclusivity. In particular, the use of "client" rather than "women" is more reflective of the diverse population of patients served by the Title X program. Gender identity should never be a barrier to receiving the care one needs, and all people who are capable of becoming pregnant,

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[22] *See Rural Hospital Closures: January 2010 – Present*, THE CECIL G. SHEPS CTR. FOR HEALTH SERVS. RES., http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/ (last visited July 25, 2019).

[23] *See Quick Maps – Medically Underserved Areas/Populations*, U.S. DEP'T HEALTH & HUM. SERV. (2019) https://data.hrsa.gov/hdw/Tools/MapToolQuick.aspx?mapName=MUA; M. MacDowell et al., *A National View of Rural Health Workforce Issues in the USA*, 10 RURAL REMOTE HEALTH 1531 (2010), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3760483/ [https://perma.cc/W4XT-6NSG] (visualizing medically underserved areas and populations).

[24] *See generally* Carol Adaire Jones et al., *Health Status and Health Care Access of Farm and Rural Populations*, U.S. DEPT. AGRIC. (Aug. 2009), https://www.ers.usda.gov/webdocs/publications/44424/9371_eib57_1_.pdf?v=0 [https://perma.cc/6B6T-7X3T].

[25] *See generally* Lisa L. Lindley & Katrina M. Walsemann, *Sexual Orientation and Risk of Pregnancy Among New York City High-School Students*, 105 AM. J. PUB. HEALTH 1379 (2015); Karen Schantz, *Pregnancy Risk Among Bisexual, Lesbian, and Gay Youth: What Does Research Tell Us?*, ACT FOR YOUTH CTR. OF EXCELLENCE (Apr. 2015), http://www.actforyouth.net/resources/rf/rf_lgb-prg_0415.pdf (summarizing research).

[26] *See* Colleen S. Poon & Elizabeth M. Saewyc, *Out Yonder: Sexual-Minority Adolescents in Rural Communities in British Columbia*, 99 AM. J. PUB. HEALTH 118 (Mar. 28, 2008), *available at* http://doi.org/10.2105/AJPH.2007.122945.

[27] *See* Trish Williams et al., *Peer Victimization, Social Support, and Psychosocial Adjustment of Sexual Minority Adolescents*, 34 J. YOUTH & ADOLESCENCE 471 (Oct. 2005), *available at* https://doi.org/10.1007/s10964-005-7264-x.

including queer, transgender, and nonbinary people, as well as their partners, may have a need for family planning care.

We would also recommend that HHS expand the definition of inclusivity, as well as the list of examples of underserved communities, to expressly include intersex persons. Intersex people have been identified as a health disparity population by the National Institutes of Health (NIH), the American Association of Medical Colleges, and the National Academies of Sciences, Engineering, and Medicine (NASEM). A recent NASEM report found that "Intersex health disparities appear to be driven in large part by the medical approach to intersex traits, which has been informed by the same stigmas experienced by SGD [sexual and gender diverse] populations."[28] Intersex people are more likely to experience a number of sexual and reproductive health needs—some related to intersex traits themselves, but many related to unnecessary early genital surgeries. These concerns may include sexual pain, sexual trauma, sexually transmitted infections, miscarriages, complex pregnancies, hormone imbalance, and increased risk or uncertainty about risk for infertility or reproductive cancers.[29] Intersex people also face barriers to seeking sexual and reproductive health care, including minority stress, internalized shame and stigma regarding intersex traits, past medical trauma, avoiding care due to fear of mistreatment, and lack of sensitivity, clinical knowledge, and cultural competence among providers.[30] Proactive efforts to ensure inclusion and equity for intersex patients are thus especially urgent for family planning providers.

Specifically, we recommend the following:

- In § 59.2, add "intersex" to the definition of "Inclusivity," so that it reads: "...lesbian, gay, bisexual, transgender, ~~and~~ queer, and intersex (LGBTQI+) persons."
- In § 59.6(b)(2), add "intersex" to the examples of underserved communities, so that it reads: "...lesbian, gay, bisexual, transgender, ~~and~~ queer, and intersex (LGBTQI+) persons."

The COVID-19 pandemic has laid bare the many inequities in our nation's health care system and highlighted how systemic racism and other forms of oppression have resulted in pervasive health disparities and disproportionately poor health outcomes for people of color. The Title X program has a significant role to play in combating these systemic barriers to care and ensuring that all people, regardless of their race, ethnicity, age, sexual orientation, gender identity, immigration status, employer, insurance status, or any other demographic, have timely access to comprehensive, high-quality family planning and sexual health services. The proposed rule's emphasis on health equity will further support these goals.

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[28] National Academies of Sciences, Engineering, and Medicine, *Understanding the Wellbeing of LGBTQI+ Populations: Consensus Study Report* (p. 27) (Washington: 2020).
[29] *Id*. at 296-323; Rosenwohl-Mack A et al., A national study on the physical and mental health of intersex adults in the U.S., PLoS ONE 15(10): e0240088 (2020).
[30] National Academies, *supra* note 26 at 350-60, 375-76; Reis, E. & McCarthy, E.R., *What Hospitalists Should Know About Intersex Adults,* Perspectives in Biology and Medicine, 59(3):391 (2016).

Particularly in the wake of CDC's recent declaration that racism is a serious threat to public health, we would like to see systemic racism explicitly included and addressed as part of the expectations related to health equity. Systemic racism and other forms of oppression have resulted in structural barriers to health care services. The Title X family planning program and today's provision of family planning services arose out of a history of reproductive coercion and a fundamental devaluing of the bodily autonomy of people of color and people with low incomes. This history has contributed to a justifiable mistrust of the health care system, particularly with respect to family planning. As the administration raises health equity as an important goal of Title X in the proposed rule, NCLR urges HHS to acknowledge and reckon with that history as it works to further its mission "to enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services."

III. The Proposed Rule Will Restore the Title X Program to Its Core Purpose and Further the Delivery of the Standard of Care to Patients

Title X was expressly created in 1970 to make "'comprehensive family planning services readily available to all persons desiring such services."[31] The statute requires Title X projects to "offer a broad range of acceptable and effective family planning methods and services," and prioritizes a project's capacity to make rapid and effective use of federal funds for family planning.[32] The 2019 rule undermined these longstanding principles in a variety of ways. It eliminated the term "medically approved" from the regulatory requirement that projects provide "a broad range of acceptable and effective medically approved family planning methods,"[33] and it included overly permissive language that opened the door to participation in the program by providers who object to fundamental tenets of the Title X program. It also diverged from the nationally recognized clinical standards, the Quality Family Planning guidelines, published by the Office of Population Affairs and the Centers for Disease Control and Prevention in 2014.[34] Furthermore, the 2019 rule made drastic changes to pregnancy counseling by Title X providers that violated Congress' explicit, repeated mandates; contradicted central principles of medical ethics; and attempted to enlist clinicians in deceiving and delaying patients who seek information about or access to abortion providers.

The new proposed rule will undo this harm and return the Title X program to its core purpose. We are particularly heartened to see the proposed rule's references to the dignity of program beneficiaries.[35] The U.S. Supreme Court has long recognized that to realize full autonomy and dignity, individuals must be allowed to make fundamental decisions about family, marriage, and

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[31] *Planned Parenthood Federation of America, Inc. v. Heckler*, 712 F.2d 650, 651 (D.C. Cir. 1983) (quoting S. REP. NO. 91-1004, at 2 (1970)).
[32] 42 U.S.C. §300.
[33] 83 Fed. Reg. at 25530.
[34] MMWR 2014; 63 (4) (April 25, 2014).
[35] 86 Fed. Reg. at 19821, 19825, 19830 (proposed sec. 59.5(a)(3)).

procreation free from undue interference by the government.[36] Health care providers are key partners in this process, facilitating fully informed decision-making about the medical and health care aspects of these fundamental decisions. In support of this role, providers must operate according to established principles of medical ethics, including informed consent.[37] Family planning providers should thus offer patients counseling around all options concerning birth control and abortion, and make appropriate referrals upon the patient's request. The 2019 rule was squarely at odds with this cornerstone principle of health care, as it prevented providers from being able to discuss all options with their patients and refer them for appropriate care as necessary.[38]

This is why the Title X program requires non-directive counseling. A patient who clearly indicates they wish to end a pregnancy should not be unwillingly steered toward a different choice; they should be given complete and accurate information about where they can obtain appropriate abortion care. But the 2019 rule violated this basic promise. It distorted the role of family planning providers, conscripting them to further a political preference that cut off access to even basic information about abortion—all in violation of the law and fundamental rights, and at the expense of patients when they are in a critical time of need. The Constitution's

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[36] *Obergefell v. Hodges*, 135 S. Ct. 2584, 2597 (2015) ("The fundamental liberties protected by [the Fourteenth Amendment's Due Process Clause]. . . extend to certain personal choices central to individual dignity and autonomy, including intimate choices that define personal identity and beliefs."); *Lawrence v. Texas*, 539 U.S. 558, 574 (2003) ("Persons in a homosexual relationship may seek autonomy for these purposes [marriage, procreation, contraception, family relationships, child rearing, and education], just as heterosexual persons do."); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992) ("These matters [personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education], involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment."); *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (explaining that the Constitution protects an individual's right to be "free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."); *Loving v. Virginia*, 388 U.S. 1, 12 (1967) ("The freedom to marry has long been recognized as one of the vital personal rights essential to the orderly pursuit of happiness by free men.").

[37] *See AMA Principles of Medical Ethics*, American Medical Association ch. 2 § 1.3, *available at* https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-2.pdf ("Truthful and open communication between physician and patient is essential for trust in the relationship and for respect for autonomy.").

[38] Numerous courts considering legal challenges to the 2019 rule recognized that it undermined medical ethics. *See*, *e.g.*, *Mayor and City Council of Baltimore v. Azar*, 392 F.Supp3d 602, 614 (D. Md. 2019) (acknowledging that "[t]he AMA strongly opposed the [Final Rule when first proposed] as interfering with and undermining the patient-physician/provider relationship" (citation omitted)); *Oregon v. Azar*, 389 F. Supp. 3d 898, 919 (D. Or. 2019), *vacated and remanded sub nom. California by & through Becerra v. Azar*, 950 F.3d 1067 (9th Cir. 2020), *cert. granted sub nom. Am. Med. Ass'n v. Cochran*, 141 S. Ct. 1368 (2021), and *cert. granted sub nom. Oregon v. Cochran*, 141 S. Ct. 1369 (2021) ("The unrebutted evidence demonstrates, at this stage of the proceedings, that the Final Rule would force medical providers to violate their ethical and professional obligations."); *State v. Azar,* 385 F. Supp. 3d 960, 998 (N.D. Cal. 2019), *vacated and remanded sub nom. California by & through Becerra v. Azar,* 950 F.3d 1067 (9th Cir. 2020), *cert. granted sub nom. Am. Med. Ass'n v. Cochran,* 141 S. Ct. 1368 (2021)*, and cert. granted sub nom. Oregon v. Cochran,* 141 S. Ct. 1369 (2021) ("the Final Rule's prohibition on providing abortion referrals, restrictions on the content of referral lists, and mandate on referrals for prenatal care are also squarely at odds with established ethical standards"); *Washington v. Azar*, 376 F. Supp. 3d 1119, 1130 ("[Plaintiffs] have also presented facts and argument that the Final Rule likely violates Section 1554 of the ACA because the Final Rule . . . violates the principles of informed consent and the ethical standards of health care professions.").

guarantee of equal dignity is betrayed when the government manipulates the patient-provider relationship and constrains choices around intensely personal, intimate, and ultimately life-changing matters, especially the choice to become or remain pregnant. The 2019 rule restricted the free flow of medically accurate and relevant information in health care settings, thereby compromising the equal dignity of Title X patients.

Our organizations applaud HHS for the proposed rule's return to the core mission of the Title X program, which will once again meet patients' expectations that they will receive high-quality client-centered care that includes comprehensive, medically accurate counseling and information, and referrals for any other services sought. Specifically, we strongly support the following changes and urges HHS to finalize them:

- The inclusion of "FDA-approved contraceptive services" and reinstatement of the term "medically approved" to the proposed definition of family planning services;
- The requirement that Title X service sites refer patients to another provider if the site does not offer the contraceptive method of the patient's choice;
- The requirement to provide services "in a manner that is client-centered, culturally and linguistically appropriate, inclusive, and trauma-informed; protects the dignity of the individual; and ensures equitable and quality service delivery consistent with national recognized standards of care;"
- The reinstatement of the requirement to offer nondirective options counseling to pregnant patients on each of the three options (prenatal care and delivery; infant care, foster care, or adoption; and pregnancy termination), if requested by the patient, including referral upon request.
- The elimination of unnecessary and unworkable physical, systems, and administrative separation, contrary to the requirements and realities of modern quality health care.

We cannot emphasize enough the importance of seeing our nation's top public health agency returning to a focus on patients' health care needs, something that was lacking in the prior administration. It comes at a critical time, when a distressing number of states are advancing legislation to block transgender people from the life-saving health care they need. Political interference in medical care is dangerous, and this NPRM is the right move, restoring the Title X program's commitment to adhering to medical ethics and standards of care. We hope that HHS will use its powerful position to oppose these ongoing attacks on transgender people's health care and continue to lead by example in ensuring access to high-quality, evidence-based care for all.

IV. Modernizing the Title X Regulations Will Help Ensure the Program's Future Success

The Title X family planning program has been a noteworthy public health success. And while returning largely to the 2000 regulations will go a long way toward ensuring that success

continues, changes in the health care delivery landscape necessitate updates to the Title X regulations to account for the context in which services currently are delivered in the family planning safety net.

The NPRM makes an important update in § 59.5(b)(1) in recognition 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 NPRM preamble specifically mentions physician assistants and nurse practitioners as the types of health care providers that provide consultation in Title X settings. Indeed, nurse practitioners, certified nurse midwives, and physician assistants accounted for 67% of the Title X program's full-time equivalent (FTE) Clinical Services Provider (CSPs) in the 2019; physicians and registered nurses with an expanded scope of practice accounted for 24% and 9% of all CSP FTEs, respectively.

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 CSPs represent only one facet of health care providers in Title X settings.[39] In 2019, 23% - or more than 1.07 million – 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.[40] These professionals not only account for a substantial number of Title X encounters on their own, but also provide critical support to CSPs in team-based care models typical to modern health care delivery. They are more likely to be Black, Indigenous, and People of Color (BIPOC)—racial/ethnic groups that are both persistently underrepresented in health care professions and more reflective of clients served through the Title X program.[41] We encourage HHS to recognize the critical role these health care professionals play in the Title X program.

Among the enhancements it proposes to the 2000 regulations through the NPRM, HHS also specifically highlights "telemedicine." The importance of telehealth, more broadly, has been growing in recent years and has become particularly clear in the context of the COVID-19 public health emergency. Since spring 2020, use of telehealth modalities has allowed tens – if not hundreds – of thousands of Title X users to remotely access many Title X services without placing themselves at increased risk for potential COVID-19 exposure.

We recommend use of the term "telehealth" rather than "telemedicine" in the NPRM, as "telehealth" refers to a broader scope of remote health care services than "telemedicine" and includes non-clinical services like counseling and education. Accordingly, in addition to its change from "physician" to "[health care] provider" in § 59.5(b)(1), HHS can further improve

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[39] C Fowler, J Gable, B Lasater, and K Asman, *Family Planning Annual Report: 2019 National Summary* (Washington, DC: Office of Population Affairs, 2020).

[40] *Id*.

[41] E Salsberg, C Richwine, and S Westergaard S, et al, "Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce," *JAMA Netw Open.* 2021;4(3):e213789. doi:10.1001/jamanetworkopen.2021.3789.

the Title X regulations by explicitly naming and defining "telehealth" to clarify that section as follows:

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

We also recommend adjusting the nondiscrimination language in section 59.5(a)(4) to make it more consistent with similar language in other statutes and regulations as follows:

> Provide services without ~~regard of~~ 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.

While the application of the nondiscrimination provisions found in section 1557 of the Affordable Care Act (discussed below) will address a number of these bases, we encourage HHS to make explicit in the Title X regulations that program beneficiaries will not face discrimination when seeking services.

The NPRM proposes making a "technical correction" to section 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. The previous administration, which finalized the faith-based organizations rule on December 17, 2020, explicitly declined to apply this rule to Title X. Furthermore, the faith-based organizations rule, insofar as it applies to HHS grant programs, only "applies to grants awarded in HHS social service programs." As Title X is a health service program, with grants made to entities "to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services," 45 CFR part 87 is not applicable, and should therefore not be included in the final Title X rule.

The Department should also take this opportunity to provide further clarification on the applicability of 45 CFR Part 92 (Nondiscrimination on the basis of race, color, national origin, sex, age, or disability in health programs or activities receiving federal financial assistance and programs or activities administered by the Department of Health and Human Services under Title I of the Patient Protection and Affordable Care Act or by entities established under such title) as well as the statute under which it was authorized, section 1557 of the Affordable Care Act. The scope of applicability of 45 CFR Part 92, under rules promulgated by the prior

administration, does not include the Department itself but does include many, if not most, Title X service sites that receive federal financial assistance (for example through accepting Medicaid payments.) The Department should make clear the scope of entities in the Title X sphere that are subject to Section 1557 and its implementing regulations. Further, should the Department make changes to 45 CFR Part 92 in the future such that Title X grantees are within the scope of that regulation, it should update Table 1 to Section 59.12 at that time.

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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. NCLR appreciates the opportunity to comment on the NPRM, "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services." If you require additional information about the issues raised in these comments, please contact NCLR's federal policy director Julie Gonen at jgonen@nclrights.org or 202-734-3547.

Sincerely,

National Center for Lesbian Rights
Bay Area Lawyers for Individual Freedom (BALIF)
Equality California
Equality Federation
Family Equality
GLBTQ Legal Advocates & Defenders (GLAD)
GLMA: Health Professionals Advancing LGBTQ Equality
Human Rights Campaign
interACT: Advocates for Intersex Youth
Lambda Legal
Movement Advancement Project
National Black Justice Coalition
National LGBTQ Task Force
SIECUS: Sex Ed for Social Change