



Advancing Reproductive Rights and Health in a **New Administration**



Advancing Reproductive Rights and Health in a New Administration: **Steps for Improvement and Change**

The next President will have the opportunity to advance a reproductive health agenda that will make a profound difference in the lives and health of women, men, and families in the United States and around the world. Greater investments in reproductive health care will improve women's health, reduce the incidence of disease, and promote healthy childbearing. Moreover, ensuring access to reproductive health services is essential to women's full and equal participation in society.

For too long, our nation's reproductive health policies have failed to address adequately the health care needs of women and their families. Skyrocketing costs and ideologically- driven government restrictions have put reproductive health services out of reach for millions of women. Here at home, this failure has led to persistent health disparities, including those based on income, race, ethnicity, gender, primary language, sexual orientation, immigration status, and disability, that are unacceptable in a country with the wealth and resources of the United States. The impact abroad has had similarly deleterious effects, with a growing unmet need for contraception, a rise in maternal mortality, and the increasing spread of HIV/AIDS, particularly among women.

We urge the next President to articulate and implement a vision for a new, commonsense approach to the nation's and the world's pressing reproductive health needs, and to take concrete steps to:

- ✓ **Prioritize prevention;**
- ✓ **Improve access to abortion care;**
- ✓ **Support healthy pregnancies;**
- ✓ **Guarantee access to comprehensive, quality, affordable health care for all;**
- ✓ **Reclaim America's global leadership on reproductive health;**
- ✓ **Restore integrity to the government's public health decision-making processes;**
- ✓ **Invest in research and initiatives to improve women's health; and**
- ✓ **Appoint judges and executive officials who are highly qualified and committed to individual rights and justice.**

The undersigned coalition of medical, public health, research, religious and religiously-affiliated, women's health, legal, and other advocacy organizations calls on the next President to advance and implement the agenda outlined below and begin to put the United States back on a path that honors, respects, and protects the health and rights of women and their families both in the United States and abroad.

Abortion Care Network
Advocates for Youth
African American Women Evolving, Inc.
American Association of University Women (AAUW)
American Civil Liberties Union

American College of Obstetricians and Gynecologists
American Jewish World Service
American Medical Student Association
American Social Health Association
Association of Reproductive Health Professionals
Black Women's Health Imperative
Catholics for Choice
Center for American Progress Action Fund
Center for Genetics and Society
Center for Health and Gender Equity
Center for Inquiry
Center for Reproductive Rights
Choice USA
Feminist Majority
Generations Ahead
Guttmacher Institute
Healthy Teen Network
International Planned Parenthood Federation, Western Hemisphere Region
International Women's Health Coalition
Ipas
Jewish Women International
Law Students for Reproductive Justice
Legal Momentum
Moving Forward Initiative
NARAL Pro-Choice America
National Abortion Federation
National Asian Pacific American Women's Forum
National Coalition of STD Directors (NCSD)
National Council of Jewish Women
National Family Planning & Reproductive Health Association
National Health Law Program (NHeLP)
National Institute for Reproductive Health
National Latina Institute for Reproductive Health
National Network of Abortion Funds
National Organization for Women
National Partnership for Women & Families
National Women's Law Center
National Women's Health Network
New Mexico Center on Law and Poverty
Northwest Women's Law Center
Pathfinder International
Physicians for Reproductive Choice and Health
Planned Parenthood Federation of America

Population Action International
Population Connection
Raising Women's Voices for the Health Care We Need
Rebecca Project for Human Rights
Religious Coalition for Reproductive Choice
Reproductive Health Technologies Project
Secular Coalition for America
Sexuality Information and Education Council of the United States (SIECUS)
Sierra Club
SisterSong
The MergerWatch Project
Union for Reform Judaism
Unitarian Universalist Association of Congregations
Women of Reform Judaism
Women Thrive Worldwide



Steps for the First **100 Days**



Steps for the First 100 Days

★ Indicates a Priority for the First 100 Days

Prioritize Prevention

- ★ Increase Funding for the Title X Family Planning Program to \$700 million. _____ 6
- ★ Expand Coverage of Medicaid-Funded Family Planning Services. _____ 6
- ★ Invest in Comprehensive Sex Education. _____ 6
- ★ Restore Incentives to Provide Affordable Birth Control at College Health Centers and Certain Safety Net Providers. _____ 6

Improve Access To Abortion Care

- ★ Strike Budgetary Restrictions That Block Women's Access to Abortion Care. _____ 6

Support Healthy Pregnancies

- ★ Increase Funding for the Title V Maternal and Child Health (MCH) Services Block Grant to \$850 Million. _____ 7

Guarantee Access to Comprehensive, Quality, Affordable Health Care for All

- ★ Put Forward a Health Care Reform Plan That Guarantees Equal Access to Comprehensive, High-Quality, Affordable Health Care for All. _____ 7
- ★ Reverse the HHS Federal Refusal Rule. _____ 7

Reclaim America's Global Leadership on Reproductive Health

- ★ Rescind the Global Gag Rule. _____ 8
- ★ Restore Funding to the United Nations Population Fund (UNFPA). _____ 8
- ★ Provide \$1 Billion for International Family Planning Programs. _____ 8

Restore Integrity to the Government's Public Health Decision-Making Processes

- ★ De-Fund Abstinence-Only Programs. _____ 8
- ★ Review Policies that Restrict Access to Emergency Contraception (EC) and Eliminate Restrictions that Lack Scientific Support. _____ 9

Select Judges and Executive Officials Who Are Highly Qualified and Committed to Individual Rights and Justice

- ★ Select Judicial Nominees with a Demonstrated Commitment to Fundamental Legal Protections and Civil Liberties, Including Reproductive Rights. _____ 9
- ★ Reestablish a Standard of Excellence for Federal Appointees _____ 9

PRIORITIZE PREVENTION

Increase Funding for the Title X Family Planning Program to \$700 million.

The Title X family planning program is vital to our nation's health care safety net, providing preventive health services to nearly five million low-income and uninsured women and men each year, at more than 4,400 health centers nationwide.⁷ Recent data confirm its cost-effectiveness. For every \$1.00 spent to provide services in the nationwide network of publicly-funded family planning clinics, \$4.02 is saved in Medicaid expenses.⁸ Yet current funding is woefully inadequate given the increasing demand for services, the rising cost of prescription drugs and lab tests, and increasing costs for health care personnel.^{9, 10} FY 2008 program funding is \$300 million. Had its budget kept up with medical inflation since 1980, program funding would now be \$759 million.¹¹ We urge the President to include \$700 million for Title X in his first budget submitted to Congress.

Expand Coverage of Medicaid-Funded Family Planning Services. Medicaid provides cost-effective family-planning services for millions of low-income Americans. However, states that have sought to expand access to family planning services must navigate a cumbersome, time-consuming, administrative process. The President should submit a budget to Congress that requires states to establish parity between the income level at which a woman is eligible for pregnancy care and the income level at which she is eligible for family planning services under Medicaid. This important change would expand eligibility for family planning services to more than three million women each year, prevent more than 500,000 unintended pregnancies, and allow both states and the federal government to achieve significant savings.¹²

Invest in Comprehensive Sex Education.

Complete, accurate, and age-appropriate sex education helps young people reduce their risk of unintended pregnancies and sexually transmitted infections (STIs), including HIV/AIDS. Programs that include information about both abstinence and contraception help keep young people safe by delaying sexual activity and increasing contraceptive use when they do have sex.¹³ Moreover, most parents agree with a broad range of professional health organizations that young people should receive comprehensive sex education. Currently, the United States has no federal sex education program. The President should include at least \$50 million to promote comprehensive sex education in our schools and communities nationwide in his first budget submitted to Congress.

Restore Incentives to Provide Affordable Birth Control at College Health Centers and Certain Safety Net Providers.

Nearly four million women who depend on college health centers and safety net providers for their birth control have seen prices increase dramatically as an unintended consequence of a change in the Deficit Reduction Act.¹⁴ Birth control that previously cost \$5 to \$10 per month is now prohibitively expensive for many women and students, costing as much as \$40 or \$50 a month. This problem can be easily fixed administratively, at no cost to taxpayers. The Secretary of Health and Human Services (HHS) should issue a new regulation to alleviate this burden on college-age and low-income women.

IMPROVE ACCESS TO ABORTION CARE

Strike Budgetary Restrictions That Block Women's Access to Abortion Care.

Bans on public funding for abortion services have severely restricted access to safe abortion care for women, disproportionately affecting poor women,

women of color, and certain immigrant women. The President's budget should strike language restricting abortion funding for (i) Medicaid-eligible women and Medicare beneficiaries (Hyde amendment); (ii) federal employees and their dependents (FEHB program); (iii) residents of the District of Columbia; (iv) Peace Corps volunteers; (v) Native-American women; and (vi) women in federal prisons. The budget submitted to Congress also should omit language known as the Federal Refusal Clause (Weldon amendment) and call on Congress to reject this language in its annual health spending bill. The Weldon amendment denies federal funding if an "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."²⁴

SUPPORT HEALTHY PREGNANCIES

Increase Funding for the Title V Maternal and Child Health (MCH) Services Block Grant to \$850 Million. This critical safety net program improves maternal health and reduces infant mortality by providing direct health services; important enabling services, including transportation, translation, and family support; population-based screenings and education; and infrastructure needs assessment. Current funding is \$666 million. We urge the President to fund the Title V MCH Services Block Grant at its authorized level of \$850 million in his first budget submitted to Congress.

GUARANTEE ACCESS TO COMPREHENSIVE, QUALITY, AFFORDABLE HEALTH CARE FOR ALL

Put Forward a Health Care Reform Plan That Guarantees Equal Access to Comprehensive, High-Quality, Affordable Health Care for All.

It is imperative that the President put forward a health care reform plan that guarantees access to comprehensive, high-quality, affordable health care for all. This plan should ensure culturally and linguistically-appropriate, patient-centered care that will reduce disparities in access and health outcomes. Comprehensive benefits must include access to the full range of reproductive health services, including contraception, maternity care, and abortion care. To be successful, such a plan must reform our payment system, guarantee quality, and control rising costs in the health care system. In developing any health care reform plan, it is critical to harness the expertise of women's health advocates so that women's health concerns are adequately addressed.

Reverse the HHS Federal Refusal Rule.

A proposed HHS rule published on August 26, 2008 would obstruct access to reproductive and other health services, counseling, and referrals and could open the door for more widespread health service refusals. Federal law has long protected the rights of health care professionals to refuse to provide abortion services, while ensuring patient access to needed care. This new, expansive interpretation of existing law not only takes patients' health care needs out of the equation but also conflicts with accepted medical standards of health care and treatment and creates possible conflicts with state laws designed to enhance access to reproductive health services. If not withdrawn, the Secretary

of HHS should take immediate steps to reverse this policy.

RECLAIM AMERICA'S GLOBAL LEADERSHIP ON REPRODUCTIVE HEALTH

Rescind the Global Gag Rule. On his second day in office, President Bush issued an executive order, known as the “global gag rule,” that forces foreign recipients of U.S. family planning aid to stop using their own funds for legal abortion-related services or to advocate for safe abortion laws and policies. The global gag rule has stifled the public debate in developing countries where clandestine abortion takes an enormous toll on women’s health and lives.³⁶ It has also led to dramatic cutbacks in services, closures of clinics, and serious shortfalls in contraceptive supplies. The President should immediately rescind this dangerous policy, restore cut funding, and remove this politically motivated obstacle to health care for women around the world.

Restore Funding to the United Nations Population Fund (UNFPA). The United States has failed to support the critical work that UNFPA does to promote voluntary family planning and maternal health in 150 countries. Over the last seven years, the Bush Administration has distorted the application of the Kemp-Kasten law to justify its political decision to withhold the funds that Congress has consistently appropriated for this critical partner agency. The President should make available to UNFPA as soon as possible all funds appropriated by Congress for FY 2009. Further, he should include \$65 million within the International Organizations and Programs Account for a U.S. contribution to UNFPA in his FY 2010 budget request to Congress.

Provide \$1 Billion for International Family Planning Programs. In the last decade, U.S. funding for international family planning programs has declined by almost 40 percent.³⁷ Today, more than 200 million women in the developing world wish to delay, space, or complete childbearing, but do not have access to modern contraceptives.³⁸ The President should increase investment in international family planning, including programs to help ensure that those displaced by conflict and natural disasters have full access to life-saving reproductive health care. In addition, it is particularly important that reproductive health services be integrated into programs addressing HIV/AIDS and vice versa. Current funding is \$461 million for USAID’s overseas family planning program; the Bush Administration, for the seventh consecutive year, blocked any U.S. contribution to UNFPA. We urge the President to include \$1 billion for international family planning programs, including \$65 million for UNFPA, in his first budget submitted to Congress.

RESTORE INTEGRITY TO THE GOVERNMENT'S PUBLIC HEALTH DECISION-MAKING PROCESSES

De-Fund Abstinence-Only Programs. The Bush Administration has promoted dangerous, ineffective abstinence-only programs that contain inaccurate information about sexual and reproductive health. Since 1998, federal policymakers have allocated more than \$1.3 billion taxpayer dollars for abstinence-only programs, despite overwhelming evidence that this massive federal expenditure has failed completely to achieve its stated goals. The President’s budget should de-fund abstinence-only programs by (i) abolishing the abstinence-only program within the Title V MCH Services Block Grant; (ii) abolishing the Community-Based Abstinence Education program; (iii) de-linking the Adolescent

Family Life Act (AFLA) from the A-H definition in the Title V abstinence-only program; and (iv) tightening AFLA program eligibility in order to end funding for all programs that promote an abstinence-only approach.

Review Policies that Restrict Access to Emergency Contraception (EC) and Eliminate Restrictions that Lack Scientific Support. We urge the President to direct relevant agencies to reexamine Bush Administration policies that have blocked or limited women's access to EC. The President should direct the Secretary of Defense to add EC to the military's basic core formulary; the Department of Justice should include discussion of EC in its guidelines for hospital treatment of sexual assault survivors; and USAID should include the medication in its Commodities Program. Finally, the President should direct the Secretary of HHS to instruct the FDA to review and evaluate the scientific data underlying the age restriction on over-the-counter access to EC to ensure that the FDA's policy is based on sound science rather than politics.

SELECT JUDGES AND EXECUTIVE OFFICIALS WHO ARE HIGHLY QUALIFIED AND COMMITTED TO INDIVIDUAL RIGHTS AND JUSTICE

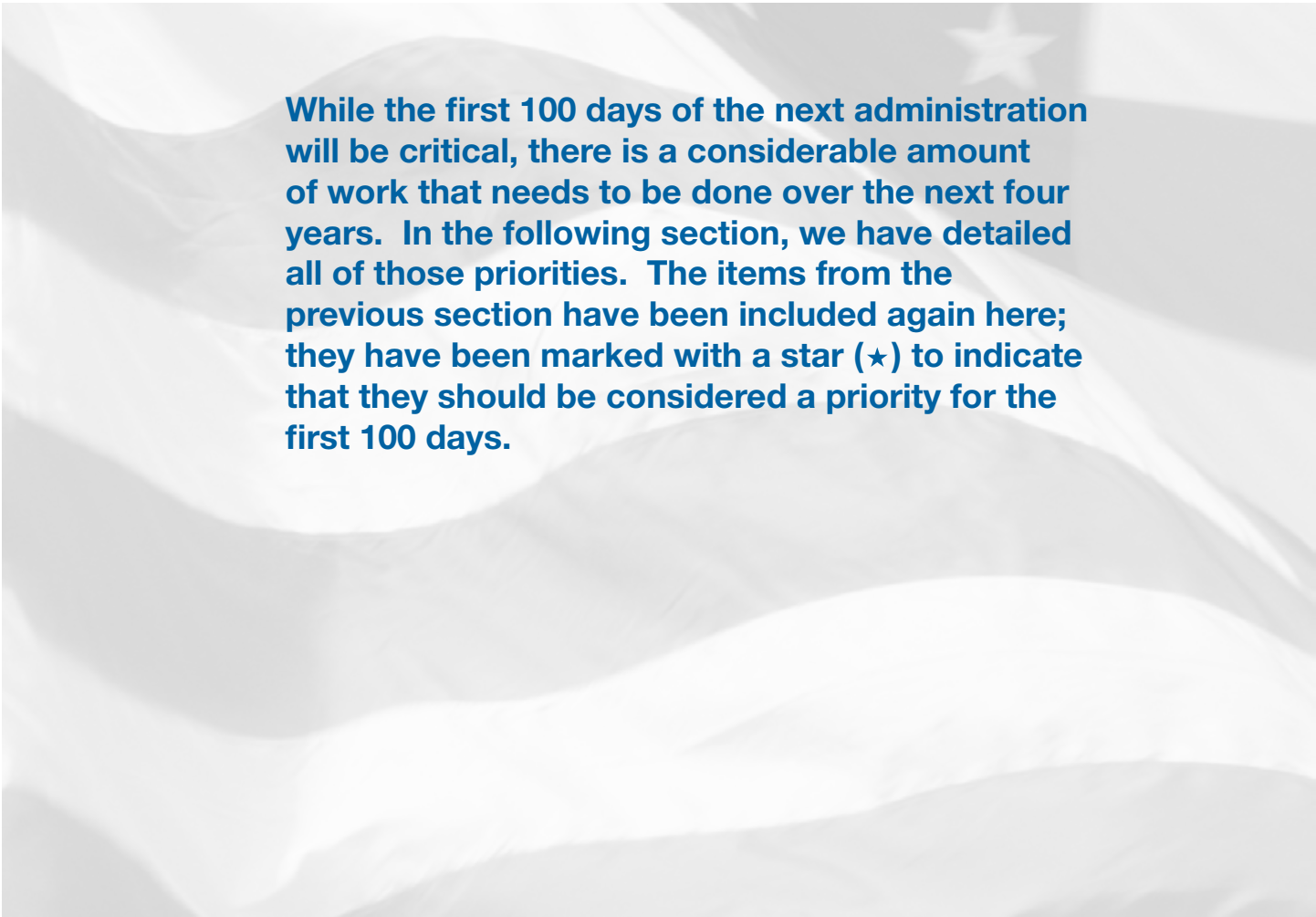
Select Judicial Nominees with a Demonstrated Commitment to Fundamental Legal Protections and Civil Liberties, Including Reproductive Rights. It is critical that only fair and independent judicial nominees with a demonstrated commitment to fundamental legal rights be appointed to the federal courts, including the Supreme Court and lower courts. The President should nominate individuals who, in addition to meeting the requirements of

honesty, integrity, character, temperament, and intellect, demonstrate a commitment to justice, civil rights, equal rights, individual liberties, and the fundamental constitutional right to privacy, including the right to have an abortion.

Reestablish a Standard of Excellence for Federal Appointees. We urge the President to appoint senior leaders throughout the federal government who have demonstrated track records of leadership in their fields, knowledge of and commitment to the work of the agencies and programs they are charged with leading, and experience in managing multilayered networks of experts with respect and integrity. These leaders must respect the rule of law and ensure that evidence-based findings will not be suppressed, distorted, or manipulated to advance a political agenda. Where relevant, they should display a commitment to promoting the health and rights of women and men in the United States and throughout the world.



Advancing Reproductive Rights and Health in a New Administration: Steps for Improvement and Change



While the first 100 days of the next administration will be critical, there is a considerable amount of work that needs to be done over the next four years. In the following section, we have detailed all of those priorities. The items from the previous section have been included again here; they have been marked with a star (★) to indicate that they should be considered a priority for the first 100 days.

PRIORITIZE PREVENTION

Today, half of all pregnancies in the United States – and more than eight in ten teen pregnancies¹ – are unintended.² An estimated 17.5 million women are in need of subsidized contraceptive services and supplies, a figure that likely will continue to grow in step with rising rates of uninsurance.³ Between 1994 and 2001, the unintended pregnancy rate among low-income women shot up by 29 percent, even as it fell 20 percent for more affluent women.⁴ A poor woman in America is now four times as likely as a more affluent woman to have an unintended pregnancy.⁵ At the same time, the United States continues to have the highest rates of sexually transmitted infections (STIs) in the industrialized world. One in four young women has an STI⁶ and recent data confirm that rates of HIV are 40 percent higher than previously reported. The President should prioritize prevention by increasing access to affordable reproductive health services, including contraception and STI-related services, and by providing young people with comprehensive sex education.

★ Increase Funding for the Title X Family Planning Program to \$700 million.

The Title X family planning program is vital to our nation's health care safety net, providing preventive health services to nearly five million low-income and uninsured women and men each year, at more than 4,400 health centers nationwide,⁷ many of whom would otherwise have no access to health care. Recent data confirm the cost-effectiveness of publicly-funded services. For every \$1.00 spent to provide services in the nationwide network of publicly-funded family planning clinics, \$4.02 is saved in Medicaid expenses.⁸ Yet current funding is woefully inadequate given the increasing demand for services, the rising cost of prescription drugs and lab tests, and increasing costs for health care

personnel.^{9, 10} The program is funded in FY 2008 at \$300 million, an amount that has not kept pace with the cost of inflation or with increased demand for services. Had its budget kept up with medical inflation since 1980, program funding would now be \$759 million.¹¹ We urge the President to include \$700 million for Title X in his first budget submitted to Congress.

★ Expand Coverage of Medicaid-Funded Family Planning Services.

Medicaid plays an enormous role in providing cost-effective family-planning services for millions of low-income Americans. However, states that have sought to expand access to family planning services – expansions that both help women to plan their families and save state and federal dollars – must navigate a cumbersome, time-consuming, administrative process. The President should submit a budget to Congress that requires states to expand access by establishing parity between the income level at which a woman is eligible for pregnancy care and the income level at which she is eligible for family planning services under Medicaid. This important change would expand eligibility for family planning services to more than three million women each year, prevent more than 500,000 unintended pregnancies, and allow both states and the federal government to achieve significant savings.¹²

★ Invest in Comprehensive Sex Education.

Complete, accurate, and age-appropriate sex education helps young people reduce their risk of unintended pregnancies and STIs, including HIV/AIDS. Sex education programs that include information about both abstinence and contraception help keep young people safe by delaying sexual activity and increasing contraceptive use when they do have sex.¹³ Most parents believe that young people should receive comprehensive sex education, as do a broad range of professional health organizations including the American Public Health Association, the American

Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the American Medical Association. Currently, the United States has no federal sex education program. We urge the President to invest in the lives and health of our nation's young people by providing at least \$50 million to promote comprehensive sex education in our schools and communities nationwide in his first budget submitted to Congress.

★ **Restore Incentives to Provide Affordable Birth Control at College Health Centers and Certain Safety Net Providers.** Nearly four million women who depend on college health centers and safety net providers for their birth control have seen prices increase dramatically as an unintended consequence of a change in the Deficit Reduction Act (DRA).¹⁴ Birth control that previously cost \$5 to \$10 per month is now prohibitively expensive for many women and students, costing as much as \$40 or \$50 a month. This problem has been allowed to persist for too long, although it could have been easily fixed administratively, at no cost to taxpayers. The Secretary of Health and Human Services (HHS) should issue a regulation to alleviate this burden on college-age and low-income women.

Review Title X Program Guidelines. The Secretary of HHS should direct the Deputy Assistant Secretary for Population Affairs to review the Title X guidelines to ensure that they are consistent with the current evidence-based best practices and standards of care for clinical, education, and counseling services and to allow the flexibility to deliver client-centered care. The guidelines should be consistent with those of relevant government- and private-sector public health and medical agencies and organizations.

Increase Funding for the Centers for Disease Control and Prevention's (CDC) STI Prevention Program to \$267 million.

Approximately 19 million new cases of STIs occur each year,¹⁵ giving the United States some of the highest rates of STIs of any industrialized nation.¹⁶ Young people are at particularly high risk, comprising nearly 50 percent of all new STIs each year.¹⁷ Women are especially threatened: they are more easily infected, less likely to show symptoms, and more likely to suffer long-term consequences such as pelvic inflammatory disease, infertility, ectopic pregnancy, and cervical cancer.¹⁸ Despite these startling statistics and grave risks, base STI program funding levels have remained frozen for more than a decade. Of particular importance to women is CDC's Infertility Prevention Program, which is an STI prevention success story. In the areas where it has been implemented, rates of Chlamydia – the leading cause of infertility in the United States – have significantly diminished.¹⁹ Current funding for STI prevention is \$157 million. We urge the President to include \$267 million for CDC's STI prevention programs in his first budget submitted to Congress.

Direct the Surgeon General to Renew the "Call to Action to Promote Sexual Health and Responsible Sexual Behavior." The Surgeon General should mobilize public support for science-based approaches to sexual health in a renewed Call to Action. This Call to Action should build upon the 2001 Call from then-Surgeon General David Satcher, in which he sought to engage the public in a thoughtful discussion about sexuality.²⁰ The new Call to Action should acknowledge the positive aspects of sexuality as well as address a broad range of sexual health issues, including STIs, HIV/AIDS, unintended pregnancy, and abortion. It also should acknowledge that sex education must be age-appropriate and evidence-based. In addition, the Surgeon General should launch a targeted campaign to combat the staggering rates of STIs in this country. The Surgeon General should address these public health crises in

conjunction with the development of a broader, comprehensive, domestic HIV/AIDS strategy.

Increase Funding for CDC's Division of Adolescent and School Health (DASH) to \$66.6 million. DASH plays a critical role in promoting evidence-based behavioral health interventions with strong programs in HIV and STI prevention. The CDC should tighten eligibility requirements to guarantee that funding is barred from entities that provide misleading information about reproductive health. Current funding is \$40.2 million. We urge the President to include \$66.6 million for DASH in his first budget submitted to Congress.

Expand Eligibility for the Public Health Service Act's 340B Drug Pricing Program. The 340B Drug Pricing Program, created through the Veterans Health Care Act of 1992, requires pharmaceutical manufacturers participating in the Medicaid program to provide discounts on covered outpatient drugs purchased by certain safety net providers, including Title X clinics. Unfortunately, key safety net providers, including many non-Title X family planning providers, do not currently qualify for 340B pricing even though they offer the same services to similar low-income, uninsured, and underinsured Americans. As a result, many of these health care providers have been forced to pass along increasing costs to their low-income patients. We urge the President to work with Congress to enact a statutory amendment to the 340B program to allow participation by key safety net providers that serve vulnerable populations identical to those now eligible to participate.

Remove Barriers to Family Planning Services under Medicaid. Medicaid provides vital contraceptive coverage to millions of low-income women of reproductive age. It is the largest source of public funding for family planning services

by far, providing more than 60 percent of public funding for contraceptive or related preventive care.²¹ Over the past several years, however, the Bush Administration has erected barriers that prevent states from making family planning services more widely available to low-income women through the Medicaid program. We urge the Secretary of HHS to suspend and revise regulations implementing parts of the DRA to maintain "freedom of choice" protections for family planning services, which allow beneficiaries enrolled in managed care plans to choose the provider of their choice to receive family planning services and to make clear that "preventive services" in benchmark benefit packages include family planning services.

In addition, until legislation is enacted to obviate the need for family planning waivers, we urge the Administration to expedite the Centers for Medicare and Medicaid Services (CMS) process for applying for and renewing Medicaid family planning waivers and to remove the arbitrary restrictions that were placed on state Medicaid family planning waiver programs approved under the Bush Administration.

Call on Congress to Pass the Prevention First Act. The Prevention First Act is a comprehensive package of preventive health and education measures designed to help reduce unintended pregnancy and the need for abortion. This commonsense legislation includes measures to help women obtain family planning services and information by: increasing funding for Title X and expanding family planning services under Medicaid; guaranteeing equity in contraceptive coverage by requiring private insurers that offer prescription coverage also to cover all FDA-appropriate prescription contraceptives; ensuring that sexual assault survivors receive factually-accurate information about emergency contraception (EC) and access

to EC upon request; authorizing \$10 million for important public education programs to inform women and doctors about EC and its benefits; authorizing \$20 million in annual funding for teen pregnancy prevention programs; and establishing the first-ever federal program for comprehensive sex education that requires taxpayer-funded federal programs to include medically accurate information about contraception.

IMPROVE ACCESS TO ABORTION CARE

Abortion is a vital part of women's reproductive health care. At least half of American women will experience an unintended pregnancy by age 45, and, at current rates, about one-third will have had an abortion.²² The majority of Americans support a woman's right, recognized in the U.S. Supreme Court's 1973 *Roe v. Wade* decision, to choose to continue or terminate a pregnancy. Yet, over the past three decades, attacks from the courts, harmful policies enacted at the state and federal levels, and continued threats of violence and harassment at reproductive health centers have eroded access to abortion care and made the right to choose illusory for too many women. A recent survey found that 87 percent of all U.S. counties have no identifiable abortion provider, and in non-metropolitan areas, the figure rises to 97 percent.²³

We urge the Administration to take the following actions to improve access to safe and legal abortion services.

- ★ **Strike Budgetary Restrictions That Block Women's Access to Abortion Care.** Bans on public funding for abortion services have severely restricted access to safe abortion care for women who depend on the government for their health care. These policies create an unjust obstacle to quality health care and inflict

disproportionate harm on poor women, women of color, and certain immigrant women who already face significant barriers to receiving timely, high-quality health care. Limited resources can force women to delay the procedure, which then becomes more expensive and more complicated. Women who have health coverage through the federal government should receive high-quality and comprehensive services, at least equal to those that women in most private health insurance plans receive. The President's budget should strike language restricting abortion funding for (i) Medicaid-eligible women and Medicare beneficiaries (Hyde amendment); (ii) federal employees and their dependents (FEHB program); (iii) residents of the District of Columbia; (iv) Peace Corps volunteers; (v) Native-American women; and (vi) women in federal prisons. The President should omit these restrictions in the budget submitted to Congress and indicate a commitment to working with Congress to repeal these restrictions fully.

The President's budget also should omit language known as the Federal Refusal Clause (Weldon amendment) and call on Congress to reject this language in its annual health spending bill. The language states that "[n]one of the funds made available in [the Departments of Labor, HHS and Education Appropriations bill] 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."²⁴

Remove the Ban on Abortion at Military Facilities. Although the Constitution guarantees American women the right to safe and legal abortion, a woman serving in the U.S. military, or the female spouse or dependent of a service member, cannot

exercise this constitutional right in a U.S. military medical facility either domestically or abroad. A federal statute bans almost all abortion services at U.S. military hospitals and other medical facilities, with a narrow exception for “life, rape, or incest.” Even a servicewoman whose health is jeopardized by her pregnancy may not obtain abortion care at a U.S. military health facility, even if she pays for the procedure with her own money. This ban – which impacts more than 100,000 U.S. servicewomen and military dependents – is particularly devastating for those stationed overseas who are forced either to attempt to obtain abortion care in a local medical facility where they are stationed or to travel to a medical facility in the United States or another country to obtain the procedure. The President should urge Congress to respect the health of our servicewomen, military spouses, and dependents and repeal the abortion ban at U.S. military facilities.

Call on Congress to Pass the Freedom of Choice Act (FOCA).

On April 18, 2007, in *Gonzalez v. Carhart* and *Gonzales v. Planned Parenthood Federation of America*, the Supreme Court for the first time upheld a ban on access to abortion that did not include an exception to protect a woman’s health. The Court’s decision is in direct conflict with established law, allows the federal government to override the medical decisions of a woman and her doctor, and declares open season on rights that women have relied on since *Roe v. Wade* was decided 35 years ago. As Justice Ginsburg observed in her dissent, the “Court’s hostility to the right *Roe* and *Casey* secured is not concealed.”²⁵ FOCA would guarantee the right to choose whether and when to become a parent for future generations. We urge the President to signal public support for FOCA and call on Congress to pass this important legislation.

Reinvigorate the National Task Force on Violence Against Health Care Providers.

Arson, blockades, and attempted bombings at reproductive health centers underscore the need for a renewed commitment to preventing and combating clinic violence. A Presidential directive to the Attorney General to reinvigorate the National Task Force on Violence Against Health Care Providers would help ensure that existing laws prohibiting clinic violence are fully enforced and that state and local law enforcement agencies are aware of the critical role they play in ensuring the safety of patients and providers.

SUPPORT HEALTHY PREGNANCIES

Prenatal care is vital to improved maternal and child health. Women who see a health care provider regularly during pregnancy have healthier babies, are less likely to deliver prematurely, and are less likely to have other serious problems that can be related to pregnancy. But today, the United States lags behind the rest of the world in many indicators of maternal and infant health and ranks only 30th in preventing maternal death, with rates nearly four times higher for women of color than for white women.^{26, 27} The continuing high incidence of low-birthweight babies, many with severe long-term health consequences, born to women of color at all income levels is a serious problem.

The Administration can dramatically improve the health of women and children in the United States by ensuring that every woman has access to health insurance, implementing policies that encourage prenatal care, and funding nutrition and other support services for pregnant and nursing women. Specifically, the President should ensure affordable and high-quality prenatal care for the one in seven pregnant women who lacks coverage and access

to pregnancy-related support services for low-income women.²⁸

★ **Increase Funding for the Title V Maternal and Child Health (MCH) Services Block Grant to \$850 Million.** This critical safety net program improves maternal health and reduces infant mortality by providing direct health services; important enabling services, including transportation, translation, and family support; population-based screenings and education; and infrastructure needs assessment. Current funding is \$666 million. We urge the President to fund the Title V MCH Services Block Grant at its authorized level of \$850 million in his first budget submitted to Congress.

Restore Medicaid Reimbursements for Birth Center Facilities. The Bush Administration recently denied federal Medicaid reimbursement for birth center facility charges in several states. This action reversed 20 years of practice by CMS. Birth centers are a critical component of our nation's health care safety net, giving women and families choices about their pregnancy- and delivery-related care. More than 50 percent of birth centers in the United States serve Medicaid clients, and in many rural areas more than 70 percent of birth center clients have Medicaid coverage.²⁹ This change in long-standing policy denies low-income women and their families access to this safe, cost-effective option for pregnancy, delivery, and other reproductive health services. The Secretary of HHS should take immediate steps to clarify that birth centers are eligible for reimbursement in order to protect this critical care for low-income pregnant women.

Request Systematic, Evidence-Based Review of Best Practices for Improving Pregnancy Outcomes. The Secretary of HHS should direct the Agency for Healthcare Research and Quality, in conjunction with professional medical

societies and consumer groups, to conduct a systematic, evidence-based review of best practices for improving pregnancy outcomes, including recommendations for improving the quality of maternity care and birthing practices for all women and a review of research findings on fertility services and pre-term labor prevention. In addition to the new and ongoing medical research at the National Institutes of Health (NIH), a comprehensive research review is necessary to capitalize on the information we already have at our disposal.

End the Practice of Shackling Pregnant Women in Custody. The use of physical or mechanical restraints on women who are pregnant, incarcerated, or detained in the United States during transport, labor, delivery, and immediately after delivery, without regard to their individual circumstances, should come to an end. This practice violates international human rights treaties and standards, constitutes cruel and inhumane treatment, and can endanger the health of the woman and/or the fetus. Indeed, in 2007, the American College of Obstetricians and Gynecologists called for an end to this practice, agreeing that it puts "the health and lives of the women and unborn children at risk."³⁰ We urge the President to issue an executive order directing all federal departments and agencies responsible for the custody or control of pregnant prisoners and detainees to end this dehumanizing and dangerous practice. The order should apply to all women regardless of age, in the custody or control of any federal agency, department, or contractor, including those held by state or local governments by agreement or order of any federal authority. The Administration also should work with Congress to encourage states to end this practice in local jails, prisons, and detention centers.

Increase Funding for the Substance Abuse and Mental Health Services Administration's (SAMHSA) Drug Treatment Programs for Pregnant and Parenting Mothers to \$70 Million.

Most traditional drug treatment programs disregard the unique needs of pregnant and parenting women and prohibit children's involvement in, or presence during, the treatment process. As a result, pregnant and parenting women – whose recovery is critical to their own health and the health of their families – have few appropriate treatment options. Family treatment programs, in contrast, cater to the unique needs of pregnant and parenting women, enabling them to recover from their addictions. Unfortunately, family treatment programs currently comprise less than five percent of all treatment programs. The Administration should urge Congress to reauthorize the Pregnant and Parenting Women program under SAMHSA's Center for Substance Abuse Treatment at \$70 million and invest in the health of women and families. Current program funding is \$12 million.

GUARANTEE ACCESS TO COMPREHENSIVE, QUALITY, AFFORDABLE HEALTH CARE FOR ALL

In the United States, disparities in health care – in insurance coverage, access, and quality of care – are leading contributors to inequalities in health status. Accordingly, a top priority of the President should be to fix our broken health care system in recognition of the right to comprehensive, high-quality, and affordable health care.

- ★ **Put Forward a Health Care Reform Plan That Guarantees Equal Access to Comprehensive, High-Quality, Affordable Health Care for All.** The health care crisis is taking a serious toll on U.S. health and wallets. It affects people across the

economic spectrum – not just the poor and uninsured, but also middle-class and working families who are at risk of losing insurance or going deep into debt to pay for care their insurance does not cover. Women, in particular, are struggling to bear the burden of unaffordable health care.

It is imperative that the President put forward a health care reform plan that guarantees access to comprehensive, high-quality, affordable health care for all. This plan should ensure culturally and linguistically-appropriate, patient-centered care that will reduce disparities in access and health outcomes. Comprehensive benefits must include access to the full range of reproductive health services, including contraception, maternity care, and abortion care. To be successful, such a plan must reform our payment system, guarantee quality, and control rising costs in the health care system. In developing any health care reform plan, it is critical to harness the expertise of women's health advocates and ensure that they have a seat at the health policy table so that women's health concerns are adequately addressed.

- ★ **Reverse the HHS Federal Refusal Rule.** A proposed HHS rule published on August 26, 2008 would obstruct access to reproductive and other health services, counseling, and referrals and could open the door for more widespread health service refusals. Federal law has long protected the rights of health care professionals to refuse to provide abortion services, while ensuring patient access to needed care. This new, expansive interpretation of existing law not only takes patients' health care needs out of the equation but also conflicts with accepted medical standards of health care and treatment and creates possible conflicts with state laws designed to enhance access to reproductive health services. If not withdrawn, the Secretary of HHS should take immediate steps to reverse this policy.

Address Barriers Created by the Citizen Documentation Requirements. Under the DRA, individuals now are required to provide satisfactory documentary evidence of citizenship or nationality when initially applying for Medicaid or upon a recipient's first Medicaid re-determination. The July 1, 2006 rule to implement this provision has had a chilling effect on access to Medicaid for both citizens and eligible immigrants alike. A majority of states report that the citizenship documentation requirement has caused a decline in Medicaid enrollment,³¹ and the Congressional Budget Office has estimated that nearly all of those turned away for lack of documentation were U.S. citizens.³²

Accordingly, we urge the President to call on Congress to repeal the citizenship documentation requirement and restore state determination of citizenship verification processes. For immediate relief, we urge the Secretary of HHS to ensure that CMS issue a "Dear State Medicaid Director" letter that creates a "good cause" exemption allowing Medicaid coverage during the citizenship verification period, and gives states flexibility to determine what documentation is sufficient for establishing eligibility. In addition, new regulations should be issued to ease the burden and mitigate the impact of these onerous and unnecessary citizen documentation requirements.

Call on Congress to Pass the Legal Immigrant Children's Health Improvement Act (ICHIA). We urge the President to call on Congress to enact ICHIA to grant states the option of covering more pregnant women and children, including targeted low-income children, under the Medicaid and State Children's Health Insurance (SCHIP) programs. ICHIA would address some problems created by the 1996 welfare reform legislation, which barred all legal immigrants – including children – from eligibility for Medicaid, SCHIP, and other safety net

services for the first five years that they live in the United States. The legislation would restore access to health care for hundreds of thousands of immigrant children and pregnant women at a nominal cost. It is critical to restore equity in the health care system by ensuring that lawfully residing immigrant children and pregnant women have access to health care services on the same basis as citizens.

RECLAIM AMERICA'S GLOBAL LEADERSHIP ON REPRODUCTIVE HEALTH

U.S. investments in family planning and reproductive health ease rapid population growth rates overseas and yield an array of benefits, including improved maternal and child health, fewer unintended pregnancies and abortions, lower HIV infection rates, enhanced women's and girls' education, higher standards of living, and more sustainable development. An estimated 200 million women want to delay or avoid pregnancy but lack access to effective family planning.³³ The demand is expected to rise 40 percent by 2025.³⁴ Lack of access to family planning is a major factor behind the 76 million unintended pregnancies every year in the developing world, as well as a contributing factor in many of the 19 million unsafe abortions each year – abortions that lead to 68,000 deaths annually.³⁵

Given the critical importance of these services in women's lives, we urge the Administration to remove the restrictions on foreign assistance for women's health that have been a centerpiece of our foreign policy and to signal to the world that the United States is prepared to reclaim its historic leadership in this arena.

★ **Rescind the Global Gag Rule.** On his second day in office, President Bush followed the path charted by Presidents Reagan and George H.W. Bush and issued

an executive order, known as the “global gag rule,” that forces foreign organizations to stop using their own funds for legal abortion-related services or to advocate for safe abortion laws and policies in order to be eligible for desperately-needed U.S. family planning aid. The global gag rule has stifled the public debate in developing countries where clandestine abortion takes an enormous toll on women’s health and lives.³⁶ It has also led to dramatic cutbacks in services, closures of clinics, and serious shortfalls in contraceptive supplies. In part, these cutbacks are a consequence of defunding the International Planned Parenthood Federation, the largest provider globally of sexual and reproductive health services. The President should immediately repeal this dangerous policy, restore funding, and remove this politically motivated obstacle to health care for women around the world.

★ **Restore Funding to the United Nations Population Fund (UNFPA).** The United States has failed to support the critical work that UNFPA does to promote voluntary family planning and maternal health in 150 countries. Over the last seven years, the Bush Administration has distorted the application of the Kemp-Kasten law to justify its political decision to withhold the funds that Congress has consistently appropriated for this critical partner agency. The President should make available to UNFPA as soon as possible any funding appropriated by Congress for FY 2009. Further, he should include \$65 million within the International Organizations and Programs Account for a U.S. contribution to UNFPA in his FY 2010 budget request to Congress.

★ **Provide \$1 Billion for International Family Planning Programs.** In the last decade, U.S. funding for international family planning programs has declined by almost 40 percent.³⁷ Today, more than 200 million women in the developing world wish

to delay, space, or complete childbearing, but do not have access to modern contraceptives.³⁸ Lack of access to family planning services contributes to a host of devastating consequences, including resource insecurity, social instability, and maternal and child death. In order to meet these 21st century challenges, the President should increase investment in international family planning, including programs to help ensure that those displaced by conflict and natural disasters have full access to life-saving reproductive health care. In addition, in countries with high HIV prevalence, where most new HIV infections are occurring in women, it is particularly important that reproductive health services be integrated into programs addressing HIV/AIDS and vice versa. Current funding is \$461 million for USAID’s overseas family planning program; the Bush Administration, for the seventh consecutive year, blocked any U.S. contribution to UNFPA. We urge the President to include \$1 billion for international family planning programs, including \$65 million for UNFPA, in his first budget submitted to Congress.

Provide \$900 Million for International Maternal and Child Health (MCH) Programs. Up to 15 percent of pregnant women around the world will experience potentially fatal complications during childbirth, and one in nine women will die from complications of pregnancy or childbirth.³⁹ Survival rates depend on the distance and time women must travel to receive skilled medical care. The leading killers are known – hemorrhage, eclampsia or high blood pressure, unsafe abortion, sepsis or infections, obstructed labor – yet not enough has been done to address them. An investment in international MCH programs would support efforts to ensure skilled care by nurses, midwives, or doctors during pregnancy and childbirth, including emergency services; care for mothers and newborn babies after delivery;

and the resources necessary to care for the millions of women and children that experience – and too often die from – pregnancy-related complications. The requested amount would put us on track toward scaling up proven interventions to meet our proportional share of the global need to save the lives of six million children in the 42 countries responsible for 90 percent of child deaths.⁴⁰ Current funding for international MCH programs is \$450 million. The President should include \$900 million in his first budget request submitted to Congress.

Strengthen Global HIV/AIDS Prevention Programs. President Bush’s Emergency Plan for AIDS Relief (PEPFAR) is providing unprecedented funding for the expansion of programs addressing HIV and AIDS worldwide, specifically for expanded access to anti-retroviral therapy. In an epidemic in which there are five new infections for every two people put on treatment, efforts to prevent HIV need to be redoubled to slow this pandemic.⁴¹ Implementing these recommendations will have a greater impact on saving the greatest number of lives while using scarce U.S. taxpayer funds most wisely. PEPFAR was reauthorized in 2008 with policy shortfalls that need to be addressed. Until those are remedied through legislation, the Administration should take the following actions:

Promote Country-Level Decision-Making About Prevention Investments. Despite the recommendations of the Government Accountability Office,⁴² the Institutes of Medicine,⁴³ and other experts that countries need greater flexibility in determining how to prevent the most HIV infections, PEPFAR calls for 50 percent of funds for prevention of sexual transmission to go toward abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction. Decisions about how to invest in prevention programs should be the primary responsibility of the people in-country who

are engaged in the day-to-day realities of the epidemic. Moreover, when calculating these expenditures, the Administration should “count” all funds for these activities – whether in stand-alone programs or part of a more comprehensive set of interventions.

Mitigate the Harm of the Anti-Prostitution Pledge in PEPFAR.

The global AIDS law, as a condition of eligibility for funding, requires recipient organizations to have a policy opposing prostitution. This policy has impeded PEPFAR’s ability to work with some of the organizations most trusted by the women who are among the most vulnerable to HIV. Moreover, in August 2008, a federal court found the requirement unconstitutional as applied to U.S.-based organizations. The U.S. Agency for International Development and HHS should revise their guidelines as applied to domestic and foreign non-governmental organizations to comply with the court ruling as well as to allow for the most effective foreign groups to partner with the United States in the fight against AIDS.

Support Integrating HIV and Other Reproductive Health Services. As with all health programs, being able to provide the broadest range of primary health services in any setting is the most cost-effective approach to improving health outcomes. Worldwide, almost half of the people living with HIV or AIDS are women, and in sub-Saharan Africa – where heterosexual transmission is highest – 61 percent of those living with HIV or AIDS are women.⁴⁴ It is therefore critically important that services are coordinated and integrated to serve women at risk for HIV and unintended pregnancy. In order to meet the reproductive health needs of HIV-positive women, ready access to information, counseling, and services should be available in treatment programs to enable them to choose to have children or to prevent a pregnancy.

Also, integration is paramount to the treatment of other STIs for women and men seeking HIV/AIDS services. Within reproductive health programs, clients should have access to HIV testing and counseling, as well as information and services to prevent other STIs. To that end, the Administration should issue new guidance encouraging linkages between family planning and PEPFAR programs.

Clarify USAID Policy on Abortion Information and Services. The Helms amendment, which prohibits foreign assistance for the “performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions,” does permit funding for abortion in cases of life endangerment, rape, and incest according to a 1994 policy interpretation by USAID. This policy, however, has never been implemented. In addition, a long-standing provision contained in the annual foreign aid appropriations bill specifies that “the term ‘motivate’ shall not be construed to prohibit the provision, consistent with local law, of information or counseling about all pregnancy options.” This has never been fully implemented either. A new guidance interpreting the Helms amendment should be issued to clarify these existing exceptions and to reconsider further how USAID could be more proactive, within the confines of the law, to prevent unsafe abortion and treat women suffering from incomplete or septic abortion.

Urge Ratification of the United Nation’s Convention on the Elimination of Discrimination Against Women (CEDAW). The most comprehensive international agreement on basic human rights for women is CEDAW. The agreement is an important tool to reduce violence and discrimination against women and girls, ensure women and girls receive equitable access to education and health care, and secure access to the legal system for women and girls if their

human rights have been violated. Though 185 countries have ratified the agreement, and though President Carter signed the treaty, the United States has failed to ratify the document.⁴⁵ At the start of each new congressional session, the Administration sends a letter to the Senate Foreign Relations Committee containing a priority list of treaties that it would like to move forward for ratification. The Administration should include CEDAW on the priority list.

RESTORE INTEGRITY TO THE GOVERNMENT’S PUBLIC HEALTH DECISION-MAKING PROCESSES

The work of U.S. government scientists and experts and the international credibility of U.S. scientific agencies have been undermined by the government’s promotion of public health policies based on ideology rather than sound science. To improve health outcomes for women and families across the nation and restore the credibility of governmental agencies that provide health services or conduct health research, the Administration must ensure that federal agencies charged with carrying out these critical tasks do so based on scientific and medical evidence rather than the narrow interests of ideological extremists.

★ **De-Fund Abstinence-Only Programs.** The Bush Administration has promoted dangerous, ineffective abstinence-only programs that contain inaccurate information about sexual and reproductive health. Since 1998, federal policymakers have allocated more than \$1.3 billion taxpayer dollars for abstinence-only programs through three separate programs and funding earmarks, despite overwhelming evidence that this massive federal expenditure has failed completely to achieve its stated goals. Multiple studies show abstinence-only curricula to be utterly ineffective, and continued

funding of these programs ignores not only experts' advice, but the wishes of most parents.

The President's budget should de-fund abstinence-only programs by (i) abolishing the abstinence-only program within the Title V MCH Services Block Grant; (ii) abolishing the Community-Based Abstinence Education program; (iii) de-linking the Adolescent Family Life Act (AFLA) from the A-H definition in the Title V abstinence-only program; and (iv) tightening AFLA program eligibility in order to end funding for all programs that promote an abstinence-only approach.

★ **Review Policies that Restrict Access to EC and Eliminate Restrictions that Lack Scientific Support.** As part of an effort to reestablish public confidence in the government's decision-making processes as they relate to reproductive health, we urge the President to direct relevant agencies to reexamine Bush Administration policies that have blocked or limited women's access to EC. In a wide range of health care and policy contexts and in a relentless pursuit of its ideological agenda, the Bush Administration has dismissed medical evidence and public health recommendations in support of providing access to this safe, effective, and FDA-approved contraceptive option. The President can take a number of positive steps to remedy the situation. The President should direct the Secretary of Defense to add EC to the military's basic core formulary (as Pentagon medical officials tried to do several years ago, before being overridden by Bush appointees); the Department of Justice should include discussion of EC in its guidelines for hospital treatment of sexual assault survivors; and USAID should include the medication in its Commodities Program. Finally, the President should direct the Secretary of HHS to instruct the FDA to review and evaluate the scientific data underlying the

age restriction on over-the-counter access to EC to ensure that the FDA's policy is based on sound science rather than politics.

Review and Update Federal Websites to Ensure the Accuracy of All Information on Sexual and Reproductive Health.

The Bush Administration has censored government websites to propagate misleading information about reproductive health. The Administration should perform an inventory of the information available on its websites, eliminating inaccurate, biased, or incomplete statements and adding new materials as necessary to ensure that readers have a full and unbiased understanding of their reproductive options. Examples of websites to be reviewed include: the Office of Population Affairs, Administration for Children and Families (<http://www.4parents.gov>); the CDC's "Male Latex Condoms and Sexually Transmitted Diseases," 2000 (<http://www.cdc.gov/hiv/pubs/facts/condoms.htm>); and HHS' Abstinence Promotion website (<http://www.girlshealth.gov/body/abstinence/index.cfm>).

INVEST IN RESEARCH AND INITIATIVES TO IMPROVE WOMEN'S HEALTH

Even with the enactment of comprehensive health reform legislation, research, education, and targeted health services for certain populations will be needed to ensure that all women can lead healthy lives. To make certain that the Administration has a thorough understanding of the diverse issues that impact women's health status, it should restore and protect offices and programs with an explicit focus on women's issues.

Restore the Office of Women's Budget Initiatives and Outreach in the White House. In January 2001, President Bush disbanded a formally organized office for

women's issues in the Executive Office of the President: the Office of Women's Initiatives and Outreach. The Administration should reestablish this important office and signal its commitment to ensuring that women and their families are a top priority. From the mid-1990s until early 2001, this office served as a liaison between the White House and women's organizations, listening to women's concerns and proposals and bringing these ideas to the President and others in the Administration. As part of its broad mandate, the office strengthened relationships with women's and reproductive health organizations and put issues important to women and their families – such as family planning, domestic violence, abortion, and the participation of women in clinical research trials – at the top of the Administration's agenda.

Express Support for the Women's Health Offices Act (WHOA). Offices of women's health are located in agencies across HHS to serve as the government's champion and focal point for women's health issues. These offices ensure that women's health needs are at the center of our nation's health care agenda. Unfortunately, few of these offices are permanently authorized in federal law, and many lack the formal authority to do their important work most effectively. The President should encourage Congress to pass the WHOA, which provides permanent authorization for offices and positions of women's health in each of the federal health agencies, and request increased funding for the offices of women's health in his first budget submitted to Congress. Finally, the President should direct his Administration to engage the offices fully in developing health policy and setting priorities.

Support Women's Health Research. Recent budget limitations on the NIH, coupled with recent political pressures, have limited public investment in research

necessary to understand and support women and men in attaining full reproductive and sexual health. We urge the President to support greater investment in behavioral and biomedical research at the NIH. Specifically, increased funding for the Eunice Kennedy Shriver National Institute of Child Health and Human Development, which conducts research in areas such as pre-term birth, pregnancy, childbirth, sexual health, contraceptive development and evaluation, and infertility prevention, should be a priority. We also encourage the Administration to invest in the development of safe and effective STI- and HIV-prevention technologies, including vaccines and microbicides.

SELECT JUDGES AND EXECUTIVE OFFICIALS WHO ARE HIGHLY QUALIFIED AND COMMITTED TO INDIVIDUAL RIGHTS AND JUSTICE

- ★ **Select Judicial Nominees with a Demonstrated Commitment to Fundamental Legal Protections and Civil Liberties, Including Reproductive Rights.** Federal judges make decisions every day that have a broad and lasting impact on women's lives. Federal judges are appointed for life, and the decisions they make can affect women and their families for generations. It is critical that only fair and independent judicial nominees with a demonstrated commitment to fundamental legal rights be appointed to the federal courts, including the Supreme Court and lower courts. The President should nominate individuals who, in addition to meeting the requirements of honesty, integrity, character, temperament, and intellect, demonstrate a commitment to justice, civil rights, equal rights, individual liberties, and the fundamental constitutional right to privacy, including the right to have an abortion.

★ Reestablish a Standard of Excellence

for Federal Appointees. We urge the President to appoint senior leaders throughout the federal government who have demonstrated track records of leadership in their fields, knowledge of and commitment to the work of the agencies and programs they are charged with leading, and experience in managing multilayered networks of experts with respect and integrity. These leaders must respect the rule of law and ensure that evidence-based findings will not be suppressed, distorted, or manipulated to advance a political agenda. Where relevant, they should display a commitment to promoting the health and rights of women and men in the United States and throughout the world.

¹ Lawrence B. Finer and Stanley K. Henshaw, “Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001,” *Perspectives on Sexual and Reproductive Health* 38, no.2 (2006): 90–96.

² Ibid.

³ Guttmacher Institute, “In Brief: Facts on Publicly Funded Contraceptive Services in the United States,” (August 2008), http://www.guttmacher.org/pubs/fb_contraceptive_serv.pdf (accessed September 23, 2008).

⁴ Rachel Benson Gold, “Rekindling Efforts to Prevent Unplanned Pregnancy: A Matter of ‘Equity and Common Sense,’” *Guttmacher Policy Review* 9, no.3 (2006): 2-7.

⁵ Ibid.

⁶ The Centers for Disease Control and Prevention, “Nationally representative CDC study finds 1 in 4 teen-age girls has a sexually transmitted disease,” (March 11, 2008), <http://www.cdc.gov/STDCconference/2008/media/release-11march2008.htm> (accessed September 23, 2008).

⁷ Christina Fowler, Julia Gable, and Jiantong Wang, *Family Planning Annual Report: 2006 National Summary* (Research Triangle Park, NC: RTI International, February 2008).

⁸ Jennifer J. Frost, Lawrence B. Finer, and Athena Tapales, “The Impact of Publicly Funded Family Planning Clinic Services on Unintended Pregnancies and Government Cost Savings,” *Journal of Health Care for the Poor and Underserved* 19, no.3 (2008).

⁹ Adam Sonfield, “One Million New Women in Need of Publicly Funded Contraception,” *Guttmacher Policy Review* 9, no.3 (2006): 20.

¹⁰ Adam Sonfield, “Summer Price Spike: A Case Study about Publicly Funded Clinics and the Cost of Contraceptive Supplies,” *Guttmacher Policy Review* 9, no.4 (2006): 2-5.

¹¹ Guttmacher Institute, memo on Title X Funding from Adam Sonfield to interested parties, (February 5, 2008).

¹² Jennifer J. Frost, Adam Sonfield, and Rachel Benson Gold, *HYPERLINK “http://www.guttmacher.org/pubs/2006/08/16/or28.pdf” \o “blocked::http://www.guttmacher.org/pubs/2006/08/16/or28.pdf” Estimating the Impact of Expanding Medicaid Eligibility for Family Planning Services*, Occasional Report 28 (Washington, DC: Guttmacher Institute, August 2006).

¹³ Douglas Kirby, *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and*

Sexually Transmitted Diseases (Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy, 2007).

¹⁴ The National Campaign to Prevent Teen and Unplanned Pregnancy, "Policy Brief: Restoring Affordable Birth Control," (September 2008), www.thenationalcampaign.org/policymakers/PDF/Briefly_Policy%20Brief_AffordableBC.pdf (accessed September 24, 2008); Tessa McClellan, "Birth Control Prices Remain High," CBS.com (May 8, 2008), <http://www.cbsnews.com/stories/2008/05/06/politics/uwire/main4076566.shtml> (accessed September 24, 2008).

¹⁵ Hillard Weinstock, Stuart Berman, and Willard Cates, Jr., "Sexually Transmitted Diseases among American Youth: Incidence and Prevalence Estimates, 2000," *Perspectives on Sexual and Reproductive Health* 36, no.1 (January/February 2004): 6-10.

¹⁶ Jacqueline E. Darroch, Jennifer J. Frost, and Susheela Singh, *Teenage Sexual and Reproductive Behavior in Developed Countries: Can More Progress Be Made?* Occasional Report 3 (New York, NY: The Alan Guttmacher Institute, 2001).

¹⁷ Weinstock, Berman and Cates, Jr., "Sexually Transmitted Diseases," 2004. *Supra* note 15.

¹⁸ Lars Westrom and David Eschenbach, "Pelvic Inflammatory Disease," in *Sexually Transmitted Diseases*, 3rd ed., ed. King Holmes, P. Frederick Sparling, Per-Anders Mardh, Stanley Lemon, Walter Stamm, Peter Piot, and Judith Wasserheit (New York, NY: McGraw Hill, 1999), 783-809.

¹⁹ The Centers for Disease Control and Prevention, *Sexually Transmitted Disease Surveillance 2005 Supplement, Chlamydia Prevalence Monitoring Project Annual Report 2005* (Atlanta, GA: U.S. Department of Health and Human Services, December 2006).

²⁰ Letter from David Satcher, Surgeon General, U.S. Department of Health and Human Services, introducing the Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior, (July 9, 2001), <http://www.surgeongeneral.gov/library/sexualhealth/call.htm> (accessed September 29, 2008).

²¹ The Kaiser Family Foundation and Guttmacher Institute, "Medicaid's Role in Family Planning," (October 2007), http://www.guttmacher.org/pubs/IB_medicaidFP.pdf (accessed September 9, 2008).

²² Guttmacher Institute, "In Brief: Facts on Induced Abortion in the United States," (July 2008), http://www.guttmacher.org/pubs/fb_induced_abortion.pdf (accessed September 9, 2008).

²³ Rachel K. Jones et al., "Abortion in the United States: Incidence and Access to Services, 2005," *Perspectives on Sexual and Reproductive Health* 40, no.1 (2008): 6-16.

²⁴ Consolidated Appropriations Act, 2008. PL 110-161, 121 Stat 1844 (2007).

²⁵ *Gonzales v. Carhart*, 127 S. Ct. 1610, 1650 (2007) (Ginsburg, J., dissenting).

²⁶ World Health Organization, *Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF, UNFPA* (New York, NY and Geneva: WHO, UNICEF, UNFPA, 2004).

²⁷ D.L. Hoyert, National Center for Health Statistics, "Maternal Mortality and Related Concepts," *Vital Health Statistics*, 3rd ser., no.33 (Feb. 2007).

²⁸ Kenneth E. Thorpe, Jennifer Flome, and Peter Joski, *The Distribution of Health Insurance Coverage Among Pregnant Women, 1999* (Washington, DC: March of Dimes, April 2001).

²⁹ American Association of Birth Centers, forthcoming survey data, 2008.

³⁰ Letter from Ralph Hale, American College of Obstetricians and Gynecologists, to Malika Saada Saar of the Rebecca Project for Human Rights regarding the shackling of incarcerated pregnant women in labor, (June 12, 2007), <http://www.acog.org/departments/underserved/20070612SaarLTR.pdf> (accessed September 22, 2008).

³¹ Vernon Smith et al., Kaiser Commission on Medicaid and the Uninsured, *As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2007 and 2008* (Washington, DC The Kaiser Family Foundation, October 2007); United States Government Accountability Office, *States Reported That Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens* (Washington, DC: GAO, June 2007).

³² Letter from Peter Orszag, CBO Director, to Cong. Nancy Pelosi regarding CBO estimate of SCHIP reauthorization bill, H.R. 3963, October 25, 2007, cited in Kaiser Commission on Medicaid and the Uninsured, *Key Facts: Citizenship Documentation in Medicaid*, (March 2007), <http://www.kff.org/medicaid/upload/7533-02.pdf> (accessed September 25, 2008).

³³ Susheela Singh et al., Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care

(New York, NY: The Alan Guttmacher Institute, 2003).

³⁴ United Nations Population Fund, *State of World Population 2004: The Cairo Consensus at Ten: Population, Reproductive Health and the Global Effort to End Poverty* (New York, NY: UNFPA, 2004).

³⁵ Family Care International: Women Deliver Initiative, "Improve Maternal Health," <http://www.womendeliver.org/facts/maternal.htm> (accessed September 23, 2008).

³⁶ Grimes DA et al., "Unsafe abortion: the preventable pandemic," *Lancet*, 2006, 368(9550):1908–1919.

³⁷ Craig Lasher, *The Future of U.S. Government Funding for Family Planning & Reproductive Health Programs in the Evolving U.S. Aid Architecture*, Research Commentary 3, no.1 (Washington, DC: Population Action International, March 2008).

³⁸ Singh et al., *Adding It Up*, 2008. *Supra* note 33.

³⁹ UNFPA, *Cairo Consensus at Ten*, 2004. *Supra* note 34.

⁴⁰ Global Health Council, "Where do child deaths occur?" http://www.globalhealth.org/child_health/child_mortality/where_occur/ (accessed September 25, 2008).

⁴¹ United Nations General Assembly, *Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: Midway to the Millennium Development Goals* (New York, NY: United Nations, April 2008).

⁴² United States Government Accountability Office, *Global Health Spending Requirement Presents Challenges for Allocating Prevention Funding under the President's Emergency Plan for AIDS Relief* (Washington, DC: GAO, April 2006).

⁴³ Committee for the Evaluation of the President's Emergency Plan for AIDS Relief (PEPFAR) Implementation, *Institute of Medicine, PEPFAR Implementation: Progress and Promise* (Washington, DC: The National Academies Press, March 2007), 113.

⁴⁴ United Nations, *Declaration of Commitment on HIV/AIDS, 2008*. *Supra* note 41.

⁴⁵ Office of the High Commissioner for Human Rights, *Convention on the Elimination of Discrimination Against Women: Status of Ratification* (New York, NY: United Nations, last updated February 15, 2008).

Advancing Reproductive Rights and Health in a New Administration

Appendix

Increase Funding for the Title X Family Planning Program to \$700 million. The Title X family planning program is vital to our nation's health care safety net, providing preventive health services to nearly five million low-income and uninsured women and men each year, at more than 4,400 health centers nationwide. Recent data confirm its cost-effectiveness. For every \$1.00 spent to provide services in the nationwide network of publicly-funded family planning clinics, \$4.02 is saved in Medicaid expenses. Yet current funding is woefully inadequate given the increasing demand for services, the rising cost of prescription drugs and lab tests, and increasing costs for health care personnel. FY 2008 program funding is \$300 million. Had its budget kept up with medical inflation since 1980, program funding would now be \$759 million. We urge the President to include \$700 million for Title X in his first budget submitted to Congress.

➤ **Statutory Authority for the Title X Family Planning Program**

Title X of the Public Health Service Act, known as the Title X Family Planning Program, was enacted in 1970 to "assist in making comprehensive voluntary family planning services readily available to all persons desiring such services."¹ Title X authorizes the Secretary to make grants to public or nonprofit entities to provide family planning services, with priority given to person from low-income families.

➤ **Administration of the Title X Family Planning Program**

The program is administered within the Office of Public Health and Science, Office of Population Affairs by the Office of Family Planning. It is located within the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services. The Deputy Assistant Secretary of Population Affairs (DASPA) oversees the program.

➤ **Recent Funding History**

FY	Funding for Title X
2004	278,300,000
2005	286,000,000
2006	283,100,000
2007	283,100,000
2008	300,000,000

➤ **Suggested Budget and Appropriations Language**

"Provided further, That of the funds made available under this heading, [\$300,000,000] \$700,000,000 shall be for the program under title X of the Public Health Service Act to provide for voluntary family planning projects."

Note that the relevant change is in brackets, as it would appear in the Budget of the United States Government—Appendix.

¹ Family Planning Services & Population Research Act of 1970, Pub. L. No. 91-572, 84 Stat. 1504 (1970) (codified at 42 U.S.C. §§ 300 et seq.).

Expand Coverage of Medicaid-Funded Family Planning Services. Medicaid provides cost-effective family-planning services for millions of low-income Americans. However, states that have sought to expand access to family planning services must navigate a cumbersome, time-consuming, administrative process. The President should submit a budget to Congress that requires states to establish parity between the income level at which a woman is eligible for pregnancy care and the income level at which she is eligible for family planning services under Medicaid. This important change would expand eligibility for family planning services to more than three million women each year, prevent more than 500,000 unintended pregnancies, and allow both states and the federal government to achieve significant savings

➤ **Congressional Budget Office (CBO) Estimated Savings of Similar Proposal**

The Congressional Budget Office estimated in July 2007 that a provision included in the Children's Health and Medicare Protection Act (H.R. 3162) resulted in cost savings of \$200 million over 5 years and \$400 million over 10 years. The proposal requested here expands eligibility for family planning services beyond the proposal scored by CBO; as such, the estimate would be expected to result in savings greater than \$400 million over 10 years.

➤ **Suggested Legislative Language As Basis for Budget Request**

The Unintended Pregnancy Reduction Act (S. 1075/H.R. 2523) was introduced in the 110th Congress by Senators Hillary Rodham Clinton (D-NY) and Harry Reid (D-NV) in the Senate and Representative Nita Lowey (D-NY) in the House. The bill amends Title XIX of the Social Security Act to expand eligibility for family planning services under the Medicaid program.

Invest in Comprehensive Sex Education. Complete, accurate, and age-appropriate sex education helps young people reduce their risk of unintended pregnancies and sexually transmitted infections (STIs), including HIV/AIDS. Programs that include information about both abstinence and contraception help keep young people safe by delaying sexual activity and increasing contraceptive use when they do have sex. Moreover, most parents agree with a broad range of professional health organizations that young people should receive comprehensive sex education. Currently, the United States has no federal sex education program. The President should include at least \$50 million to promote comprehensive sex education in our schools and communities nationwide in his first budget submitted to Congress.

➤ **Suggested Budget Language**

In the Budget of the United States Government for Fiscal Year 2010, the President should demonstrate the Administration's support for investing in comprehensive sex education with the following statement:

The President intends to work with Congress on a legislative proposal that provides at least \$50 million for sex education programs that go beyond abstinence-only to embrace more comprehensive approaches that include age-appropriate information and education that fosters healthy relationships and encourages appropriate preventive health behaviors. At a minimum, funded programs:

- (A) Are age-appropriate and medically accurate;
- (B) Stress the value of abstinence while not ignoring those young people who have had or are beginning to have sexual intercourse;
- (C) Provide information about health benefits and side effects of contraceptives, including condoms, as a means to prevent pregnancy and reduce the risk of contracting sexually transmitted infections, including HIV/AIDS;
- (D) Encourage family communication about sexuality between parents and children;
- (E) Teach young people the skills to make responsible decisions about sexuality, including how to avoid unwanted verbal, physical, and sexual advances and refrain from making unwanted verbal, physical, and sexual advances;
- (F) Teach young people how alcohol and drug use can effect responsible decision-making; and
- (G) Do not teach or promote religion.

Restore Incentives to Provide Affordable Birth Control at College Health Centers and Certain Safety Net Providers. Nearly four million women who depend on college health centers and safety net providers for their birth control have seen prices increase dramatically as an unintended consequence of a change in the Deficit Reduction Act. Birth control that previously cost \$5 to \$10 per month is now prohibitively expensive for many women and students, costing as much as \$40 or \$50 a month. This problem can be easily fixed administratively, at no cost to taxpayers. The Secretary of Health and Human Services (HHS) should issue a new regulation to alleviate this burden on college-age and low-income women.

➤ **Deficit Reduction Act Provision Authorizing Secretary to Address Issue**

The Deficit Reduction Act specifies the purchasers to whom sales at nominal prices may be excluded from the calculation of best price: a) a covered entity described in section 340B(a)(4) of the Public Health Service Act; b) an intermediate care facility for the mentally retarded; and c) a State-owned or operated nursing facility.²

The statute includes a fourth category for “[a]ny other facility or entity that the Secretary determines is a safety net provider to which sales of such drugs at a nominal price would be appropriate based on the factors described in clause (ii).”³ The four factors intended to guide the Secretary’s decision to allow additional providers to purchase nominally-priced drugs include a) the type of facility or entity; b) the services provided by the facility or entity; c) the patient population served by the facility or entity; and d) the number of other facilities or entities eligible to purchase at nominal prices in the same service area.⁴

➤ **Bush Administration Regulation that Declined to Restore Affordable Birth Control**

The Centers for Medicare and Medicaid Services (CMS) proposed a rule to implement various provisions of the Deficit Reduction Act, including the limitation on facilities to which nominal price applies. Despite the statutory provision allowing the Secretary of HHS to designate other facilities eligible to purchase nominally-priced drugs, Secretary Leavitt declined “to expand the exclusion to other safety-net providers” based on his belief “that the entities specified in the statute are sufficiently inclusive and capture the appropriate safety net providers.”⁵

Although CMS received numerous comments urging it to identify additional safety-net providers, it declined to do so when promulgating the final rule.⁶ Many commenters argued that nominal pricing exceptions should continue to be extended to safety-net providers that offer low-cost birth control to low-income, uninsured or underinsured patients, such as non-Title X family planning clinics and college and university health centers. However, CMS did “not agree that the broad categories of populations served by the clinics suggested by the commenters, which include student health centers, constitute a vulnerable population.”⁷ As such, the final Medicaid prescription drug regulation “exercises the Secretary’s authority to choose not to expand that list of entities.”⁸

➤ **Procedural Requirements to Revise Regulation**

In order to amend the existing rule, CMS must follow notice and comment rulemaking procedures set out in the Administrative Procedure Act (APA).⁹ Because the APA defines “rulemaking” as “agency

² 42 U.S.C. § 1396r-8(c)(1)(D)(i)(I)-(III) (2008).

³ *Id.* at (c)(1)(D)(i)(IV).

⁴ *Id.* at (c)(1)(D)(ii).

⁵ Dep’t of Health and Human Svcs., Medicaid Program; Prescription Drugs, 71 Fed. Reg. 77,174, 77,184-85 (proposed Dec. 22, 2006) (to be codified at 42 C.F.R. pt. 447).

⁶ Dep’t of Health and Human Svcs., Medicaid Program; Prescription Drugs, 72 Fed. Reg. 39,142, 39,204 (July 17, 2007) (to be codified at 42 C.F.R. pt. 447).

⁷ *Id.* at 39,205.

⁸ *Id.* at 39,204.

⁹ See 5 U.S.C. § 553(b)-(d) (2008). First, an agency must publish a general notice of the proposed rule in the Federal Register, along with information about the legal authority for the rule. During the comment period, the agency gives interested persons the opportunity to submit their own written views, data, and arguments on the proposed rule. The agency considers the public’s comments and decides either to withdraw the proposed rule or to publicly promulgate a final rule. If the agency opts to finalize the proposed rule, this final rule must be a “logical outgrowth” of the proposed rule. See *Weyerhaeuser Co. v. Costle*, 590 F.2d 1011,

process for formulating, amending, or repealing a rule”¹⁰ and requires notice and comment procedures for “rulemaking,”¹¹ these procedures generally must precede a decision to amend a rule.¹²

The APA’s requirements apply whether or not an agency acts pursuant to a Presidential directive.¹³ Despite the President’s position as head of the Executive Branch, he may not promulgate regulations himself, but he may direct an agency to exercise its authority, delegated by Congress, to promulgate regulations.

➤ **Suggested Language for Presidential Memorandum to the Department of Health and Human Services**

Subject: Restoring Access of Certain Family Planning Clinics and College and University Health Centers and their Patients to Affordable Birth Control

In 1990, Congress passed the Medicaid Prescription Drug Rebate Program [Section 4401 (a) (3) of Title IV of the Omnibus Budget Reconciliation Act of 1990] to ensure that state Medicaid programs receive the lowest or “best price” for drugs in the market with some exceptions. One exception included drugs purchased at “nominal” or significantly reduced prices by certain safety-net providers, including family planning clinics and college and university health centers. In 2006, Congress passed the Deficit Reduction Act of 2005 (DRA), in part to address a concern that manufacturers were selling nominally priced drugs for purposes not intended by the 1990 Act.

Accordingly, the DRA included a provision [Section 6001 (d)] that restricts the purchasers for which sales at nominal prices may be excluded from the calculation of best price. In addition to specifying three categories of health care entities not subject to the restriction, Congress gave the Secretary of Health and Human Services (HHS) authority and guidelines to designate additional entities to which the sale of drugs at nominal prices would be appropriate.

Despite the authority provided to HHS under the statute, the Center for Medicare and Medicaid Services (CMS) chose not to designate additional entities whose purchase of nominally priced drugs would be exempt from the Medicaid best price in the final Medicaid prescription drug regulation published on July 17, 2007 in the Federal Register (72 FR 39142) and codified at 42 CFR 447.508. As a result, drug manufacturers are no longer willing to sell drugs and devices at nominal prices to hundreds of family planning clinics and every college and university health center, thus increasing the cost of birth control to these clinics and their patients by as much as ten-fold. Millions of low-income women and college students have lost access to affordable birth control dramatically increasing their risk of unintended pregnancy.

For these reasons, you have informed me that you will promulgate new regulations to designate additional entities to which the sale of drugs and devices at a nominal price would be appropriate, thereby restoring access of family planning clinics and college and university health centers to affordable birth control. I hereby direct you to take that action within thirty days to designate a fourth category of entities that includes family planning clinics and college and university health centers, under Section 1927 (c) (1) (D) (IV) of the Social Security Act.

You are hereby authorized and directed to publish this memorandum in the Federal Register.

1031 (D.C. Cir. 1978) (striking down EPA regulations because they were not a “logical outgrowth” of the proposed rules”). The published final rule must contain a “concise general statement of [its] basis and purpose” (5 U.S.C. § 553(c)), and a date for the rule to become effective, which cannot be less than thirty days from the date of publication (5 U.S.C. § 553(d)).

¹⁰ 5 U.S.C. § 551(5) (2008).

¹¹ 5 U.S.C. § 553 (2008).

¹² See *Columbia Falls Aluminum Co. v. Env'tl. Protection Agency*, 139 F.3d 914, 919 (D.C. Cir. 1998) (“Once a rule is final, an agency can amend it only through a new rulemaking.”); *Homemakers N. Shore, Inc. v. Bowen*, 832 F.2d 408, 413 (7th Cir. 1987) (“once a regulation is adopted by notice-and-comment rulemaking . . . , its text may be changed only in that fashion.”).

¹³ See *Chamber of Commerce of U.S. v. Reich*, 74 F.3d 1322, 1327 (D.C. Cir. 1996) (“that the Secretary’s regulations are based on the President’s Executive Order hardly seems to insulate them from judicial review under the APA, even if the validity of the Order were thereby drawn into question”).

Strike Budgetary Restrictions That Block Women’s Access to Abortion Care. Bans on public funding for abortion services have severely restricted access to safe abortion care for women, disproportionately affecting poor women, women of color, and certain immigrant women. The President’s budget should strike language restricting abortion funding for (i) Medicaid-eligible women and Medicare beneficiaries (Hyde amendment); (ii) federal employees and their dependents (FEHB program); (iii) residents of the District of Columbia; (iv) Peace Corps volunteers; (v) Native-American women; and (vi) women in federal prisons ...

Hyde Amendment and Related Funding Restrictions

➤ **Current Language of Relevant Funding Restrictions**

Population	Location of Provision	Relevant Language
<p>Medicaid-Eligible Women and Medicare Beneficiaries</p>	<p>Budget of the United States Government—Appendix. Detailed Budget Estimates by Agency. Title V General Provisions—This Act (Departments of Health and Human Services, Education, and Labor). Page 766-77 of FY2009 Budget.</p>	<p>“Sec. 507. (a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion.</p> <p>(b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act shall be expended for health benefits coverage that includes coverage of abortion.</p> <p>(c) The term “health benefits coverage” means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.</p> <p>Sec. 508. (a) The limitations established in the preceding section shall not apply to an abortion—</p> <p>(1) if the pregnancy is the result of an act of rape or incest; or</p> <p>(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.”</p>
<p>Federal Employees</p>	<p>Budget of the United States Government—Appendix. Detailed Budget Estimates by Agency. Title VI General Provisions—This Act (Department of the Treasury). Page 975 of FY2009 Budget.</p>	<p>“Sec. [615] 609. No funds appropriated by this Act shall be available to pay for an abortion, or the administrative expenses in connection with any health plan under the Federal employees health benefits program which provides any benefits or coverage for abortions.</p>

		Sec. [616] 610. The provision of section [615] 609 shall not apply where the life of the mother would be endangered if the fetus were carried to term, or the pregnancy is the result of an act of rape or incest.”
District of Columbia Residents	Budget of the United States Government—Appendix. Detailed Budget Estimates by Agency. General Provisions—District of Columbia (Other Independent Agencies). Page 1157 of FY2009 Budget.	“Sec. [824] 825. None of the funds appropriated under this Act shall be expended for any abortion except where the life of the mother would be endangered if the fetus were carried to term or where the pregnancy is the result of an act of rape or incest.”
Peace Corps Volunteers	Budget of the United States Government—Appendix. Detailed Budget Estimates by Agency. Peace Corps—Federal Funds. Page 836 of FY2009 Budget.	“ <i>Provided</i> , That none of the funds appropriated under this heading shall be used to pay for abortions.”
Native American Women	N/A	Proposing to delete the above provision on Page 766-77 (Department of Labor) would also reach the restrictions on Native American women, since Section 806 of the Indian Health Care Improvement Act, Pub. L. No. 94-437, imports into the Indian Health Service any restrictions on abortion funding imposed on the Department of Health and Human Services. See Indian Health Care Improvement Act, Pub. L. No. 94-437, § 806 (“Any limitation on the use of funds contained in an Act providing appropriations for the Department of Health and Human Services for a period with respect to the performance of abortions shall apply for that period with respect to the performance of abortions using funds contained in an Act providing appropriations for the Indian Health Service”).
Women in Federal Prisons	Budget of the United States Government—Appendix. Detailed Budget Estimates by Agency. General Provisions—Department of Justice. Page 731 of FY2009 Budget.	“Sec. 202. None of the funds appropriated by this title shall be available to pay for an abortion, except where the life of the mother would be endangered if the fetus were carried to term, or in the case of rape: <i>Provided</i> , That should this prohibition be declared unconstitutional by a court of competent jurisdiction, this section shall be null and void.”

➤ **Suggestion for Striking Relevant Funding Restrictions**

For each of the above provisions,

[Sec. 507. (a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion. (b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act shall be expended for health benefits coverage that includes coverage of abortion. (c) The term “health benefits coverage” means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.]

Note that the provision is in brackets, as it would appear in the Budget of the United States Government—Appendix.

➤ **Clinton Administration Precedent for Striking Relevant Funding Restrictions**

In the Budget for Fiscal Year 1999, for example, President Clinton struck Sec. 103 of the general provisions for the Department of Justice. Section 103 prohibited any funds appropriated by the title to pay for an abortion unless the life of the mother was threatened or in the case of rape. The provision was in brackets, as above. The bracketed provision included a footnote, which read, “The Administration proposes to delete this provision and will work with the Congress to address the issue of abortion funding.”

Strike Budgetary Restrictions That Block Women’s Access to Abortion Care. ... The budget submitted to Congress also should omit language known as the Federal Refusal Clause (Weldon amendment) and call on Congress to reject this language in its annual health spending bill. The Weldon amendment denies federal funding if an “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.”

Weldon Amendment

➤ **Current Language of Relevant Funding Restrictions**

Sec. 508 ... (d)(1) 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.

(2) In this subsection, the term “health care entity” includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.”

➤ **Suggestion for Striking Relevant Funding Restriction**

[Sec. 508 ... (d)(1) 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.

(2) In this subsection, the term “health care entity” includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.”]

Note that provision is in brackets, as it would appear in the Budget of the United States Government—Appendix.

Increase Funding for the Title V Maternal and Child Health (MCH) Services Block Grant to \$850 Million.

This critical safety net program improves maternal health and reduces infant mortality by providing direct health services; important enabling services, including transportation, translation, and family support; population-based screenings and education; and infrastructure needs assessment. Current funding is \$666 million. We urge the President to fund the Title V MCH Services Block Grant at its authorized level of \$850 million in his first budget submitted to Congress.

➤ **Statutory Authority for the Maternal and Child Health Block Grant**

Congress enacted Title V of the Social Security Act in 1935, 42 U.S.C. §§701-710. In 1981, Title V funding to states was converted to a block grant as a part of the Omnibus Budget Reconciliation Act of 1981. This restructuring consolidated seven existing maternal and child health programs. Additional amendments in the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239, further defined how funds could be used and increased states’ reporting requirements on key indicators of maternal and child health.

➤ **Administration of the Maternal and Child Health Block Grant**

The Maternal and Child Health Block Grant is administered by the Division of State and Community Health (DSCH) within the Maternal and Child Health Bureau at the Health Resources and Services Administration, Department of Health and Human Services. The DSCH oversees the day-to-day administration of the Maternal and Child Health Services Title V Block Grant Program and acts as liaison to 10 HRSA field offices that serve the States and jurisdictions.

➤ **Recent Funding History**

FY	Funding for MCH Block Grant
2003	730,710,000
2004	730,817,000
2005	723,928,000
2006	692,521,000
2007	693,000,000
2008	693,000,000

➤ **Suggested Change to Relevant Budget Table**

Program and Financing (in million of dollars)

Identification code 75-0350-0-1-550 2008 actual 2009 est. 2010 est.

Obligations by program activity:

00.18 Maternal and Child Health Block Grant.....693 693 850

Put Forward a Health Care Reform Plan That Guarantees Equal Access to Comprehensive, High-Quality, Affordable Health Care for All. It is imperative that the President put forward a health care reform plan that guarantees access to comprehensive, high-quality, affordable health care for all. This plan should ensure culturally and linguistically-appropriate, patient-centered care that will reduce disparities in access and health outcomes. Comprehensive benefits must include access to the full range of reproductive health services, including contraception, maternity care, and abortion care. To be successful, such a plan must reform our payment system, guarantee quality, and control rising costs in the health care system. In developing any health care reform plan, it is critical to harness the expertise of women's health advocates so that women's health concerns are adequately addressed.

Note: this request requires the President to take informal steps in the first 100 days to make health care reform a priority.

Reverse the HHS Federal Refusal Rule. A proposed HHS rule published on August 26, 2008 would obstruct access to reproductive and other health services, counseling, and referrals and could open the door for more widespread health service refusals. Federal law has long protected the rights of health care professionals to refuse to provide abortion services, while ensuring patient access to needed care. This new, expansive interpretation of existing law not only takes patients' health care needs out of the equation but also conflicts with accepted medical standards of health care and treatment and creates possible conflicts with state laws designed to enhance access to reproductive health services. If not withdrawn, the Secretary of HHS should take immediate steps to reverse this policy.

➤ **Legal Authority to Rescind the HHS Rule**

An agency is entitled to adjust existing rules, including rescind them, to reflect its policies, so long as the change is amply justified with a “reasoned analysis”¹⁴ and does not conflict with clear Congressional intent.¹⁵ Procedurally, in order to rescind the HHS rule, the Secretary of HHS must initiate informal rulemaking, also known as “notice and comment” rule making, as required by the Administrative Procedures Act (APA).¹⁶ A rule that has been promulgated through informal rule making must also give notice and an opportunity to comment prior to an agency’s decision to rescind the rule.¹⁷ Secretary Leavitt promulgated the rule according to notice and comment requirements. As such, a new administration must also follow notice and comment rule making as required under the APA and provide a “reasoned analysis” for the change in policy within its notice when it rescinds the HHS rule.

The APA’s requirements apply whether or not an agency acts pursuant to a Presidential directive.¹⁸ Despite the President’s position as head of the Executive Branch, he may not promulgate regulations himself, but he may direct an agency to exercise its authority, delegated by Congress, to promulgate regulations.

➤ **Suggested Language for Presidential Memorandum**

Subject: Department of Health and Human Services “Provider Conscience Regulation”

In [December 2008/January 2009], the Department of Health and Human Services (HHS) adopted a rule, that it calls the “Provider Conscience Regulation,” which purportedly was issued to ensure that HHS funds “do not support morally coercive or discriminatory practices or policies” and to educate recipients of those funds about their legal obligations under existing federal refusal laws. The underlying laws primarily give individuals and institutions the ability to refuse to provide, or prohibit requiring the performance or participation in, abortion or sterilization services. The Rule, however, broadens the scope and reach of these existing laws beyond Congressional intent.

The Rule threatens to impose burdens on patients’ access to vital health services and information. The rule is unnecessary in light of Title VII of the Civil Rights Act of 1964, which prohibits employment discrimination on the basis of religion, and likely to cause confusion to the regulated community because of the overlap with Title VII protections—concerns expressed by the Equal Employment Opportunity Commission (EEOC) in comments submitted to HHS that essentially oppose the rule. Furthermore, HHS failed to undertake coordination with the

¹⁴ *Motor Vehicles Mfrs. Assn. of United States, Inc. v. State Farm Mut. Automobile Ins. Co.*, 463 U.S. 29, 42 (1983), quoting *American Trucking Assoc., Inc. v. Atchison, T. & S.F.R. Co.*, 387 U.S. 397, 416 (1967).

¹⁵ *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-843 (1984).

¹⁶ See 5 U.S.C. § 553(b)-(d) (2008) (setting forth notice and comment rule making procedures); 5 U.S.C. § 551(5) (defining “rule making” as an “agency process for formulating, amending, or repealing a rule”).

¹⁷ *Consumer Energy Council of Am. v. Fed. Energy Regulatory Comm’n*, 673 F.2d 425, 446 (D.C. Cir. 1982), aff’d 463 U.S. 1216 (1983), rehearing denied 463 U.S. 1250 (1983) (“The value of notice and comment prior to repeal of a final rule is that it ensures that an agency will not undo all that it accomplished through its rulemaking without giving all parties an opportunity to comment on the wisdom of repeal.”). See also, *Columbia Falls Aluminum Co. v. Envtl. Protection Agency*, 139 F.3d 914, 919 (D.C. Cir. 1998) (“Once a rule is final, an agency can amend it only through a new rulemaking.”); *Homemakers N. Shore, Inc. v. Bowen*, 832 F.2d 408, 413 (7th Cir. 1987) (“once a regulation is adopted by notice-and-comment rulemaking . . . , its text may be changed only in that fashion”).

¹⁸ See *Chamber of Commerce of U.S. v. Reich*, 74 F.3d 1322, 1327 (D.C. Cir. 1996) (“that the Secretary’s regulations are based on the President’s Executive Order hardly seems to insulate them from judicial review under the APA, even if the validity of the Order were thereby drawn into question”).

appropriate expert federal agencies, including the EEOC, as required under the principles and directives of Executive Order 12866 when it promulgated the Rule.

For these reasons, you have informed me that you will propose to rescind the Rule in accordance with the "notice and comment" procedures of the Administrative Procedure Act. I hereby direct you to take that action as soon as possible. I further direct that, within 30 days, you publish in the Federal Register the notice rescinding the Rule for public comment.

You are hereby authorized and directed to publish this memorandum in the Federal Register.

Rescind the Global Gag Rule. On his second day in office, President Bush issued an executive order, known as the “global gag rule,” that forces foreign recipients of U.S. family planning aid to stop using their own funds for legal abortion-related services or to advocate for safe abortion laws and policies. The global gag rule has stifled the public debate in developing countries where clandestine abortion takes an enormous toll on women’s health and lives. It has also led to dramatic cutbacks in services, closures of clinics, and serious shortfalls in contraceptive supplies. The President should immediately rescind this dangerous policy, restore cut funding, and remove this politically-motivated obstacle to health care for women around the world.

➤ **Clinton Administration Memorandum Rescinding Global Gag Rule to the Acting Administrator of the Agency for International Development**

Subject: AID Family Planning Grants/Mexico City Policy

The Foreign Assistance Act of 1961 prohibits nongovernmental organizations ("NGO's") that receive Federal funds from using those funds "to pay for the performance of abortions as a method of family planning, or to motivate or coerce any person to practice abortions." (22 U.S.C. 2151b(f)(1)). The August 1984 announcement by President Reagan of what has become known as the "Mexico City Policy" directed the Agency for International Development ("AID") to expand this limitation and withhold AID funds from NGO's that engage in a wide range of activities, including providing advice, counseling, or information regarding abortion, or lobbying a foreign government to legalize or make abortion available. These conditions have been imposed even where an NGO uses non-AID funds for abortion-related activities.

These excessively broad anti-abortion conditions are unwarranted. I am informed that the conditions are not mandated by the Foreign Assistance Act or any other law. Moreover, they have undermined efforts to promote safe and efficacious family planning programs in foreign nations. Accordingly, I hereby direct that AID remove the conditions not explicitly mandated by the Foreign Assistance Act or any other law from all current AID grants to NGO's and exclude them from future grants.

Restore Funding to the United Nations Population Fund (UNFPA). The United States has failed to support the critical work that UNFPA does to promote voluntary family planning and maternal health in 150 countries. Over the last seven years, the Bush Administration has distorted the application of the Kemp-Kasten law to justify its political decision to withhold the funds that Congress has consistently appropriated for this critical partner agency. The President should make available to UNFPA as soon as possible all funds appropriated by Congress for FY 2009. Further, he should include \$65 million within the International Organizations and Programs Account for a U.S. contribution to UNFPA in his FY 2010 budget request to Congress.

➤ **Suggested Language for Presidential Memorandum to the Secretary of State**

Subject: United Nations Population Fund (UNFPA)

The President directs the Secretary of State to release all FY09 Congressionally appropriated funds to UNFPA with due speed.

Provide \$1 Billion for International Family Planning Programs. In the last decade, U.S. funding for international family planning programs has declined by almost 40 percent. Today, more than 200 million women in the developing world wish to delay, space, or complete childbearing, but do not have access to modern contraceptives. The President should increase investment in international family planning, including programs to help ensure that those displaced by conflict and natural disasters have full access to life-saving reproductive health care. In addition, it is particularly important that reproductive health services be integrated into programs addressing HIV/AIDS and vice versa. Current funding is \$461 million for USAID’s overseas family planning program; the Bush Administration, for the seventh consecutive year, blocked any U.S. contribution to UNFPA. We urge the President to include \$1 billion for international family planning programs in his first budget submitted to Congress.

➤ **Statutory Authority for the International Family Planning Program**

Section 104 of the Foreign Assistance Act of 1961, as amended in 1973, authorizes the President, “in order to increase the opportunities and motivation for family planning and to reduce the rate of population growth . . . to furnish assistance, on such terms and conditions as he may determine, for voluntary population planning.”¹⁹ Because no foreign assistance authorization legislation has been enacted into law since 1985, the annual Department of State, Foreign Operations, and Related Programs Appropriations Act has both authorized and appropriated funds for the international family planning program in recent years.

➤ **Administration of the International Family Planning Program**

The bilateral program is administered by USAID by the Office of Population and Reproductive Health within the Bureau for Global Health. The U.S. contribution to UNFPA is administered by the Bureau for Population, Refugees, and Migration of the Department of State.

➤ **Recent Funding History**

FY	USAID Bilateral Funding for International Family Planning (enacted levels)²⁰	U.S. Contributions to UNFPA
2004	429,500,000	0
2005	437,300,000	0
2006	435,600,000	0
2007	435,600,000	0
2008	457,300,000	0

➤ **Suggested Budget and Appropriations Language**

(i) Bilateral USAID Program. Title III, Global Health and Child Survival

“*Provided further*, That of the funds appropriated under this paragraph the following amounts should be allocated as follows: . . . and [\$395,000,000] *\$935,000,000* for family planning/reproductive health, including in areas where population growth threatens biodiversity or endangered species:”

Note that the relevant change is in brackets, as it would appear in the Budget of the United States Government—Appendix.

¹⁹ Foreign Assistance Act of 1961, Pub. L. No. 87-195, 75 Stat.424 (1961), Sec. 104 as added by sec. 2(3) of the Foreign Assistance Act of 1973, 87 Stat. 715 (1973) (codified at 22 U.S.C. 2151b.).

²⁰ Reflects across-the-board budget cuts of up to 1%.

(ii) U.S. Contribution to UNFPA. Title VI, Contributions to the United Nations Population Fund

“SEC. 660. (a) LIMITATIONS ON AMOUNT OF CONTRIBUTION- Of the amounts made available under *the* ‘International Organizations and Programs’ [and ‘Global Health and Child Survival’] account[s] for fiscal year [2008] *2010*, [\$40,000,000] *\$65,000,000* shall be made available for the United Nations Population Fund (UNFPA): [*Provided*, That of this amount, not less than \$7,000,000 shall be derived from funds appropriated under the heading ‘International Organizations and Programs’.]”

Note that the provision is in brackets, as it would appear in the Budget of the United States Government—Appendix.

De-Fund Abstinence-Only Programs. The Bush Administration has promoted dangerous, ineffective abstinence-only programs that contain inaccurate information about sexual and reproductive health. Since 1998, federal policymakers have allocated more than \$1.3 billion taxpayer dollars for abstinence-only programs, despite overwhelming evidence that this massive federal expenditure has failed completely to achieve its stated goals. The President’s budget should de-fund abstinence-only programs by (i) abolishing the abstinence-only program within the Title V MCH Services Block Grant; (ii) abolishing the Community-Based Abstinence Education program; (iii) de-linking the Adolescent Family Life Act (AFLA) from the A-H definition in the Title V abstinence-only program; and (iv) tightening AFLA program eligibility in order to end funding for all programs that promote an abstinence-only approach.

➤ **Suggested Budget and Appropriations Language**

The President should signal in the *Budget of the United States Government—Appendix* his intention to end funding for abstinence-only programming. Specifically:

(i) Abolishing Section 510(b)(2) of Title V of the Social Security Act

“This legislative proposal provides for [an extension] *the elimination* of the Title V abstinence education program, which provides grants to States to implement abstinence-only education programs.”

(ii) Abolishing the Community-Based Abstinence Education Program

[*Provided further*, That [\$110,836,000] \$136,664,000 shall be for making competitive grants to provide abstinence education (as defined by section 510(b)(2) of the Social Security Act) to adolescents, and for Federal costs of administering the grant: *Provided further*, That grants under the immediately preceding proviso shall be made only to public and private entities which agree that, with respect to an adolescent to whom the entities provide abstinence education under such grant, the entities will not provide to that adolescent any other education regarding sexual conduct, except that, in the case of an entity expressly required by law to provide health information or services the adolescent shall not be precluded from seeking health information or services from the entity in a different setting than the setting in which abstinence education was provided: *Provided further*, That within amounts provided herein for abstinence education for adolescents, up to [\$10,000,000] \$10,000,000 may be available for a national abstinence education campaign: *Provided further*, That in addition to amounts provided herein for abstinence education for adolescents, [\$4,500,000] \$4,410,000 shall be available from amounts available under section 241 of the Public Health Service Act to carry out evaluations (including longitudinal evaluations) of adolescent pregnancy prevention approaches:]

Note that the provision is in brackets, as it would appear in the Budget of the United States Government—Appendix.

Program and Financing (in million of dollars)

Identification code 75-1536-0-1-506 2008 actual 2009 est. 2010 est.

Obligations by program activity:

01.30 Abstinence education (discretionary)109 137 0

(iii) De-linking the Adolescent Family Life Act (AFLA) from the A-H definition in the Title V Abstinence-Only Program

The President should ask Congress to remove appropriations language that—by waiving Congressionally approved earmarks under section 2010(c) of title XX of the Public Health Service

Act and tying prevention service demonstration grants to section 510(b)(2) of title V of the Social Security Act—distorts the original intention of AFLA:

["*Provided*, That of the funds made available under this heading for carrying out title XX of the Public Health Service Act, \$13,120,000 shall be for activities specified under section 2003(b)(2), all of which shall be for prevention service demonstration grants under section 510(b)(2) of title V of the Social Security Act, as amended, without application of the limitation of section 2010(c) of said title XX"]

Note that the relevant language to be deleted is in brackets, as it would appear in the Budget of the United States Government—Appendix.

Review Policies that Restrict Access to Emergency Contraception (EC) and Eliminate Restrictions that Lack Scientific Support. We urge the President to direct relevant agencies to reexamine Bush Administration policies that have blocked or limited women’s access to EC. The President should direct the Secretary of Defense to add EC to the military’s basic core formulary ...

Department of Defense Basic Core Formulary

➤ Legal Authority for Department of Defense Basic Core Formulary

The Department of Defense was directed by Section 1074g of Chapter 55 of Title 10 of the United States Code to establish an effective, efficient, integrated pharmacy benefits program for the military health system, to include a formulary of pharmaceutical agents.²¹ This statutory requirement was implemented by regulation,²² which established the TRICARE Pharmacy Benefits Program and formulary management for pharmaceutical agents dispensed through military treatment facility (MTF) pharmacies, the TRICARE Mail Order Pharmacy Program, and the TRICARE Retail Pharmacy Program.

➤ Substantive and Procedural Requirements to Amend the Basic Core Formulary

The Department of Defense Pharmacy and Therapeutics (P&T) Committee was established in order to “assure that the selection of pharmaceutical agents for the uniform formulary is based on broadly representative professional expertise concerning relative clinical and cost effectiveness of pharmaceutical agents and accomplishes an effective, efficient, integrated pharmacy benefits program.”²³ The P&T Committee is charged with developing a uniform formulary of pharmaceutical agents, reviewing such formulary on a periodic basis, and making additional recommendations regarding the formulary as the committee determines necessary and appropriate.²⁴ The P&T Committee accomplishes formulary management through the Uniform Formulary, the Basic Core Formulary, and the Extended Core Formulary. Pharmaceutical agents are selected for inclusion in the Uniform Formulary (UF) based upon “the relative clinical effectiveness and cost effectiveness.”²⁵

The Basic Core Formulary (BCF) is a subset of the pharmaceutical agents that are included in the UF. The BCF is the minimum formulary of drugs that must be available at all MTFs. A pharmaceutical agent will be included on the BCF if it meets the following conditions:

- (1) the pharmaceutical agent is classified as generic or formulary on the UF; (2) the pharmaceutical agent is in a therapeutic class that supports the primary care scope of practice for Primary Care enrollment sites; and (3) the pharmaceutical agent is determined to provide greater value than other UF agents in that therapeutic class because of the DoD P&T Committee’s determination of the relative clinical effectiveness and relative cost effectiveness of the agent.²⁶

The Director of TRICARE Management Activity has ultimate responsibility for formulary management.²⁷ The Director’s final decisions “are based on the Director’s review of the final determinations of the P&T Committee and the comments and recommendations of the Beneficiary Advisory Panel.”²⁸

²¹ 10 U.S.C. 1074g

²² 32 C.F.R. 199.21.

²³ *Id.* at (c).

²⁴ 10 U.S.C. 1074g.

²⁵ 32 C.F.R. 199.21 (a)(3)(ii).

²⁶ See Memorandum from William Winkenwerder, Jr., MD, The Assistant Secretary of Defense, to Surgeon General of the Army, Surgeon General of the Navy, Surgeon General of the Air Force, Subject: TRICARE Pharmacy Benefit Program Formulary Management (Dec. 22, 2004), *available at* <http://www.ha.osd.mil/policies/2004/04-032.pdf>.

²⁷ *Id.*; 32 C.F.R. 199.21(g)(3).

²⁸ 32 C.F.R. 199.21(g)(3). The Beneficiary Advisory Panel is an independent advisory panel for the Director of TMA in the development of a uniform formulary. See Charter, Uniform Formulary Beneficiary Advisory Panel, *available at* <http://www.tricare.mil/pharmacy/BAP/BAPCharter27July2006.pdf>. The BAP did not exist in 2002, when the original determination was made to add Plan B[®] to the BCF.

Once a pharmaceutical agent is added to the BCF, all MTFs must then have it on their formulary, and “the Services have no authority to direct otherwise.”²⁹

➤ **Relevant Background on the Exclusion of Plan B[®] from the Department of Defense Basic Core Formulary**

On February 12, 2002, the P&T Committee Executive Council reviewed the request of a provider at a military treatment facility (MTF) to add Plan B[®], an emergency contraceptive, to the BCF.³⁰ The Council reviewed a variety of factors in its consideration, including Plan B[®]'s increased efficacy over other emergency contraceptive treatments, the cost of Plan B[®], the fact that MTFs already provided emergency contraception therapy with regular oral contraceptives, the need for timely administration of the drug, the recommendations of major medical groups, and the fact that ethical consultants for the three services concluded there were “no apparent reasons to preclude the use of Plan B at MTFs, since it is an FDA-approved contraceptive and not, as some would argue, an abortifacient.”³¹

The Council voted to add Plan B[®] to the BCF but decided that it would not be official until “the Council verifies with [TRICARE Management Authority] that this action is consistent with existing DoD policy.”³²

On March 28, 2002 the Director of the TRICARE Management Authority (TMA) signed an Action Memo approving the recommendation.³³ On April 3, 2002, the co-chair of the P&T Committee informed Council members and service pharmacy consultants of the decision. The Council was informed again of the decision on May 7, 2002.³⁴

However, on May 8, 2002 Co-chairs of the P&T Executive Council reconvened the Council to announce that the Director of TMA had rescinded his earlier approval, and that the Assistant Secretary of Defense for Health Affairs wanted to review the Council's recommendation to include Plan B[®].³⁵ There was no justification or discussion of why approval was rescinded.

➤ **Suggested Language for Presidential Memorandum to the Secretary of Defense**

Subject: Exclusion of Plan B[®] from Military Treatment Facilities

On March 28, 2002, the Director of TRICARE Management Activity, at the recommendation of the Department of Defense Pharmacy and Therapeutics Committee, approved the addition of Plan B[®], an emergency contraceptive pill, to the Basic Core Formulary, the minimum formulary of drugs that must be available at all military treatment facilities. On May 8, 2002, the Director rescinded the earlier approval and removed Plan B[®] from the Basic Core Formulary.

I am informed that in rescinding approval, the Director appears to have based his decision on factors other than the clinical effectiveness, cost effectiveness, and other pertinent factors. Accordingly, I hereby direct that you promptly add Plan B[®] to the Basic Core Formulary, consistent with the original decision of March 28, 2002.

You are hereby authorized and directed to publish this memorandum in the *Federal Register*.

²⁹ See Memorandum from William Winkenwerder, Jr., MD, The Assistant Secretary of Defense, to Surgeon General of the Army, Surgeon General of the Navy, Surgeon General of the Air Force, Subject: TRICARE Pharmacy Benefit Program Formulary Management (Dec. 22, 2004), *available at* <http://www.ha.osd.mil/policies/2004/04-032.pdf>.

³⁰ See Memorandum from Department of Defense, Pharmacoeconomic Center, to Executive Director, TRICARE Management Activity (TMA), Subject: Minutes of the Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Executive Council Meeting 10-12 (Feb. 12, 2002), *available at* http://www.tricare.mil/pharmacy/PT_Cmte/PT_C/Feb_02_PT_Exec_Council_Minutes.pdf.

³¹ *Id.* at 11-12.

³² *Id.* at 12.

³³ See Minutes, Dep't of Def., Pharmacy & Therapeutics Comm. Executive Council Meeting 2 (May 7, 2002), *available at* http://www.tricare.mil/pharmacy/PT_Cmte/PT_C/May_02_PT_%20Exec%20Minutes.pdf.

³⁴ *Id.*

³⁵ *Id.*

Review Policies that Restrict Access to Emergency Contraception (EC) and Eliminate Restrictions that Lack Scientific Support. We urge the President to direct relevant agencies to reexamine Bush Administration policies that have blocked or limited women’s access to EC ... The President should direct ... the Department of Justice should include discussion of EC in its guidelines for hospital treatment of sexual assault survivors ...

Department of Justice Sexual Assault Protocol

➤ Statutory Authority for the Sexual Assault Protocol

The National Protocol for Sexual Assault Medical Forensic Examination³⁶ was developed by the Department of Justice Office on Violence Against Women (OVW). Section 1405 of the Violence Against Women Act (VAWA) of 2000 directed the Attorney General to develop a “recommended national protocol” on sexual assault forensic examinations.³⁷ Prior to developing the protocol, the Attorney General was instructed to review existing national, State, tribal, and local protocols. The Attorney General was also instructed to consult with experts, including rape crisis centers, State and tribal sexual assault and domestic violence coalitions and programs, and programs for emergency room medicine.³⁸ Although these consultations were required by statute,³⁹ they did not consist of formal notice and comment.

The Office on Violence Against Women (OVW) is responsible for developing and revising the SAFE Protocol. OVW is authorized by statute to carry out “the functions of the Department of Justice under the Violence Against Women Act of 1994... and the Violence Against Women Act of 2000,” including “the development of policy, protocols, and guidelines.”⁴⁰

➤ Procedural Requirements to Revise the Sexual Assault Protocol

The SAFE Protocol is considered by the Department of Justice to be a “significant guidance document.”⁴¹ Development and revisions of significant guidance documents are governed by Executive Order 13422⁴² and the Office of Management and Budget’s “Final Bulletin for Agency Good Guidance Practices” (OMB Bulletin),⁴³ which were issued in January 2007.

The OMB Bulletin delineates the standard elements of significant guidance documents.⁴⁴ For a revision to an existing guidance document, the OMB Bulletin requires the new document to note that it is a revision and to identify the document that it replaces.⁴⁵ The OMB Bulletin specifies that significant guidance documents must be listed on the agency’s website.⁴⁶ It also requires agencies to develop a mechanism for public feedback about significant guidance documents. The OMB Bulletin makes clear that “[p]ublic comments under these procedures are for the benefit of the agency, and no formal response to comments by the Agency is required by this Bulletin.”⁴⁷

According to the Executive Order and OMB Bulletin, OVW can revise the SAFE Protocol unilaterally. OVW must follow the procedures required by the Executive Order and OMB Bulletin, but

³⁶ Office of Violence Against Women, U.S. Dep’t of Justice, A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents, NCJ 206554 (Sept. 2004), *available at* <http://www.ncjrs.gov/pdffiles1/ovw/206554.pdf>.

³⁷ Violence Against Women Act of 2000, Public Law 106-386, 114 Stat. 1515, §1405(a)(3) (2000).

³⁸ *Id.* at §1405(b).

³⁹ *Id.*

⁴⁰ 42 U.S.C. § 3796gg-0b.

⁴¹ Office on Violence Against Women, U.S. Dep’t of Justice, Significant Guidance Documents, http://www.ovw.usdoj.gov/significant_guidance.htm.

⁴² Executive Order 12866 of September 30, 1993, as amended by E.O. 13258 of February 26, 2002 and E.O. 13422 of January 18, 2007, Regulatory Planning and Review, *available at* http://www.whitehouse.gov/omb/infoereg/eo12866/eo12866_amended_01-2007.pdf.

⁴³ Memorandum for the Heads of Executive Departments and Agencies, from Rob Portman, Executive Office of the President, Office of Management and Budget (Jan. 18, 2007), <http://www.whitehouse.gov/omb/memoranda/fy2007/m07-07.pdf>.

⁴⁴ *Id.* at II.2.

⁴⁵ *Id.* at II.2.E.

⁴⁶ *Id.* at III.1.

⁴⁷ *Id.* at III.2.a.

revisions to the SAFE Protocol do not require public input or comment beforehand.⁴⁸ This is consistent with the fact that the SAFE Protocol did not undergo official public notice and comment when it was first developed.

➤ **Suggested Language for Presidential Memorandum to the Secretary of Defense**

Subject: Exclusion of Discussion of Pregnancy Prevention from the National Protocol for Sexual Assault Medical Forensic Examination

In 2004, the Department of Justice Office on Violence Against Women published The National Protocol for Sexual Assault Medical Forensic Examination (SAFE Protocol), which provides detailed guidelines for criminal justice and health care practitioners in responding to the immediate needs of sexual assault victims.

In marked contrast to the SAFE Protocol's treatment of other medical concerns faced by sexual assault survivors, the SAFE Protocol's treatment of pregnancy prevention is vague and lacks detail. I am informed that the decision to exclude a discussion of specific pregnancy prevention options was based on factors other than best practices and accepted standards in the treatment of sexual assault survivors.

Accordingly, I hereby direct that you promptly add a discussion of specific pregnancy prevention options to the SAFE Protocol, treating pregnancy evaluation and care in the same detailed and explicit manner that the SAFE Protocol treats other medical concerns facing sexual assault survivors.

You are hereby authorized and directed to publish this memorandum in the Federal Register.

⁴⁸ Note that there is a subset of significant guidance documents defined as "economically significant" guidance documents, which do require notice in the Federal Register, public comment, and a response to public comment from the agency. But the SAFE Protocol does not appear to be considered an economically significant guidance document by DOJ, nor does it meet the definition, which is reasonably anticipated to "lead to an annual effect on the economy of \$100 million or more or adversely affect in a material way the economy or a sector of the economy." *Id.* at l.5.

Review Policies that Restrict Access to Emergency Contraception (EC) and Eliminate Restrictions that Lack Scientific Support. We urge the President to direct relevant agencies to reexamine Bush Administration policies that have blocked or limited women's access to EC ... The President should direct USAID [to] include the medication in its Commodities Program ...

USAID Commodities Program

➤ **Procedural Requirements to Amend the USAID Commodities Program**

The Commodities Security and Logistics Division of USAID's Office of Population and Reproductive Health administers a centralized system for commodity procurement; supports a program for health commodities and logistics management; works with country programs and other donors to ensure that these commodities are available to those who choose to use them; and maintains a database on USAID commodity assistance. The Assistant Administrator for Global Health and the Director of the Office of Population and Reproductive Health is responsible for determining whether to add Plan B® to the commodities list. Such an evaluation includes an evaluation of price, in country demand, and other relevant factors.

Federal regulations provide the rules and procedures applicable to commodity transactions financed by USAID.^[1]

➤ **Suggested Language for Presidential Memorandum to the Director of the Office of Population and Reproductive Health**

Subject: Adding Plan B® to the USAID Commodities Program

The United States Agency for International Development (USAID) supplies oral contraceptive pills that are the FDA-approved formulations approved for use as emergency contraception. However, USAID does not currently fund separate packaging of pills for this purpose, nor has USAID purchased Plan B®, the only dedicated emergency contraceptive product on the market in the United States.

I hereby direct that USAID take appropriate steps to explore adding Plan B® to the commodities list that is the basis of the family planning and reproductive health commodities USAID provides to countries in the Agency's Africa, Asia/Near East, Europe & Eurasia, and Latin America/Caribbean regions.

You are hereby authorized and directed to publish this memorandum in the Federal Register.

Review Policies that Restrict Access to Emergency Contraception (EC) and Eliminate Restrictions that Lack Scientific Support. We urge the President to direct relevant agencies to reexamine Bush Administration policies that have blocked or limited women’s access to EC ... the President should direct the Secretary of HHS to instruct the FDA to review and evaluate the scientific data underlying the age restriction on over-the-counter access to EC, to ensure that the FDA’s policy is based on sound science rather than politics.

FDA Plan B[®] Over-the-Counter Status

➤ **Legal Authority for FDA to Grant Over-the-Counter Status**

The federal Food, Drug, and Cosmetic Act (FDCA) established the Food and Drug Administration within the Department of Health and Human Services.⁴⁹ FDA’s mission is to “promote the public health by promptly and efficiently reviewing clinical research and taking appropriate action on the marketing of regulated products in a timely manner...” and “with respect to such products, protect the public health by ensuring that—human . . . drugs are safe and effective.”⁵⁰

The Secretary of Health and Human Services, acting through the Commissioner of the FDA, is charged by the FDCA with implementing the requirements of the FDCA, “providing overall direction” to the FDA, and “research relating to foods, drugs, cosmetics, and devices in carrying out this Act.”⁵¹

By law, FDA may approve a switch from prescription to over-the-counter status if use of the drug is safe and effective for self-medication in accordance with proposed labeling.⁵² FDA manuals of policies and procedures, as well as federal regulations, delineate the procedure by which a drug is switched from prescription to over-the-counter status. The authority to approve an OTC switch application ultimately rests with the Secretary of Health and Human Services.⁵³

➤ **Suggested Language for Presidential Memorandum to the Secretary of Health and Human Services**

Subject: Restrictions on Plan B[®] Approval

On August 24, 2006, the Food and Drug Administration (FDA) approved Plan B[®], an emergency contraceptive pill, for restricted sale as an over-the-counter product.⁵⁴ It is available without a prescription for consumers 18 years and older, and by prescription only for women 17 years and younger.

Independent evidence, including a review by the U.S. Government Accountability Office, suggests that the FDA based its assessment of a switch from prescription to over-the-counter status on factors other than whether use of the drug is safe and effective for self-medication in accordance with proposed labeling. Accordingly, I hereby direct that you promptly instruct the FDA to review and evaluate the scientific data underlying the decision to switch Plan B[®] from prescription to over-the-counter status only for consumers 18 years and older, and to take appropriate steps to ensure that FDA’s decision is consistent with the scientific and medical evidence.

You are hereby authorized and directed to publish this memorandum in the *Federal Register*.

⁴⁹ 21 U.S.C. § 393(a).

⁵⁰ 21 U.S.C. § 393(b)(1) and (2)(b).

⁵¹ 21 U.S.C. § 393(d).

⁵² See 21 U.S.C. § 353(b)(1); 21 C.F.R. § 310.200(b) (2005).

⁵³ Cite.

⁵⁴ See Memorandum from Steven Galson, MD, MPH, Director, Center for Drug Evaluation and Research, to NDA 21-045, S-011, Subject: Plan B[®] (Aug. 24, 2006).

Select Judicial Nominees with a Demonstrated Commitment to Fundamental Legal Protections and Civil Liberties, Including Reproductive Rights. It is critical that only fair and independent judicial nominees with a demonstrated commitment to fundamental legal rights be appointed to the federal courts, including both the Supreme Court and lower courts. The President should nominate individuals who, in addition to meeting the requirements of honesty, integrity, character, temperament, and intellect, demonstrate a commitment to justice, civil rights, equal rights, individual liberties, and the fundamental constitutional right to privacy, including the right to have an abortion.

Circuit	Vacancy Created By	Reason	Vacancy Date
First			
	Selya, Bruce M.	Senior	12/31/06
	Torres, Ernest C.*	Senior	12/1/06
Second			
	Straub, Chester J.	Senior	7/16/08
	Gershon, Nina*	Senior	10/16/08
	Scullin, Frederick J., Jr.*	Senior	3/13/06
Third			
	Alito, Samuel A., Jr.	Elevated	1/31/06
	Van Antwerpen, Franklin S.	Senior	10/23/06
	Jordan, Kent A.*	Elevated	12/13/06
	Hardiman, Thomas M.*	Elevated	3/15/07
Fourth			
	Murnaghan, Francis	Deceased	8/31/00
	Phillips, J. Dickson, Jr.	Senior	7/31/94
	Widener, H. Emory, Jr.	Deceased	9/19/07
	Wilkins, William W.	Senior	7/1/07
	Messitte, Peter J.*	Senior	9/1/08
	Howard, Malcolm J.*	Senior	12/31/05
	Payne, Robert E.*	Senior	5/7/07
	Broadwater, W. Craig*	Deceased	12/18/06
Fifth			
	Polozola, Frank J.*	Senior	1/15/07
	Barbour, William H.*	Senior	2/4/06
Sixth			
	O'Meara, John Corbett*	Senior	1/1/07
	Echols, Robert L.*	Senior	3/1/07
Seventh			
	Ripple, Kenneth F.	Senior	9/1/08
	Filip, Mark R.*	Resigned	3/9/08
	Sharp, Allen*	Senior	11/1/07
Eighth			
	Moody, James M.*	Senior	9/30/08
	Wilson, Jr., William R.*	Senior	9/30/08
	Kornmann, Charles B.*	Senior	7/31/08
Ninth			
	Trott, Stephen S.	Senior	12/31/04
	Manella, Nora M.*	Resigned	5/22/06

	Schiavelli, George P.*	Resigned	10/5/08
	Jenkins, Martin J.*	Resigned	4/3/08
	Van Sickle, Fred*	Senior	5/1/08
Tenth			
	Figa, Phillip S.*	Deceased	1/5/08
	Nottingham, Edward W.*	Resigned	10/29/08
	Brimmer, Clarence A*	Senior	9/27/06
Eleventh			
	Bucklew, Susan*	Senior	8/1/08
District of Columbia			
	Randolph, A. Raymond	Senior	11/1/08
	Roberts, John G.	Elevated	9/29/05
	Hogan, Thomas F.*	Senior	5/1/08
	Kessler, Gladys*	Senior	1/22/07

* Denotes District Court vacancy

Reestablish a Standard of Excellence for Federal Appointees. We urge the President to appoint senior leaders throughout the federal government who have demonstrated track records of leadership in their fields, knowledge of and commitment to the work of the agencies and programs they are charged with leading, and experience in managing multilayered networks of experts with respect and integrity. These leaders must respect the rule of law and ensure that evidence-based findings will not be suppressed, distorted, or manipulated to advance a political agenda. Where relevant, they should display a commitment to promoting the health and rights of women and men in the United States and throughout the world.

The following is a representative sample of positions of interest. Please note that it is neither exhaustive nor in order of priority.

Department	Position
Health and Human Services	
	Secretary
	Deputy Secretary
	General Counsel
	Assistant Secretary for Planning and Evaluation
	Assistant Secretary for Health
	Surgeon General
	Deputy Assistant Secretary for Population Affairs
	Inspector General
	Assistant Secretary, Administration for Children and Families
	Administrator, Centers for Medicare and Medicaid Services
	Director, Center for Medicaid State Operations, Centers for Medicare and Medicaid Services
	Director, Center for Family and Children's Health Programs Group, Centers for Medicare and Medicaid Services
	Director, Centers for Disease Control and Prevention
	Director, Office of Global Health Affairs
	Administrator, Health Resources and Services Administration
	Associate Administrator, Maternal and Child Health Bureau
	Director, National Institutes of Health
	Director, National Institutes of Child Health and Human Development
	Administrator, Substance Abuse and Mental Health Services Administration
	Commissioner, Food and Drug Administration
Justice	
	Attorney General
	Deputy Attorney General
	Solicitor General
	Assistant Attorney General, Office of Legal Counsel
	Assistant Attorney General, Office of Legislative Affairs
	Assistant Attorney, General Criminal Division
	Director, U.S. Marshals Service
	Associate Attorney General, Office of the Associate Attorney General
	Assistant Attorney General, Antitrust Division, Office of the Associate Attorney General

	Assistant Attorney General, Civil Rights Division
	Assistant Attorney General for Justice Programs, Office of Justice Programs
	Director, Office of Violence Against Women
State	
	Secretary of State
	Deputy Secretary of State
	Director of Foreign Assistance
	Under Secretary for Democracy and Global Affairs
	Assistant Secretary of State, Bureau of Population, Refugees, and Migration
	Deputy Assistant Secretary, PRM
	Women's Human Rights Coordinator
	Office Director, Office to Monitor & Combat Trafficking in Persons
U.S. Agency for International Development	
	Administrator
	Assistant Administrator, Global Health
	Deputy Assistant Administrator, Global Health
	Assistant Administrator, Program & Policy Coordination
Presidential Initiatives	
	Millennium Challenge Corporation CEO
	U.S. Global AIDS Coordinator
Executive Office of the President	
National Security Council	
	Deputy National Security Advisor for International Economics Affairs
	also subordinate Office Directors
	Director
	Deputy Director
	Associate Director for National Security Programs
Independent Agencies	
Equal Employment Opportunity Commission	
	Chairman
	Vice Chairman
	General Counsel
Federal Trade Commission	
	Chairman
	Chief of Staff