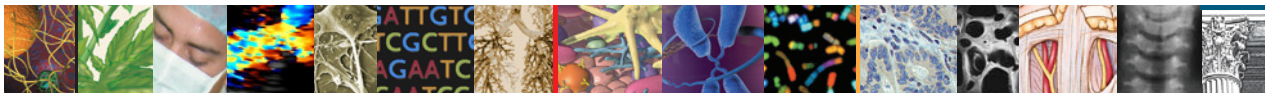

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Perspective

Radical Changes for Reproductive Health Care — Proposed Regulations for Title X

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On June 1, 2018, the Department of Health and Human Services (HHS) proposed new regulations for the Title X Family Planning Program. If enacted, these regulations will radically alter the mix of health care providers and the range, quality, and effectiveness of services offered to support the reproductive health and childbearing decisions of low-income women, men, and adolescents in the United States. In addition, the new regulations will constrain the ability of clinicians within the system to follow professional recommendations for respecting patients' autonomy and ability to make informed choices about childbearing and health care. The American Medical Association, the American College of Physicians, and eight specialty physician, nursing, and physician assistant organizations have issued statements opposing the proposed regulations.[1]

Title X of the Public Health Service Act provides grants to 91 state health departments and nonprofit health agencies that subcontract with about 4000 service sites that offer contraceptive services, cancer screening, treatment for sexually transmitted infections, and referral to primary care to about 4 million clients each year. In 2015, 48% of the sites were local health departments; 26%, federally qualified health centers; 4%, hospitals; 13%, Planned Parenthood clinics; and 9%, other types of reproductive health clinics.[2] Title X grants support the overall operation of these sites, which provide services pro bono or whose fees are on a sliding-scale basis, with people with fewer financial resources required to pay less. Sites also accept reimbursement from Medicaid and private insurers.

The enabling statute, enacted in 1970, explicitly states that Title X funding cannot be used "in programs where abortion is a method of family planning." The primary stated purpose of the new proposed regulations is to clarify this restriction in order to "draw a wall of separation" between the Title X program and any activities that could be considered to support abortions. A previous set of regulations that also focused on distinguishing Title X from abortion services survived a Supreme Court challenge in 1991 (*Rust v. Sullivan*) but was withdrawn by the Clinton administration and never reinstated.

The proposed regulations contain two approaches for separating Title X–supported activities from abortion services. The first alters the rules for referrals when clients being seen for family-planning services are found to be preg-

nant. The currently required practice is to support these clients with nondirective counseling as they explore their options and to provide a list of abortion providers on request. The proposed regulations permit but do not require physicians to provide nondirective counseling that can include a discussion of pregnancy termination. For pregnant clients who state clearly that they have already decided to have an abortion, physicians may provide a list of comprehensive prenatal care providers. Some (but not all) of the providers on that list might also provide abortions, but the list cannot indicate which ones do. Abortion providers that do not also provide prenatal care (that is, the majority of abortion providers) are not to be included. The proposed regulations mention only physicians in the context of counseling and referral, although other types of clinical staff provide the majority of care at Title X sites. Comments are being sought on this proposed approach to counseling and referral.

According to the proposed regulations, the benefits of this change include distinguishing abortions from other services for which clients routinely receive referrals, protecting providers who do not wish to refer clients for abortions, and expanding Title X participation to new providers who object to current abortion-referral requirements. However, the proposals conflict with American College of Obstetricians and Gynecologists (ACOG) guidelines, which state that physicians should provide accurate and unbiased information, including information about pregnancy termination, so that patients can make informed decisions regarding their reproductive health.[3] Under the ACOG guidelines, reconfirmed in 2016, physicians who object to providing certain types of information or services have a duty to refer patients to others who will do so. Furthermore, organizations — particularly those serving in resource-poor settings — have an obligation to ensure that patients do not experience "disruptive denials of service" because of personal objections by staff. Abortion is an extremely time-sensitive procedure, so delays in seeking care that are caused by providing patients with misleading referral resources have significant health consequences.

The second approach proposed for distinguishing Title X–supported activities from abortions is to mandate that all sites demonstrate physical and financial separation between the two sets of services. Currently, sites that also provide abortions can share facilities and personnel among services, as long as Title X funds are used only for family-planning activities. Under the proposed regulations, such sites will be required to maintain separate accounting records, physically separate facilities, and separate personnel, educational services, medical records, and work stations. In addition, HHS is soliciting comments about whether abortion-service sites and Title X–supported family-planning sites should be required to have different names and be part of different organizations.

It is not clear how many current Title X sites would be directly affected by this rule, but it is probably a subset of the 22% of sites that are reproductive health clinics (including Planned Parenthood clinics). Involvement of reproductive health clinics in the Title X program is geographically concentrated: only 25% of counties with local access to Title X services had reproductive health clinics as participating sites in 2015. However, many of these counties are in major metropolitan areas. Metropolitan areas where more than half of Title X clients used reproductive health clinics for care include New Haven, Hartford, Brooklyn, Newark, Baltimore, Memphis, Cleveland, Milwaukee, Minneapolis, St. Louis, Salt Lake City, Phoenix, Seattle, Portland, Los Angeles, San Francisco, San Diego, and the other metropolitan counties of California. States with less populated counties where reproductive health clinics were the only Title X sites in 2015 include Vermont, Massachusetts, New York, New Jersey, Pennsylvania, Ohio, Indiana, Illinois, Missouri, Iowa, Wisconsin, and Washington.[2]

Absent funding that would enable sites that provide both abortions and family-planning services to hire additional staff, purchase new equipment, and rent new space and absent a willingness of these clinics to diminish their quality of care by segmenting medical records, facilities, and clinicians, these sites will probably exit the Title X program. In fact, such an exodus may well be the actual intent of the proposed regulations, since eliminating Planned Parenthood's access to Title X funding is a long-standing policy goal for abortion opponents. Other providers who are unwilling to violate ACOG recommendations for ethical care may also exit.

What types of providers would take their place? The new regulations eliminate the requirement that Title X sites follow the Centers for Disease Control and Prevention family-planning quality-

of-care guidelines and emphasize that not every Title X site must offer a broad range of acceptable, effective family-planning methods and services, as long as a broad range is offered within the grantee's overall project. They also note that natural family planning is an acceptable contraceptive service that should be provided at Title X sites. Combined with the elimination of the requirement to refer pregnant clients to abortion services on request, the new regulations open the Title X system to sites that are opposed to abortion use on principle and that offer only less effective fertility-awareness methods of contraception. Given their small scale, it's unlikely that these new providers and the remaining Title X sites will be able to handle the patient volume of the exiting providers.[4] Thus, the proposed regulations will leave Title X clients in many communities with more limited access to family-planning care, lower-quality care, and care that prioritizes less effective family-planning services.

Changes implemented in April 2017 already allow grantees to shift Title X funds away from sites that also provide abortions. Several statutes and appropriation restrictions already protect providers who refuse on the basis of conscience to refer clients for abortion services. These proposed regulations go farther by restricting providers' ability to deliver sound patient care and essentially dismantling the well-established, well-functioning Title X care system, disregarding local community care systems and policy preferences. The consequent changes in the Title X system are likely to increase unintended-pregnancy rates in the most vulnerable segments of the population and are thus more likely to increase than to reduce the incidence of abortions.[5]

HHS is accepting comments on the proposed regulations through July 31 (www.federalregister.gov/documents/2018/06/01/2018-11673/compliance-with-statutory-program-integrity-requirements). Most provisions will take effect 60 days after final publication of the new rules.

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