Attorneys General of California, New York, Colorado, Connecticut, Delaware, the District of Columbia, Hawaii, Illinois, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, North Carolina, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, and Wisconsin

May 17, 2021

Via Federal eRulemaking Portal

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

RE: Comments on Proposed Rule, *Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services*, RIN 0937–AA11, 86 Fed. Reg. 19,812 (Apr. 15, 2021)

Dear Secretary Becerra:

We, the Attorneys General of California, New York, Colorado, Connecticut, Delaware, the District of Columbia, Hawaii, Illinois, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, North Carolina, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, and Wisconsin (the "States"),[1] write in support of the proposed rule, *Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services*, RIN 0937-AA11, 86 Fed. Reg. 19,812 (Apr. 15, 2021) (the "Proposed Rule") published by the U.S. Department of Health and Human Services ("HHS"). The Proposed Rule is a desperately needed action that will rectify many of the harms caused to the Title X program and our communities by the 2019 Rule, *Compliance With Statutory Program Integrity Requirements*, 84 Fed. Reg. 7,714 (Mar. 4, 2019) (the "2019 Rule" or the "Rule"). As HHS notes, the 2019 Rule has "undermined the public health of the population the program is meant to address." 86 Fed. Reg. at 19812. We agree and support HHS's effort to restore, with modifications, the Department's 2000 Title X regulations.

As State Attorneys General, we have a duty to protect our residents and to safeguard their health and safety. Prior to the 2019 Rule, Title X successfully provided our residents access to

[1] All signatories to this letter have been plaintiffs in various legal challenges to the 2019 Rule, on the grounds that the 2019 Rule was arbitrary, capricious, and contrary to law in violation of the Administrative Procedure Act, 5 U.S.C. § 706.

critical, life-saving healthcare for decades. HHS's implementation of the 2019 Rule harmed our states by, among other things, reducing the availability of family planning services and accessible reproductive healthcare in our communities. These harms have been compounded by the COVID-19 pandemic. Moreover, the 2019 Rule has caused significant harm to women and to populations that have faced difficulties accessing essential health care services, such as patients in rural areas, people of color, and lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals; doctors and other healthcare providers; and numerous entities in our states that receive federal healthcare funding.

It is crucial that HHS move quickly to reinstate the healthcare access previously provided by Title X for decades preceding the harmful 2019 Rule. We urge HHS to adopt the Proposed Rule, which will increase access to equitable, affordable, and accessible patient-centered, quality family planning services for all our residents.

I. THE 2019 RULE HAS RESULTED IN A DRAMATIC LOSS OF TITLE X PROVIDERS

The Title X program has been the linchpin of publicly funded family planning in the United States "for nearly 50 years without interruption." 86 Fed. Reg. at 19,817. The Title X program funds a wide array of critical public health services—including not only family planning counseling (which, before the 2019 Rule, included access to all 18 FDA-approved contraceptive methods), but also screenings for high blood pressure, anemia, diabetes, sexually transmitted diseases, and cervical and breast cancer. Title X providers have also assisted the States in protecting against public health threats, such as the Zika outbreak in 2015.

However, the 2019 Rule devastated the program, depriving our residents of access to many valued, qualified Title X providers. The Rule had a multitude of objectionable provisions, including the following:

- The Rule banned any Title X provider from making a referral of a pregnant patient for an abortion, even in response to the patient's direct request. 42 C.F.R. §§ 59.5(a)(5); 59.14(a) (2019).

- The Rule required that in response to a direct request for a referral, the provider may only provide a list of primary health care providers, which may or may not include providers who provide abortions. 42 C.F.R. § 59.14(b)(1)(ii)- (c)(2).

- The Rule allowed Title X grantees to give patients options counseling that discussed only prenatal care and adoption while entirely omitting any information about abortion, *see* 84 Fed. Reg. at 7714, 7724, 7733, 7744–46, and required that any counseling about abortion also include counseling about another pregnancy option—regardless of the patient's wishes, *id*. at 7747. *See* 42 C.F.R. § 59.14(e)(5).

- The Rule mandated "physical and financial separation" between a Title X program and a facility that engages in any "abortion activities," including abortion referrals, 84 Fed. Reg. at 7,715, 7,764; *see* 42 C.F.R. § 59.15, upending Title X providers' reliance in structuring their operations on HHS's longstanding view that Title X requires only financial (but not physical) separation.

The totality of these changes resulted in unprecedented provider withdrawals.[2] And new providers did not materialize to fill the deficit.[3] Before the Rule became effective, HHS funded 90 grantees supporting approximately 4,000 clinics nationwide, including specialized family planning clinics such as Planned Parenthood centers, federally qualified health centers, health departments, and school-based, faith-based, and other private nonprofit health programs.[4] Since the Rule took effect, statistics indicate that the Title X program has lost 1,272 clinics nationwide.[5] Most notably, *all* Planned Parenthood providers withdrew from the Title X program.[6] Overall, 41% of contraceptive clients previously served by Title X–funded providers were served at Planned Parenthood health centers.[7] In 2018 in New York, Planned Parenthood providers served 52% of all patients supported through the New York State Family Planning Program.[8] The extent to which the loss of Planned Parenthood providers impacted the Title X program varied from state to state, but in Connecticut, Utah, Washington, and Wisconsin, Planned Parenthood served at least 75% of contraceptive clients served at Title X–funded centers.[9]

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[2] *HHS Issues Supplemental Grant Awards to Title X Recipients*, U.S. Dep't of Health and Hum. Servs. (Sept. 30, 2019), https://www hhs.gov/about/news/2019/09/30/hhs-issues-supplemental-grant-awards-to-title-x-recipients html; Kaiser Family Found., *The Status of Participation in the Title X Federal Family Planning Program*, (Dec. 20, 2019), https://www.kff.org/interactive/the-status-of-participation-in-the-title-x-federal-family-planning-program/.

[3] Brittini Frederiksen *et al.*, Kaiser Family Found., *Key Elements of the Biden Administration's Proposed Title X Regulation* (May 5, 2021), https://www.kff.org/womens-health-policy/issue-brief/key-elements-of-the-biden-administrations-proposed-title-x-regulation/; Brittini Frederiksen *et al.*, Kaiser Family Found., *Data Note: Is the Supplemental Title X Funding Awarded by HHS Filling in the Gaps in the Program?* (Oct. 18, 2019), https://www.kff.org/womens-health-policy/issue-brief/data-note-is-the-supplemental-title-x-funding-awarded-by-hhs-filling-in-the-gaps-in-the-program/.

[4] Brittini Frederiksen *et al.*, Kaiser Family Found., *Data Note: Impact of New Title X Regulations on Network Participation* (Sept. 20, 2019), https://www kff.org/womens-health-policy/issue-brief/data-note-impact-of-new-title-x-regulations-on-network-participation; Frederiksen *et al.*, *Data Note: Is the Supplemental Title X Funding Awarded by HHS Filling in the Gaps in the Program?, supra* n. 3; U.S. Dep't of Health & Human Servs., Office of Population Affairs, *Title X Family Planning Annual Report: 2018 National Summary,* at 1 (Aug. 2019), https://opa.hhs.gov/sites/default/files/2020-07/title-x-fpar-2018-national-summary.pdf.

[5] *See* Frederiksen *et al.*, *Data Note: Impact of New Title X Regulations on Network Participation*, *supra* n. 4; Frederiksen *et al.*, *Key Elements of the Biden Administration's Proposed Title X Regulation*, *supra* n. 3.

[6] *See* Frederiksen *et al.*, *Data Note: Impact of New Title X Regulations on Network Participation*, *supra* n. 4; Frederiksen *et al.*, *Key Elements of the Biden Administration's Proposed Title X Regulation*, *supra* n. 3.

[7] Jennifer J. Frost *et al.*, Guttmacher Inst., *Publicly Funded Contraceptive Services at U.S. Clinics 2015*(Apr. 2017), https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015; Rachel Benson Gold & Lauren Cross, Guttmacher Inst., *The Title X Gag Rule is Wreaking Havoc – Just at Trump Intended* (Aug. 29, 2019), https://www.guttmacher.org/article/2019/08/title-x-gag-rule-wreaking-havoc-just-trump-intended.

[8] The New York State Family Planning Program is a funding program for family planning clinics through-out the state and was historically supported in significant part (20% of the total budget) with Title X funds.

[9] Benson Gold & Cross, *The Title X Gag Rule is Wreaking Havoc – Just at Trump Intended,* supra n. 7.

Due to this loss of providers, the number of clients served by the program dropped by 60% from 2018 to 2020.[10] The Title X network's capacity to serve female patients seeking contraceptive care is estimated to have been reduced by at least 46 percent, affecting approximately 1.6 million patients.[11]

Grantees who have withdrawn from the program have explained that the 2019 rule gave them "no option but to withdraw from the Title X program."[12] A New York grantee withdrew from Title X because compliance with the 2019 rule would prohibit it from providing patients full information about family planning options and referring patients to abortion service, and thus force it to render "inadequate and incomplete health care."[13] A Colorado provider concluded that the rule "undermin[ed] trust in the doctor-patient relationship" and that remaining in the Title X program would "compromise[] our commitment to our patients [and] our community."[14] And in Massachusetts, two out of the state's three grantees, including the state Department of Public Health, withdrew from the Title X program because they determined that they could not comply with the provisions of the 2019 Rule.

As HHS now recognizes, the withdrawal of Title X grantees has been substantial across the country. *See* 86 Fed. Reg. at 19,815. There are currently six states without any Title X-funded services: Hawaii, Maine, Oregon, Utah, Vermont, and Washington.[15] In an additional eight states—Alaska, Connecticut, Illinois, Massachusetts, Maryland, Minnesota, New York, and New Hampshire—grantees representing more than half of the Title X clinics left the Title X program.[16]

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[10] Frederiksen *et al.*, *Key Elements of the Biden Administration's Proposed Title X Regulation*, *supra* n. 3 ("The number of clients served by the program dropped from 3,939,749 clients in 2018 to 3,095,666 clients in 2019 (a 21% decrease), and then further decreased to 1,536,744 clients in 2020 which is a 60% decrease in clients served from 2018.").

[11] Mia Zolna *et al.*, Guttmacher Inst., *Estimating the impact of changes in the Title X network on patient capacity*, at 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.

[12] Sarah McCammon, *Planned Parenthood Withdraws From Title X Program Over Trump Abortion Rule*, NPR (Aug. 19, 2020), https://www.npr.org/2019/08/19/752438119/planned-parenthood-out-of-title-x-over-trump-rule; Planned Parenthood Fed'n of Am., *Trump Administration Gag Rule Forces Planned Parenthood Out Of Title X National Program For Birth Control* (Aug. 19, 2019), https://www.plannedparenthood.org/about-us/newsroom/press-releases/trump-administration-gag-rule-forces-planned-parenthood-out-of-title-x-national-program-for-birth-control-2.

[13] Pub. Health Sols., *Statement From PHS President & CEO Lisa M. David Rejecting Title X Funding* (Aug. 2, 2019), https://www healthsolutions.org/blog/statement-from-phs-president-ceo-lisa-m-david-rejecting-title-x-funding/.

[14] Boulder Valley Women's Health Ctr., *Women's Health Will Not Be Gagged* (2019), https://web.archive.org/web/20200925141536/https://www.boulderwomenshealth.org/blog/womens-health-will-not-be-gagged (2019).

[15] Frederiksen *et al.*, *Key Elements of the Biden Administration's Proposed Title X Regulation*, *supra* n. 3

[16] *Id*.

II. THE TITLE X PROVIDERS THE STATES LOST DELIVERED CRITICAL CARE TO UNDERSERVED COMMUNITIES

Under the pre-2019 Title X program, a robust and diverse group of providers and clinics delivered vital and unique services to millions of patients throughout the nation—particularly those from underserved communities. The Proposed Rule promises to restore access to these essential services.

A. Title X Plays a Central Role in Serving Disadvantaged Communities

Title X providers have particular expertise meeting the needs of diverse patient groups, including persons with disabilities and LGBTQ patients. Data shows that Title X providers spend more time on patients' initial visits for contraceptive care than clinicians at non-Title X clinics, particularly with patients who are younger, have limited English proficiency, or have other specific medical or personal needs.[17] Losing these providers made it harder for patients to obtain culturally competent care.

Low-income individuals and people of color have long relied on Title X programs for no-cost or low-cost family planning services, and were the most impacted by the reduced access to care. *See* 86 Fed. Reg. at 19,815 ("Low-income, uninsured, and racial and ethnic minorities' access to Title X family planning services has decreased, thereby contributing to the increase in health inequities and unmet health needs within these populations."). Hundreds of thousands of low-income individuals lost access to Title X clinics in 2019. *Id.* And studies show that patients who lose access to contraceptive services at a clinic of choice are often forced to switch to a less effective form of contraception.[18]

Residents of rural communities have also been heavily impacted by the loss of services resulting from the 2019 Rule. Title X family planning clinics were especially critical in rural areas, where reproductive health access is often limited by healthcare provider shortages, lack of transportation, and other factors.[19] Indeed, in rural California counties, a Title X clinic was often

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[17] Jennifer J. Frost *et al.*, Guttmacher Inst., *Variation in Service Delivery Practices Among Clinics Providing Publicly Funded Family Planning Services in 2010*, at 15 (2012), https://www.guttmacher.org/sites/default/files/report_pdf/clinic-survey-2010.pdf.

[18] Adam Sonfield, *Why Family Planning Policy and Practice Must Guarantee a True Choice of Contraceptive Methods*, 20 Guttmacher Pol'y Rev. 103 (2017), https://www.guttmacher.org/gpr/2017/11/why-family-planning-policy-and-practice-must-guarantee-true-choice-contraceptive-methods; Kristine Hopkins *et al.*, *Women's Experiences Seeking Publicly Funded Family Planning Services in Texas*, 47 Perspectives on Sexual & Reprod. Health 63-70 (June 2015), https://www.guttmacher.org/journals/psrh/2015/02/womens-experiences-seeking-publicly-funded-family-planning-services-texas; Guttmacher Inst., *A Real-Time Look at the Impact of the Recession on Women's Family Planning and Pregnancy Decisions* (Sept. 2009), https://www.guttmacher.org/sites/default/files/report_pdf/recessionfp_1.pdf; M. Antonia Biggs *et al.*, Bixby Ctr. for Global Reprod. Health, *Findings from the 2012 Family PACT Client Exit Interviews* (2014), https://bixbycenter.ucsf.edu/sites/bixbycenter.ucsf.edu/files/3.%20CEI%20Report_ADA.pdf.

[19] Am. Coll. of Obstetricians & Gynecologists *Health Disparities in Rural Women* (Feb. 2014, reaffirmed in 2016), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2014/02/health-disparities-in-rural-women ("Rural women experience poorer health outcomes and have less access to health care than urban women . . . . Health care professionals should be aware of this issue and advocate for reducing health disparities in rural women.")

the only provider offering a full range of contraceptive methods.[20] In Colorado, there are 20 rural counties that have few to no healthcare providers offering contraceptive services. Similarly, in Nevada, many rural parts of the states are reliant on Title X funded care and have little other access to a healthcare provider at all.

The harms from the 2019 Rule are severe and measurable. The Centers for Disease Control and Prevention reported that in 2019, annual cases of sexually transmitted diseases reached record highs, and preliminary 2020 data suggest that many of these concerning trends continued in 2020.[21] Colorado, for example, experienced a measurable increase in HIV cases.

There have been other considerable state-specific harms:

- In California, the State's primary Title X grantee saw a 37 percent decrease in clients from 2018 to 2019. And that percentage only increased in 2020, with an 81 percent decrease in clients served as compared to 2018.[22]

- In Colorado, there has been a decrease in long-acting reversible contraceptive use, and a decrease in the number of clients screened for chlamydia.[23] Colorado has also seen a 37% decrease in the total number of Title X clients served.

- The District of Columbia—due to provider loss—has served 12,238 fewer patients and removed pregnancy testing and counseling from its Title X scope of services.

- Michigan has experienced a 65 percent decrease in number of Title X clients seen.[24]

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[20] Title X clinics are more likely than non-Title X family planning clinics to provide a full range of FDA-approved contraceptive methods: 72% of Title X providers offer the full range, compared with 49% of non-Title X clinics. Mia R. Zolna & Jennifer J. Frost, Guttmacher Inst., *Publicly Funded Family Planning Clinics in 2015: Patterns and Trends in Service Delivery Practices and Protocols,* at 35 (2016), http://www.guttmacher.org/report/publicly-funded-family-planning-clinic-survey-2015.

[21] Ctrs. for Disease Control & Prevention, *Reported STDs Reach All-time High for 6th Consecutive Year* (Apr. 13, 2021), https://www.cdc.gov/media/releases/2021/p0413-stds html.

[22] 2020 program data from California's primary Title X grantee—Essential Access Health, Inc.—shows the devastating results of the 2019 rules. In 2018, California's Title X program saw 974,331 clients. In 2019, California's Title X program saw 611,642 Title X clients, a 37% drop. In 2020, California's Title X program only saw 186,288 clients, an 81% drop from 2018. Of these clients, a comparison of 2018 to 2020 shows that 568,202 fewer Title X clients under 100 percent of the federal poverty level were seen, 106,973 fewer Title X clients between 151 percent and 200 percent federal poverty level, and 31,541 fewer Title X clients between 201 percent to 250 percent of the federal poverty level were seen.

[23] Colorado has noted a decrease in long-acting reversible contraceptives (LARC) method use. The rate of LARC (most effective contraceptive methods) usage in 2019 was 39.4% and decreased in 2020 to 38.8%. Following implementation of the 2019 rule, the number of clients screened for Chlamydia decreased by 19 percentage points.

[24] In 2018, when Planned Parenthood was a Title X provider for a full year, Michigan's Title X program served 62,707 clients. In 2020, when Planned Parenthood was not a Title X provider for the full year, the program served 14,680.

- In Pennsylvania, due to the loss of Title X subrecipients and providers, at least three counties were left without any Title X providers and some participating grantees experienced significant reductions in total patients served.

Crucially, due to the COVID-19 pandemic, more people than ever need Title X's low-cost services. Many of our residents lost income and insurance coverage during the pandemic.[25] Others have sought to postpone pregnancy for a variety of reasons, including health concerns and financial instability due to unemployment.[26] Many people felt increased worry about their ability to pay for and obtain contraception.[27] But the 2019 Rule resulted in fewer clinics in our states and around the country, at a time when more clinics and more funding are needed to meet our residents' healthcare needs. Reduced access to reproductive health services harms our residents and our public health systems, and results in attendant fiscal harms to our states.

B. The States' Have A Significant Interest In Restoring The Expansive Title X Network in Place Prior to the 2019 Rule

In addition to the 2019 Rule's devastating impact on our communities because of the loss of access to vital Title X services, States have been forced to expend extra funds to keep clinics open. Several States have made state or local funding available to replace some of the federal funds,[28] but many of these supplemental funds are one-time grants or rely on other finite sources of support that have been or will be exhausted. For instance:

- California provided $348,488 in one-time grants to two health facilities and their affiliates.[29]

- New York made emergency appropriations to cover the loss of Title X funds from fall 2019 to through March 2020, and thereafter established annual appropriations

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[25] Taylor Riley *et al.*, Guttmacher Inst., *Estimates of the Potential Impact of the COVID-19 Pandemic on Sexual and Reproductive Health in Low- and Middle-Income Countries*, (Apr. 16, 2020), https://www.guttmacher.org/journals/ipsrh/2020/04/estimates-potential-impact-covid-19-pandemic-sexual-and-reproductive-health#. The Guttmacher Institute estimates that reduced access to reproductive care as a result of COVID-19 disruptions will result in a decline in contraception usage and a concomitant increase in unintended pregnancies.

[26] Alan Yuhas, *Don't Expect a Quarantine Baby Boom*, N.Y. Times (Apr. 8, 2020), https://www nytimes.com/2020/04/08/us/coronavirus-baby-boom.html.

[27] Laura Lindberg *et al.*, Guttmacher Inst., *Early Impacts of the COVID-19 Pandemic: Findings from the 2020 Guttmacher Survey of Reproductive Health Experiences* (June 2020), https://www.guttmacher.org/report/early-impacts-covid-19-pandemic-findings-2020-guttmacher-survey-reproductive-health.

[28] Frederiksen *et al.*, *Data Note: Impact of New Title X Regulations on Network Participation, supra* n. 4.

[29] California State Treasurer, *Treasurer Fiona Ma Encourages Health Facilities to Apply for Lifeline Grants Before Time Runs Out* (Oct. 2019), https://www.treasurer.ca.gov/newsletter/2019/oct/lifeline-grants html. California also passed legislation specifically intended to increase funding and investment in reproductive healthcare to respond to the previous federal administration's restrictions on "reproductive freedom." Office of Governor Gavin Newsom, *Governor Gavin Newsom Signs Reproductive Freedom Legislation, Including Bill to Expand Access to Care on College Campuses* (Oct. 11, 2019), https://www.gov.ca.gov/2019/10/11/governor-gavin-newsom-signs-reproductive-freedom-legislation-including-bill-to-expand-access-to-care-on-college-campuses/.

to offset the loss of Title X funds. A total of $14.2 million in state funding was allocated for this purpose in fiscal year 2021.

- Colorado spent $200,000 in 2020 to fill the Title X loss and will spend $198,583 this year.

- Hawaii made a one-time appropriation of $750,000 in state funds to offset the absence of Title X funds in state fiscal year 2020.[30] However, additional funding was not appropriated for state fiscal year 2021. As a result, there was a 100% reduction of the Hawaii State Department of Health's Title X funded staff.

- Illinois was able to fill the financial gap to support the loss of $3.7 million in federal funds.

- Maine's clinics remain open but are reliant on state and private funds, instead of Title X federal funds.

- Michigan allocated approximately $1.6 million funds to make up the loss of Title X funds.

- Massachusetts made an emergency appropriation of $8 million in state funds to fully replace lost Title X funds.[31]

- New Jersey made a fiscal year appropriation of $9.5 million to the New Jersey Department of Health for family planning services to make up for the loss of Title X funds in fiscal year 2020, increasing the State's family planning services expenditures from $7.453 million to $19.953 million.[32] The family planning line item has continued to factor into the state budget, which is $19.529 million in fiscal year 2021 and in the proposed fiscal year 2022 budget.[33]

- Oregon supported its reproductive health program and clinics with $3.1 million in state funds to make up for lost Title X funds.

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[30] Act 113, 2019 Haw. Sess. Laws 425.

[31] An Act Making Appropriations for the Fiscal Year 2019 to Provide for Supplementing Certain Existing Appropriations and for Certain Other Activities and Projects, 2019 Mass. Acts Chapter 6, https://malegislature.gov/Laws/SessionLaws/Acts/2019/Chapter6.

[32] Governor Phil Murphy, State of New Jersey, *Governor Murphy Signs Legislation Appropriating $9.5 Million for Family Planning Services* (Jan. 1, 2020), https://www nj.gov/governor/news/news/562019/approved/20200102a.shtml.

[33] State of New Jersey, The Governor's FY2022 Budget Budget in Brief, 34 (Feb. 2021), https://www.state.nj.us/treasury/omb/publications/22bib/BIB.pdf.

- Vermont has dedicated around $1.6 million for two fiscal years to fill the gap in funds.[34]

- Washington also provided general state funds to offset the loss of Title X funds, which have been allocated as temporary funding measures.

This state spending has strained state budgets, and leaves family planning programs uncertain of their abilities to continue providing care.

III. THE PROPOSED RULE MAKES CRITICAL IMPROVEMENTS TO THE TITLE X PROGRAM

The States commend HHS's decision to readopt the 2000 Title X regulations as well as the proposed revisions aimed at ensuring access to equitable, affordable, client-centered, quality family planning services. *See* 86 Fed. Reg. at 19,817. By readopting the project requirements of the 2000 regulations and eliminating the objectionable provisions of the 2019 Rule, the Proposed Rule will rebuild trust between patients and their physicians, and allow physicians to carry out their ethical obligations to their patients.[35] It will bring the program back into alignment with the Centers for Disease Control and Prevention's Quality Family Planning Guidelines.[36] And by removing the physical separation requirement, it will permit former Title X grantees who had structured their clinics and operations to comply with the prior requirement of financial separation to rapidly reenter the program, quickly increasing client access to care. As explained below, the proposed revisions to the 2000 regulations will further improve patient outcomes and ensure the provision of client-centered, quality family planning services.

A. The Title X Program Health Equity Focus Will Improve Client Outcomes

The States support the Proposed Rule's focus on advancing health equity, specifically its commitment to reducing barriers to care and health disparities among underserved communities.

As the Proposed Rule recognizes, rates of adverse reproductive health outcomes are higher among low-income and women of color. 86 Fed. Reg. at 19,817.[37] The States support a Title X

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[34] Vermont Dep't of Health, *State Opts Out Of Title X Funding That Would Limit Family Planning Services: State will use its own funds to ensure Vermonters can access full services* (Aug. 19, 2019), https://www.healthvermont.gov/sites/default/files/documents/pdf/Title%20X%20news%20release%208-19-2019.pdf.

[35] Am. Med. Ass'n, Opinion 2.1.3-Withholding Information from Patients, Code of Medical Ethics, Current Opinions (2017), https://policysearch.ama-assn.org/policyfinder/detail/1.1.1%20Patient-Physician%20Relationships?uri=%2FAMADoc%2FEthics.xml-E-1.1.1.xml ("Truthful and open communication between physician and patient is essential for trust in the relationship and for respect for autonomy. Withholding pertinent medical information from patients . . . creates a conflict between the physician's obligations to promote patient welfare and to respect patient autonomy.")

[36] Ctrs. for Disease Control & Prevention, Providing Quality Family Planning Services, Recommendations of CDC and the U.S. Office of Population Affairs, at 14 (Apr. 25, 2014), https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf.

[37] Gwendolyn Puryear Keita, *Improving the Health of Low Income Populations,* 45 Am. Psychological Ass'n (2014), https://www.apa.org/monitor/2014/03/itpi. ("[L]ow socioeconomic status is linked to such negative health outcomes as low birth weight, diabetes, depression, life expectancy, heart attacks and lower self-rated health."); Am. Coll. of Obstetricians and Gynecologists, Comm. on Health Care for Underserved Women, *Committee Opinion No.*

program that addresses longstanding health disparities and prioritizes health equity—a program that "striv[es] for the highest possible standard of health for all people and giv[es] special attention to the needs of those at greatest risk of poor health, based on social conditions."[38] Studies show that applying systems to enhance health equity can reduce State health care expenditures, reduce lost productivity from illness-related employee absenteeism, and improve patient outcomes.[39]

Many Title X providers already endeavor to enhance health equity through their programs. These Title X-funded clinics tend to have greater proportions of bilingual staff and are more likely to provide outreach to vulnerable or hard-to-reach populations, such as adolescents, LGBTQ individuals, persons experiencing homelessness, individuals with limited English proficiency, migrant workers, individuals coping with alcohol and substance abuse, refugees and immigrants, and persons with disabilities.[40]

Title X providers have historically played an essential and important role in connecting low-income individuals to other vital health services, including health insurance enrollment—which improves health outcomes across the board. For example, Title X clinics, especially in rural locations, provided health insurance enrollment education and on-site enrollment assistance.[41] A survey of Title X clinics in 2016 showed that Title X clinics were the only source of medical care for 60% of their patients.[42] The confidentiality, low cost, and high quality of care that Title X clinics provide encourage many individuals to visit Title X clinics when they would otherwise refuse to visit a medical provider.[43]

Increasing access to contraception also permits women to achieve greater economic stability—by deciding whether to become pregnant and to better time and space their pregnancies—which in turn reduces the burden on the States' social safety-net resources.

615: Access to Contraception (Jan. 2015; reaffirmed 2017), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2015/01/access-to-contraception.

[38] Paula Braveman, *What Are Health Disparities and Health Equity? We Need to Be Clear*, Public Health Rep. (Jan.-Feb. 2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863701/.

[39] Priya Bathija & Duane Reynolds, Am. Hospital Ass'n, *How Health Equity Impacts Outcomes* (Dec. 11, 2019), https://www.aha.org/news/blog/2019-12-11-how-health-equity-impacts-outcomes.

[40] Claire Brindis *et al.*, Bixby Ctr. for Global Reprod. Health, *The Impact of Title X on Publicly Funded Family Planning Services in California: Access and Quality* 6 (2014), https://bixbycenter.ucsf.edu/sites/bixbycenter.ucsf.edu/files/OPAreportRev_April2014.pdf; Heike Thiel de Bocanegra *et al.*, *Enhancing Service Delivery Through Title X Funding: Findings from California*, 44 Persp. on Sexual & Reprod. Health 262, 265 (2012), https://onlinelibrary.wiley.com/doi/10.1363/4426212.

[41] *See* Comment on 2019 Rule by Dr. Claire Brindis, HHS-OS-2018-0008-204364, https://www.regulations.gov/comment/HHS-OS-2018-0008-204364 (citing Jennifer Yarger *et al.*, *The Role of Publicly Funded Family Planning Sites in Health Insurance Enrollment*, Perspectives in Sexual and Reprod. Health. (June 2, 2017), https://www.guttmacher.org/journals/psrh/2017/04/role-publicly-funded-family-planning-sites-health-insurance-enrollment).

[42] Megan L. Kavanaugh *et al.*, *Use of Health Insurance Among Clients Seeking Contraceptive Services at Title X-Funded Facilities in 2016*, 50 Persp. on Sexual and Reprod. Health 101, 105 (2018), https://onlinelibrary.wiley.com/doi/full/10.1363/psrh.12061.

[43] *Id.* at 106.

Women's ability to use oral contraceptives is correlated with their ability to obtain higher levels of education, participate more fully in the workforce, and receive more pay—a combination that has helped reduce the gender pay gap.[44] Women who are able to time and space their pregnancies are able to focus on accomplishing their educational and professional goals. Title X clinics therefore support women's economic stability and advancement. A recent study shows that access to contraception from a Title X clinic results in a statistically significant increase in high school graduation rates.[45] Failure to graduate from high school sets individuals on a path of reduced lifetime educational attainment that has become increasingly associated with poor life outcomes, driving inequalities in lifetime earnings.[46] Title X clinics therefore support women's economic stability and advancement.[47]

Further, in seeking to advance health equity, the Title X program will better fulfill both federal and state anti-discrimination laws and policies that apply to healthcare settings overseen by HHS, including, *inter alia*, Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116 (prohibiting discrimination by covered health programs and activities against any individual based on race, color, national origin, sex, age, or disability), Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d (prohibiting discrimination based on race, color, and national origin in federally assisted programs); Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 701 *et seq*. (prohibiting discrimination based on disability, including medical conditions that limit major life activity); and the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. § 12101 *et seq.* (same).

B. Increased Availability of Telemedicine Will Benefit Patients

The States also support the Proposed Rule's revision to encourage use of telemedicine for family planning services. *See* 86 Fed. Red. at 19,818. Telemedicine is an important mechanism for delivering patient-centered healthcare outside the time and location restrictions of a face-to-face medical encounter.[48] Greater access to telemedicine will assist in overcoming barriers to obtaining health care, such as competing demands like employment or caregiving.[49] For example, the California Department of Health Care Services has determined "providing health care services through various telehealth modalities can help provide beneficiaries, especially those residing in rural and underserved areas of the State, with increased access to critically

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[44] Martha J. Bailey & Jason M. Lindo, Nat'l Bureau of Econ. Research, *Access and Use of Contraception and Its Effects on Women's Outcomes in the U.S.: NBER Working Paper 23465* (2017), https://www nber.org/system/files/working_papers/w23465/w23465.pdf; Adam Sonfield *et al.*, Guttmacher Inst., *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children*, at 7-17 (2013), https://www.guttmacher.org/sites/default/files/report_pdf/social-economic-benefits.pdf.

[45] Amanda Stevenson *et al.*, *The Impact of Contraceptive Access on High School Graduation*, 7 Science Advances, (May 5, 2021), https://advances.sciencemag.org/content/7/19/eabf6732.

[46] *Id*.

[47] Urban Inst., *'Birth Control is Transformative': Women Share Their Experiences with Contraceptive Access* (2019), https://www.urban.org/sites/default/files/publication/99912/birth_control_is_transformative_1.pdf.

[48] Karen M. Goldstein *et al.*, *Telehealth Interventions Designed for Women: an Evidence Map*, Journal of General Internal Med. (Dec. 2018), https://www.ncbi nlm nih.gov/pmc/articles/PMC6258612/.

[49] *Id*.

needed subspecialties, and could improve access to culturally appropriate care, such as allowing care with a provider whose language, race, or culture are the same as that of the beneficiary."[50]

The increase in access to telemedicine during the COVID-19 pandemic has improved health outcomes for many communities. Telehealth accommodates individuals who need timely medical care but are self-isolating or subject to quarantine, or who are following stay-at-home orders.[51] Travel is a burden, even in ordinary times, and telehealth permits patients, especially low-income patients, to avoid the strain of public transportation, ride-sharing, or a borrowed car. *See June Med. Servs. LLC v. Russo*, 140 S. Ct. 2103, 2130 (2020) (plurality op.).

The States urge HHS, as part of its investment in health equity, to ensure that access to telemedicine and Title X programs remains robust in rural areas, particularly in areas where access to broadband internet is limited. Studies have shown that low-income patients are more likely to be reliant on telephonic doctor visits, especially as "lot of people can't afford internet, and they don't have access to a data plan [for video visits]."[52]

C. The Proposed Rule Will Emphasize Patient-Centered Care

The States support the Proposed Rule's revision of the Title X rules to increase patient-centered care and choice for patients. 86 Fed. Reg. at 19,819.

The 2019 rule put a thumb on the scale to prioritize executive branch policy preferences instead of the care sought by the client. It required physicians to limit referrals, "gagged" a provider from full options counseling for a pregnant client, and provided pregnant clients with mandated prenatal referrals, even if the client expressed an intention to terminate the pregnancy.

The Proposed Rule takes important steps to refocus the Title X program on the needs of the client. The American College of Obstetricians and Gynecologists recommends that a "pregnant woman who may be ambivalent about her pregnancy should be fully informed in a balanced manner about all options, including raising the child herself, placing the child for adoption, and abortion …. There is an ethical obligation to provide accurate information that is required for the patient to make a fully informed decision."[53] Similarly, the American Medical Association states in its Code of Medical Ethics that providers "present relevant information accurately and sensitively, in keeping with the patient's preferences" and that "withholding information without the patient's knowledge or consent is ethically unacceptable."[54]

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[50] Cal. Dep't of Health Care Servs., *Medi-Cal & Telehealth* (March 23, 2021), https://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx.

[51] Vivek Chauhan *et al.*, *Novel Coronavirus (COVID-19): Leveraging Telemedicine to Optimize Care While Minimizing Exposures and Viral Transmission*, 13 J. of Emergencies, Trauma, and Shock (Mar. 19, 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7161346/.

[52] Christopher Perrone, Cal. Health Care Found., *Ending Phone Visits Would Be a Setback for Patients with Low Income*s (Apr. 30, 2021), https://www.chcf.org/blog/ending-phone-visits-setback-patients-low-incomes/.

[53] Am. Coll. of Obstetricians and Gynecologists, *Abortion Policy* (Nov. 2020), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/abortion-policy.

[54] Am. Med. Ass'n, *supra* n. 35.

In healthcare, information can "save lives," permit "alleviation of physical pain," and enable people to act in "their own best interest." *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 566 (2011); *Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council, Inc.*, 425 U.S. 748, 764, 770 (1976). Such medical information allows patients to take control of their most "intimate and personal choices . . . central to personal dignity and autonomy." *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992) (plurality op.).

Further, emphasizing patient-centered care would rebuild trust in the Title X program. Effective healthcare requires building trust to ensure a patient is comfortable sharing their concerns with the provider, especially if the patient faces challenges like linguistic barriers, behavioral health issues, substance use, and trauma. If a patient feels judged, maligned, or mislead, it would unravel the patient-provider relationship, undermining the provider's effectiveness.

Finally, a crucial aspect of patient-centered care is ensuring reasonable, barrier-free access.[55] The Proposed Rule would reduce such barriers by requiring "when feasible, that the referral provided does not unduly limit client access to services, such as excessive distance or travel time to the referral location or referral to services that are cost-prohibitive for the client." 86 Fed. Reg. at 19,819. To effectively re-adopt and enhance the 2000 rules, HHS's final rule must be clear that all Title X-funded clinics are required to offer a broad range of acceptable and effective, medically approved family planning methods and services, and adopt the proposal that sites that do not offer the broad range of methods provide a referral to a provider who does offer the patient's method of choice. *Id*. This is necessary to ensure that patients will be able to receive the full reproductive health services they desire, as Congress intended.

IV. CONCLUSION

The Attorneys General of California, New York, Colorado, Connecticut, Delaware, the District of Columbia, Hawaii, Illinois, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, North Carolina, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, and Wisconsin applaud HHS's efforts to undo the 2019 Rule and its concurrent public health harms without further delay. The Proposed Rule, which will largely restore HHS's prior Title X regulations, will expand access to the critical family planning services, reproductive care, and other health care services offered by Title X programs. The Proposed Rule, if adopted, will yield significant benefits to the States and their residents. The States endorse the increased focus on health equity and client-centered care at the heart of the Proposed Rule. The States commend HHS for its thoughtful Proposed Rule and urge it to adopt it expeditiously.

[55] In proposing the 2000 regulations, HHS stated that, under 42 U.S.C. 300a– 7(d), "grantees may not require individual employees who have such [conscience] objections to provide such [abortion] counseling." 65 Fed. Reg. 41,270, 41,274 (July 3, 2000). HHS further clarified that "in such cases the grantees must make other arrangements to ensure that the service is available to Title X clients who desire it." *Id.* The States recommend that HHS limit inclusion of language discussing the effect of the federal refusal laws on objecting grantees and individuals, see 86 Fed. Reg. at 19,817-18, as the Rule cannot and does not propose to alter those laws, and the language used may create confusion regarding how those laws impact grantees and individual employees in the context of options counseling in Title X programs.

Sincerely,

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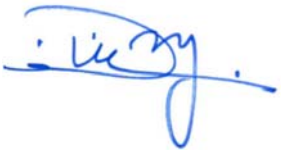

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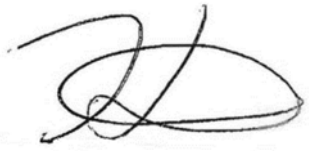

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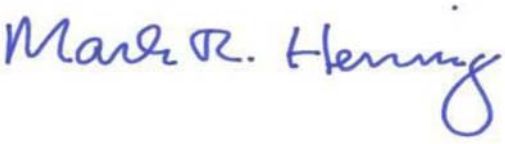

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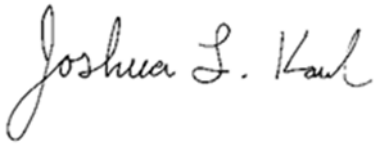

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