PRINCIPLE 1: Ensure that Sexual and Reproductive Health Care is Accessible to All People.

Sexual and reproductive health and rights are essential for sustainable economic development, are intrinsically linked to equity and well-being, and are critical to maternal, newborn, child, adolescent, family, and community health. Restrictions on reproductive rights compromise entire health systems and communities, as when an individual’s rights are limited, so are their pathways to economic, social, and political empowerment.

Unfortunately, restrictions and barriers to accessing sexual and reproductive health care are ever-present both globally and domestically. As a global community, we have made significant progress in expanding access to health care for communities worldwide, yet these advancements have been uneven and often fail to reach those that face the greatest barriers to care. While the Affordable Care Act (ACA) has produced significant improvements in access to affordable sexual and reproductive health care in the United States, there are individuals and communities who continue to face barriers to services that are essential to achieving full sexual and reproductive health, autonomy, and well-being.

To be meaningful to all, efforts to advance sexual and reproductive health and rights must extend across every category that could divide us—across race, gender, sexual orientation, class, immigration status, disability status, economic status, age, and national origin. Initiatives that foster fairness and equity in this critical arena of health care are essential to our commitment to the goal of ensuring that each person is able to make healthy decisions about sexuality and reproduction in pursuit of comprehensive physical, mental, emotional, and social health and well-being.

“IT IS MY ASPIRATION THAT HEALTH FINALLY WILL BE SEEN NOT AS A BLESSING TO BE WISHED FOR, BUT AS A HUMAN RIGHT TO BE Fought For.”

United Nations Secretary-General Kofi Annan
Promote Comprehensive Access to Sexual and Reproductive Health Services Domestically

Policymakers must ensure comprehensive sexual and reproductive health services are covered—at no or low cost—by every health plan and coverage program.

Sexual and reproductive health services have historically not been covered in a manner consistent with other health services. The ACA requires most private insurance plans and Medicaid expansion plans to cover certain preventive services, including women’s preventive services, which include but are not limited to birth control, HPV testing, and well-woman visits, without cost-sharing. It is currently estimated that 62.8 million women have coverage that includes no-cost women’s preventive services.\(^8\) Additionally, around 13 million people gained access to maternity and newborn care thanks to the ACA.\(^9\) While these coverage requirements have significantly improved the quality of coverage, they have not extended to everyone and every service. It is critical that all sexual and reproductive health care services be available to those who want or need them without cost in order for all people to achieve optimal sexual and reproductive health.

- As a first step towards guaranteeing coverage, the administration must rescind the rules that limit the birth control benefit and defend the ACA’s birth control benefit to ensure coverage for contraceptives with no cost-sharing.

- Congress should ensure comprehensive sexual and reproductive health services are covered—at no or low cost—by every health plan and coverage program. To address the above mentioned coverage gaps, Congress should pass legislation, which would require private insurance, Medicaid (both the Medicaid expansion and traditional Medicaid), Federal Employee Health Benefit Plans, State Employee health plans, Veterans Affairs, the Indian Health Service, Medicare, Tricare, and other private plans and federal programs to cover a range of reproductive health services. The legislation should:

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– Require all plans to cover abortion without restrictions;

– Require all plans to cover all FDA-approved contraceptive drugs, devices, and other products and services, including those prescribed by the covered person’s provider or as otherwise authorized under state or federal law, and coverage should be inclusive of multiple methods regardless of timing, to allow for a person to switch methods easily;

– Require all plans to cover a 12-month supply of contraception dispensed at once;

– Require all plans to cover over-the-counter contraceptives without a prescription;

– Require all plans to cover preventive services, including condoms, vasectomy/sterilization, vaccines, and STI testing;

– Require all plans to cover interpersonal violence screenings and brief counseling (which should include referrals to interpersonal violence service providers);

– Require all plans to cover maternity care and clearly spell out what that encompasses;

– Require all plans to cover gender-affirming care;

– Require all plans to cover infertility treatment and services, including in vitro fertilization and artificial insemination even when infertility is not indicated and for LGBTQ+ couples;

– Require all plans to cover all other services necessary to adhere to the Providing Quality Family Planning Services: Recommendations of the CDC and the US Office of Population Affairs;10

– Prohibit insurers from imposing medical management techniques, including prior authorization and step-therapy, on services that are required under this legislation; and

– Ensure that the benefit created under this legislation provides coverage for adolescents, consistent with medical guidelines, counseling, and follow-up care.

This legislation should ensure that access to the services covered under this newly created benefit are equally available to people without regard to race, sex (including sexual orientation and gender identity), marital or relationship status, nationality, socioeconomic status, immigration status, disability or other status. Additionally, the legislation should not include exemptions or accommodations based on religious or personal beliefs that impede access to care.

Policymakers must ensure that universal coverage bills thoughtfully address access to sexual and reproductive health care, including abortion coverage and no-cost-birth control, for all people.

Single-payer, public option, and other proposals seeking to advance coverage in the U.S have the potential to expand health care coverage to millions. However, if coverage expansions do not meaningfully address sexual and reproductive health

care, millions of people will be left with inadequate coverage that falls far short of their health care needs. It’s essential that coverage expansion proposals include strong protections for sexual and reproductive health care and dismantle existing coverage and access barriers for immigrants, LGBTQ+ individuals, and others. Additionally, any proposal should not include provisions that allow religious or personal beliefs to impede access to care.

• Every new insurance coverage proposal, at a minimum, must include coverage of comprehensive reproductive health care services, including abortion services and birth control, with no out-of-pocket costs to beneficiaries.

• Every new insurance coverage proposal should provide coverage to everyone (including individuals of all immigration statuses), a robust provider network (including both protections against discrimination and adequate reimbursement rates) and patient protections (including nondiscrimination protections and cultural competency standards) that ensures coverage actually translates into access. ¹¹

• Every new insurance coverage proposal must guarantee coverage to individuals of all immigration statuses, and undo the impact of current, legal and policy barriers that restrict access to affordable, comprehensive coverage for immigrant individuals and families.

• Every new insurance coverage proposal should ensure seamless access to culturally and linguistically competent care and services, including gender-affirming care for LGBTQ+ individuals, and promote health equity.

Lawmakers must advance the goal of universal health care coverage by immediately reversing course on recent sabotage and build upon successful implementation of the ACA.

The ACA was a historic milestone for improving health and well-being, helping to expand access to health coverage and care for millions of people, including those historically disadvantaged under the health care system such as communities of color, LGBTQ+ people, and people with low-incomes. Notably, through the ACA, coverage for women of color grew at more than twice the rate of women overall between 2013 and 2015, ¹² and, the uninsurance rate for lesbian, gay, and bisexual people decreased nine percent between 2010


and 2016.\(^{13}\) Despite this progress, nearly 30 million people remain uninsured with enduring access inequities among Blacks, Latinos, transgender people, and people living in certain parts of the country such as the South. Additionally, the 2011 national survey from the National Center on Transgender Equality found that 19 percent of transgender, nonbinary, and gender noncomforming respondents reported lacking health insurance, compared to 17 percent of the overall U.S. population.\(^{14}\) In the follow up survey in 2015, this number had declined to 14 percent, compared to 11 percent of the overall U.S. population.\(^{15}\) Even more the ACA has repeatedly endured attacks, both through repeated repeal attempts and the Trump-Pence administration policies, which have undermined progress in coverage gains, quality of plans, and consumer protections.

- Congress and the administration must not only reverse policies that undermine the ACA but also build upon the ACA to expand health insurance coverage to all by:
  - Banning substandard health plans, such as short-term health plans, association health plans, and health care sharing ministries, which have blanket exclusions of sexual and reproductive health services (including gender-affirming health services) and engage in discriminatory pricing.
  - Defending the Affordable Care Act in Court.
  - Restoring navigator funds and marketing funds to promote open enrollment.
  - Removing barriers to enrolling in plans available on the federal and state-based marketplaces.
  - Issuing guidance on 1332 waivers aimed at improving access to health benefits and services.
  - Increasing the financial assistance available to purchase private coverage on the marketplaces by expanding eligibility for tax credits to people with incomes above 400 percent of the federal poverty level and increasing funding available for tax credits and cost-sharing reductions.

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The Administration and Congress should protect and expand Medicaid to ensure robust, accessible coverage in all states and should ensure Medicaid enrollees have access to the contraceptive method of their choice from the provider of their choice—free from coercion.

Medicaid is the largest funding source supporting the delivery of family planning and related care in the country. Medicaid provides coverage to 1 in 5 women of reproductive age and funds approximately half of the births in the U.S. Increasing Medicaid access would, therefore, increase access to family planning services and supplies, as well as to other critical reproductive health care services. Women of color, in particular, would be among the populations that would benefit the most from increasing access to Medicaid. Due to systemic barriers, they are more likely to be covered under Medicaid. Women of color are also more likely to fall in the coverage gap because they reside in a state that refused to expand Medicaid under the ACA.

Medicaid is critical for achieving health equity and providing coverage for care. Unfortunately, in addition to the failure to expand Medicaid by states, the Trump administration has also supported and approved a number of attacks on the program undermining advancements towards health equity made under the previous administration. The administration and Congress must reverse the harmful damage that has been done to the Medicaid program in recent years, and commit to expanding eligibility and access to the program, taking the following steps:

- Congress should investigate—and CMS should deny—unlawful Medicaid Section 1115 demonstration projects that do not promote Medicaid’s core objectives. Despite limitations on their use, the current administration has approved waiver projects that undermine this central purpose. Congress should exercise its oversight and investigation authority to vigilantly assess approved Medicaid waiver projects, such as those imposing work requirements, that threaten access to coverage and services.

- Congress should protect Medicaid against efforts to fundamentally alter the program, including but not limited to transforming the program from an entitlement program to a per capita cap or block grant program. Congress should oppose any attempt to undermine critical health care

Additionally, due to the high prevalence of poverty in the LGBTQ+ community, especially for people of color, transgender individuals, and people with disabilities,


19 42 U.S.C.A. § 1396-1
coverage and access programs, including attempts to undermine the Medicaid program by shifting costs to states; by forcing states to cut benefits or provider payments; by lowering eligibility levels; or by otherwise undermining Medicaid’s role in providing access to critical health services, including sexual and reproductive health care.

• Congress and the administration should increase incentives and encourage all states to expand their Medicaid programs as intended under the ACA. Medicaid expansion is the most effective tool states have to provide health insurance coverage of essential health services, including reproductive health services, to people with low incomes. 20

• The administration should encourage states, especially states that have not expanded Medicaid, to implement state family planning expansions. Additionally, Congress should offer additional funding to incentivize states to implement these expansions.

• Congress should prohibit any Medicaid funds for conversion therapy.

• CMS should reinstate its 2016 guidance to ensure all Medicaid programs and plans provide comprehensive coverage for family planning services and supplies to all Medicaid enrollees, free of coercion. CMS issued guidance clarifying that Medicaid enrollees have a right to receive covered services from any qualified provider and separate guidance to improve access to long-acting reversible contraceptives. To ensure enrollees truly have the right to their contraceptive method of choice, CMS should issue guidance that ensures Medicaid enrollees, have coverage for their choice of contraceptive.

• CMS should provide oversight and enforcement of states and managed care plans to ensure they are complying with federal law, including covering the full range of services without coercive restrictions, covering removal of long-acting reversible contraceptives with no time or frequency restrictions, informing enrollees of their rights to access covered services out-of-network and ensuring out-of-network providers are reimbursed for that care, and ensuring that enrollees receive all care and information to which they are legally entitled, even when providers or Medicaid Managed Care Organizations assert religious or moral objections.

• Policymakers must ensure that all federally-supported health programs, and health insurance plans of all types, are operated in a manner that does not discriminate against or otherwise limit the participation of reproductive health providers for reasons unrelated to their qualifications; and expand the scope of health care providers that are covered under health programs and insurance options so that all Medicaid patients are able to see the provider of their choice.

Use United States Leadership to Advance Sexual and Reproductive Health Globally

The President should launch an initiative to integrate, elevate, and prioritize sexual and reproductive health and rights (SRHR) across foreign policy priorities and global health, development, and humanitarian programs.

The integration and elevation of SRHR into foreign policy and global programs must be a priority to advance the health and rights of all individuals and promote bodily autonomy. A presidential initiative should establish a clear mandate to coordinate across agencies to integrate SRHR in the implementation, review, and expansion of policies and programs across health, development, humanitarian, and human rights sectors. In order for this initiative to have a meaningful impact at a policy, programmatic, and diplomatic level, the President, in consultation with Congress, must set standards and codify definitions of sexual and reproductive health and rights and related terms to promote these rights in U.S. policy and champion their inclusion in international human rights frameworks.

- **Sexual and reproductive health and rights:** Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall well-being. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realization of sexual and reproductive rights, which are based on the human rights of all individuals to: have their bodily integrity, privacy, and personal autonomy respected; freely define their own sexuality, including sexual orientation and gender identity and expression; decide whether and when to be sexually active; choose their sexual partners; have safe and pleasurable sexual experiences; decide whether, when, and whom to marry; decide whether, when, and by what means to have a child or children, and how many children to have; have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.21

Gender: the socially constructed set of roles, rights, responsibilities, entitlements, and behaviors associated with being a woman or a man in societies. The social definitions of what it means to be masculine or feminine, and negative consequences for not adhering to those expectations, vary among cultures, change over time, and often intersect with other factors such as age, class, disability, ethnicity, race, religion, and sexual orientation.

Gender Expression: external appearance of one’s gender identity which may or may not conform to socially defined behaviors and characteristics typically associated with being either masculine or feminine.

Gender Identity: a person’s deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth. For transgender people, their birth-assigned sex and their own internal sense of gender identity do not match.

Comprehensive sexuality education: Educational programs for young people in school and out of school which include age, developmentally, and culturally appropriate, science-based, and medically accurate information on a broad set of topics related to sexuality, including human development, relationships, personal skills, sexual behaviors, including abstinence, consent, sexual health, and society and culture.

- The State Department should report on sexual and reproductive rights violations in their annual Country Reports on Human Rights Practices. These reports provide critical monitoring and accountability of human rights violations, and provide a benchmark of progress and ongoing challenges to achieving full human rights for all. As a first step towards comprehensive reporting on sexual and reproductive rights, Congress should pass and the President should champion passage of the Reproductive Rights are Human Rights Act.

- The U.S. should also encourage other nations to expand civil society engagement and increase budgetary support for sexual and reproductive health, in accordance with commitments to the Sustainable Development Goals and targets to achieve universal health coverage and ensure universal access to sexual and reproductive health care services. The United States has the opportunity to assert leadership in the global community and leverage diplomatic capacity to urge other countries to respect, protect, and fulfill the sexual and reproductive health and rights of their people. The U.S. should play a leadership role in fulfilling these global commitments and in seeking new international commitments to advancing SRHR.

- The U.S. must provide and require training for embassy and mission staff on the cross-cutting impact of SRHR on development, humanitarian, and national security priorities; guidelines and incentives to engage civil society at the Mission and headquarters level; and proactive guidance to diplomats and foreign service officers on priority SRHR policy and program areas. The Interagency Task Force on SRHR or women and girls can further play a role of annually briefing the diplomatic corps to provide priorities and direction for diplomacy.
The U.S. must protect and promote the highest standard of sexual and reproductive health and rights in multilateral fora.

As a longtime champion and leader in the creation of multilateral mechanisms that strengthen sexual and reproductive health and rights, including the formation of the United Nations Population Fund (UNFPA) and strong consensus support for the International Conference on Population and Development in Cairo, the U.S. must continue to protect and promote the highest standard of sexual and reproductive health and rights in all multilateral fora. Over the last two years, the administration has used international forums, like the Commission on the Status of Women (CSW), the Commission on Population and Development (CPD), and the World Health Assembly (WHA) to question longstanding norms and definitions of sexual and reproductive health and rights. In addition to reversing these actions, the U.S. should support outcome documents, policies at negotiations, and civil society participation for CSW, CPD, WHA, Human Rights Council and within the UN and other multilateral bodies and executive boards, which strengthen access to full, evidence-based, sexual and reproductive health and rights.

- The U.S. government can achieve this through the following actions:

  - Enshrine a definition of sexual and reproductive health and rights and negotiate from that position, as previously referenced.

  - Promote inclusion of civil society experts in multilateral forums, specifically by including diverse, evidence-based participants within the official delegations to international negotiations, like CSW, CPD and WHA. Participants and outside organizations should be representative of the populations and communities to which the outcome documents are related, promote evidence-based policies and programs for sexual and reproductive health and rights, and bring substantive professional expertise to the themes and topics being negotiated. The U.S. should not include organizations that promote harassment, discrimination, violence, or a non-rights based approach to sexual and reproductive health.

  - Ensure participants from around the world are granted visas to engage in convenings at UN headquarters, the Organization of American States, World Bank and other multilateral institutions located in the U.S. to ensure that negotiators can hear from a diversity of backgrounds.

  - Prioritize participating and serving on the Executive Board of UN Specialized Agencies related to sexual and reproductive health and rights and encourage the expansion of their programs and policies globally. The U.S. should also publicize its statements at these executive boards.
– Rejoin the Human Rights Council in order to have a seat at the table at critical discussions of human rights issues and to advance sexual and reproductive health and rights as human rights.

– Work with the UN Security Council to adopt resolutions which recognize the importance of sexual and reproductive health and rights for those impacted by conflict and call for improved access to comprehensive sexual and reproductive health services, including for survivors of conflict-related sexual and gender based violence.

The United States must commit to advancing free and informed choice across U.S. foreign assistance by replacing the politicized Kemp-Kasten language with comprehensive and enforceable anti-coercion protections across the full range of sexual and reproductive health and rights issues.

At the International Conference on Population and Development (ICPD) in Cairo, the U.S. joined 178 other countries in adopting a Program of Action that continues to serve as a comprehensive guide to development progress based on volunteerism and without coercion. Since that time, many governments have instituted new and effective safeguards against coercion in reproductive health programs. The U.S., however, has continued to rely on an outdated 35-year-old provision in law – the Kemp-Kasten Amendment – that is narrow, politically biased and ineffective at ending coercion. Current US law in this area should be replaced with clearer, enforceable, and more comprehensive protections against coercion that has the effect of actually helping end coercion.

- Congress should replace Kemp-Kasten with a blanket prohibition on U.S. funding going to coercive activities in US foreign assistance in line with the ICPD. The U.S. should clearly and comprehensively define the parameters of coercion and what activities are prohibited. Reproductive coercion is any behavior that interferes with autonomous decision making about reproductive health outcomes. Coercive activities include, but are not limited to:

  – Use of incentives or disincentives to lower or raise fertility;
  – Use of incentives or targets for uptake of specific contraceptive methods;
  – Withholding of information on reproductive health options;
  – Forced sterilization;
  – Forced abortion; and
  – Forced pregnancy.

The U.S. commitment to human rights based approaches to sexual and reproductive health, free
from all forms of coercion, must be made clear in all requests for proposals, guidance, trainings, contracts, and cooperative agreements. There must be a robust compliance monitoring system and a clear way to report and thoroughly investigate potential violations so that appropriate corrective action can be taken.

The United States should strengthen global health systems and supply chains with the goal of ending contraceptive commodity stockouts and wastage resulting from mismanaged overstocks, and ensuring access to the full range of quality contraceptive methods.

In order to do so, the administration should:

• Use diplomacy to encourage Ministries of Health and Finance to co-invest their own resources, alongside U.S. family planning assistance, to develop and implement clear policies and protocols that improve the supply chain and resolve stockouts.

• Streamline an indicator on contraceptive stockouts in USAID contracts.

• Improve method mix of contraceptives.

• Improve family planning graduation strategies to better monitor and address contraceptive stockouts and method mix with contingency plans for meeting serious pipeline and budget gaps that may result when transitioning from donor to domestic financing.

• Improve awareness of and access to emergency contraception.

The U.S. must recognize the lifesaving nature of sexual and reproductive health care in humanitarian emergencies and prioritize the provision of sexual and reproductive health services, as well as gender-based violence (GBV) programming, in U.S. humanitarian and disaster relief assistance.

Around the world we are seeing some of the highest levels of displacement and humanitarian need in history. In 2018, more than 34 million of those individuals were women of reproductive age, including more than 5 million women who were pregnant. Many individuals want to delay or avoid pregnancy during times of conflict or crisis, but

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too often they lack access to contraceptives and other reproductive health services and supplies. Additionally, humanitarian emergencies lead to heightened risks of GBV, including rape, sexual harassment, assault and exploitation, trafficking, child, early, and forced marriage and interpersonal violence.

The State Department’s Bureau of Population, Refugees and Migration (PRM) and the Office of Foreign Disaster Assistance (OFDA) should prioritize and fully fund implementing partners to:

• Ensure that the Minimum Initial Service Package (MISP) is prioritized and operational at the onset of any humanitarian crisis: The MISP is a series of critical coordination activities and life-saving health and protection interventions required to respond to the immediate sexual and reproductive health needs of those impacted by a humanitarian crisis. These activities, combined with kits of the necessary equipment and supplies, are intended to address needs at the onset of a crisis and serve as a starting point for rebuilding comprehensive sexual and reproductive health services throughout protracted crises and recovery.

• Support and implement quality comprehensive reproductive health services for the duration of a crisis and through the transition to recovery. In addition to implementing the MISP, planning for and efforts to integrate comprehensive reproductive health services into primary health care should begin as soon as possible. Comprehensive reproductive health care activities include but are not limited to: establishment of critical reproductive health coordination mechanisms; prevention of transmission of HIV and other sexually transmitted infections (STIs) and provision of supplies and services necessary for the treatment of STIs and continuation of antiretroviral treatments; provision of maternal health services, including antenatal and postnatal care and emergency obstetric and newborn care; provision of safe abortion and post-abortion services; ensuring consistent access to a full range of contraceptive supplies and services, including emergency contraception.

• Provide assistance to prevent and respond to gender-based violence (GBV) from the earliest stages of a crisis, including to address health, including sexual and reproductive health, as well as mental health and other psychosocial services, legal rights and access to justice. This includes, but is not limited to:

  – Enhancement of the health sector capacity to detect, prevent, and respond to gender-based violence through training for providers on quality, confidential care (including clinical management of rape); identifying GBV and integrating GBV into health services to ensure that survivors are able to access lifesaving and time-sensitive treatments, including both emergency contraception and Post-Exposure Prophylaxis for HIV, at the same location.

  – Survivors of gender-based violence should be provided with or referred for psychosocial services, emergency contraception and post-exposure prophylaxis and, when needed, abortion services.

  – Building local capacity and improving national systems whenever possible to promote risk reduction and better respond during crises, displacement, and recovery.

• Support efforts to ensure women’s meaningful participation in designing SRHR and other gender programing throughout the period of relief and recovery, as well as in efforts around peace building, to ensure that the human rights concerns of women, girls and other marginalized communities are considered and addressed.
To advance the health, rights, and well-being of individuals and communities around the world, U.S. international family planning and reproductive health programs must be supported by robust funding and sound policies. The U.S. should contribute its “fair share” of funding to international family planning and reproductive health programs and eliminate policy riders which undermine the effectiveness of U.S. aid.

- Congress should invest and the President should propose at least $1.66 billion for international family planning and reproductive health programs, including $111 million for UNFPA. Across the globe, U.S. investment in international family planning and reproductive health programs serve as a lifeline. In FY18 alone, U.S. foreign aid provided contraceptive services for 24.3 million women and couples, averting 7.2 million unintended pregnancies, 3.1 million abortions (2 million of which would have been unsafe) and 14,690 maternal deaths.\(^{23}\) A total of $1.66 billion, including $111 million for UNFPA, represents the US share\(^ {24}\) of total global expenditures necessary to address the current unmet need for contraceptives for 214 million women in developing countries.\(^ {25}\) UNFPA plays a critical role as the largest multilateral provider of family planning and reproductive health services. Investments in UNFPA expand the reach of our aid as it operates in more than 155 countries. UNFPA plays a critical role in ending maternal death, unmet need for family planning, and gender-based violence and harmful practices like female genital mutilation and child marriage. UNFPA has taken a lead role in responding to reproductive and community health needs in humanitarian emergencies, such as conflicts and natural disasters.

- Congress should provide significant increased investments for other global programs that promote the health, rights, and well-being of individuals and communities and advance gender equality, including Maternal, Newborn and Child Health (MNCH), the President’s Emergency Plan for AIDS Relief (PEPFAR) (at least $5.5 billion annually), U.S. contribution to the Global Fund to Fight AIDS, TB, and Malaria ($1.56 billion in annual contribution), USAID HIV programs ($350 million annually), the International Organizations and Programs account which supports U.S. contributions to international organizations and specialized agencies across a broad spectrum of development, humanitarian, and scientific activities, and gender equality programs, including those focused on gender-based violence, women’s leadership, women, peace and security, and women’s economic empowerment, as well as programming addressing the unique needs of adolescent girls, such as ending harmful practices such as child marriage and female genital mutilation/cutting.


• Congress should also:

  – Remove the Livingston amendment, which allows organizations that receive certain government grants to refuse to offer the full range of contraception based on their religious objections; this provision significantly undermines access to the full range of contraceptive methods, a critically important part of promoting health and respecting rights.

  – Eliminate onerous and unnecessary restrictions on the U.S. contribution to UNFPA including the requirement to segregate the US contribution and the dollar-for-dollar withholding for any funding UNFPA provides to China.

“If you have come to help me you are wasting your time. But if you have come because your liberation is bound up with mine, then let us work together.”

— Lilla Watson
Protect and Expand Access to Abortion Care Domestically and Globally

Abortion care is health care, and access to abortion is critical for all people. If an individual is to make their own decisions and live their healthiest life possible—a fundamental human right—they must be able to control their reproductive life and obtain quality sexual and reproductive health care and accurate information. When someone is denied the ability to care for or end their own pregnancy, they are denied the means to direct their own life, protect their health, and exercise their human rights.

The President and Members of Congress should use their pulpits and authority to protect and expand access to abortion care, destigmatize abortion, and to lift up the importance of a federal guarantee that all have access to abortion care, no matter who they are or where they live.

Access to abortion care is under attack across the United States and remains heavily restricted in countries around the world. While abortion is currently a constitutional right in the U.S., in many parts of the country, that right is solely theoretical. State legislatures have targeted providers with medically unnecessary restrictions that have shut down clinics and cut off access to care, they have passed laws that shame decision making, and attempted to ban abortion outright. Several states have only one or two abortion providers in their states, half of states restrict private insurance coverage of abortion, and two-thirds of states withhold Medicaid coverage of abortion except in the most dire circumstances of rape, incest, and life-endangerment. In addition, some states prosecute individuals choosing to end their own pregnancies, a disturbing practice we have witnessed outside of the U.S. as well. Moreover, current federal law places unjust restrictions on abortion access, including the Hyde and Helms Amendments, which withhold federal funds from abortion in the U.S. and around the world, and the Weldon Amendment, which emboldens health care providers to deny access to abortion care. Health
and wellbeing, not politics, should guide important medical decisions at every point in pregnancy.

Opponents of abortion are accelerating passage of these laws and policies as a way to prompt legal challenges in hopes of ultimately securing a Supreme Court ruling that would reverse decades of case law and make abortion wholly inaccessible nationwide. The majority of justices on the U.S. Supreme Court have indicated willingness to uphold state and federal laws that restrict access to sexual and reproductive health care, and as such, it is more important than ever that we establish a federal guarantee that all individuals have unimpeded access to abortion.

No one is free without the ability to control their own body. All people—no matter where they live, where they are from, how much money they have, or their insurance coverage—should have the means, resources, and tools to access abortion in a timely manner without barriers so that they can control if, when, and how to become pregnant and grow their family if they chose. Because abortion restrictions fall hardest on those who have limited means to navigate around barriers to health care, such as people of color, individuals with low incomes, immigrants, young people, and people in rural areas, guaranteeing unimpeded abortion access is also crucial for improving health equity and ensuring that more people are able to curate their lives with respect, dignity, integrity, and autonomy.

The President and Members of Congress have tremendous power to create policy, pass legislation, and use the bully pulpit to influence the debate around issues of importance such as this one. It is not enough that federal lawmakers seek to safeguard the status quo: Congress must work with the President to guarantee all people in the U.S. and around the world access to surgical and medication abortion without impediment. Accordingly, we ask they use this power to:

• Pass the EACH Woman Act and the Women’s Health Protection Act as necessary federal

responses to the crisis in access to abortion care in the U.S.

• End the Hyde Amendment and related restrictions and ensure that everyone has abortion coverage, regardless of their income or source of insurance.

• Repeal the Helms amendment, and replace it with endorsement of using U.S. funding for safe abortion services worldwide.

• Eliminate the Weldon Amendment, which emboldens health care providers to deny access to abortion care.

• Use the bully pulpit to:

  – Speak out against restrictions on access to abortion in the U.S. and around the world, including targeted regulation of abortion providers (TRAP) and other laws;

  – Denounce the unjust and stigmatizing criminalization of abortion, including those who end their own pregnancies by choosing self managed abortion and send strong messages that however a person chooses to end a pregnancy, they must be able to do so safely and effectively without fear of arrest;

  – Condemn anti-abortion violence and intimidation, and combat the inflammatory rhetoric used by anti-abortion individuals that can lead others to engage in violent activity. Public statements that condemn these acts would signal a deep commitment to protecting reproductive rights, civil rights, and the rule of law; and

  – Talk about abortion care in a way that normalizes it with other health care and de-stigmatizes those who have abortions and those who provide abortions.
Policymakers should ensure comprehensive insurance coverage of abortion domestically.

Everyone should have access to abortion care regardless of their source of insurance and, whether that care is within or outside a clinic setting. Studies show that a woman who seeks an abortion, but is denied, is more likely to fall into poverty than one who is able to get an abortion. Each of us should be able to make decisions about our health and our futures with dignity. However, starting with the passage of the harmful Hyde Amendment in 1976, discriminatory restrictions on public insurance coverage of abortion continue to severely limit abortion access for people with low or no incomes, as well as others who receive their health coverage or care through the federal government. Further compounding the problem, since 2010 more than 400 laws have been enacted in the U.S. that restrict and regulate abortion for medically-unnecessary reasons. The cumulative effect of these numerous restrictions has been to severely limit the availability of abortion services in some areas, creating a patchwork system where access to abortion services are available in some states but not others.

It is necessary for Congress and the administration to act to undo the barriers that make the right to have an abortion a right only in theory for too many people. At a minimum, Congress must pass the EACH Woman Act to mandate coverage of abortion in government health plans and programs, and ensure that young people and their rights to confidential care are protected in federal legislation. Such legislation must not include exemptions or accommodations based on religious or personal beliefs that would impede patient care. It is critical that existing policy riders that are designed to cut off reproductive health services, information, and advocacy be permanently repealed and blocked from being attached to annual appropriations.

- Congress should end all abortion coverage bans affecting the following populations: (i) Medicaid, Medicare, and Children’s Health Insurance Program beneficiaries; (ii) federal employees and their dependents; (iii) Peace Corps volunteers; (iv) Native Americans; (v) people getting health services through CHAMPVA and the Department of Veterans Affairs; (vi) people in federal prisons and detention centers, including those detained for immigration purposes; and (vii) people with no or low incomes in the District of Columbia through the use of local funds. Congress should end coverage restrictions in the Labor-H, FSGG, SFOPs, and CJS bills. Congress should reauthorize CHIP, IHS, and DOD without coverage bans.

- The President should put forth a President’s budget without abortion coverage restrictions and issue a Statement of Administration Policy (SAP) threatening to veto legislation that extends, reiterates, or incorporates abortion coverage restrictions such as the Hyde Amendment and the other harmful restrictions listed above.

- The President should strike language restricting abortion coverage from the President’s Budget.
and issue a Statement of Administration Policy (SAP) threatening to veto legislation that extends, reiterates, or incorporates abortion coverage restrictions such as the Hyde Amendment and the other harmful restrictions listed above.

- The administration and Congress should reverse restrictions on abortion coverage for people who are enrolled in private health care plans. Specifically, the administration should revoke EO 13535 and rescind any finalized 1303 regulations or guidance. In light of constant attacks on abortion coverage and attempts to expand coverage bans into the private market, Congress must strike 1303 of the ACA and compel private insurance coverage of abortion.

“[T]he Hyde Amendment is a transparent attempt ... to impose the political majority’s judgment of the morally acceptable and socially desirable preference on a sensitive and intimate decision that the Constitution entrusts to the individual. Worse yet, the Hyde Amendment does not foist that majoritarian viewpoint with equal measure upon everyone in our Nation, rich and poor alike; rather, it imposes that viewpoint only upon that segment of our society which, because of its position of political powerlessness, is least able to defend its privacy rights from the encroachments of state-mandated morality.”

–Justice William Brennan dissenting in Harris v. McRae
Policymakers should actively fund and promote access to safe, legal, and accessible abortion throughout the world.

As we advance the right to abortion as a critical health care service in the U.S., we must also advance this right globally. The Helms Amendment, which has been in place since 1973, prohibits the use of U.S. foreign assistance funds for “the performance of abortion as a method of family planning.” This provision restricts the ability of individuals to make their own personal medical decisions and undermines U.S. goals to advance gender equity and address maternal health and gender-based violence around the world. Furthermore, it has been overimplemented as a complete ban on U.S. funding for abortion, even in cases of rape, incest, or a life endangering pregnancy.

Globally, one in three women will experience violence in her lifetime—a rate that is often higher in humanitarian crisis and conflict settings, where rape and other forms of sexual violence are used as tools of war and where displaced communities are particularly vulnerable.

Unsafe abortion is a global health crisis driven by criminalization of the procedure and an inability to access safe abortion care. Annually, there are more than 25 million unsafe abortions worldwide that lead to millions of injuries and tens of thousands of preventable maternal deaths. The Helms Amendment exacerbates this crisis, and it is long past time for the U.S. to support safe abortion services. Over the last two decades, many countries have liberalized their abortion laws, magnifying the impact of the Helms Amendment as a significant barrier to patients receiving the care they need and to which they are legally entitled. U.S. restrictions must not stand in the way of access to legal health care.

In addition, in too many countries, laws criminalize abortion services. These laws are discriminatory—disproportionately affecting women, people living in poverty, and LGBTQ+ people—and they are a significant barrier to comprehensive reproductive health services by threatening both health care providers and people seeking care. International human rights bodies have repeatedly called for the decriminalization of abortion, and the World Health Organization reports that unsafe abortion remains a major cause of maternal mortality. Abortion laws use criminal codes to control people’s bodies and, in practice, may lead to other serious human rights abuses. For example, in countries like El Salvador where abortion is completely criminalized, women are frequently jailed for miscarriages. Despite these physical and legal risks, countries with highly restrictive abortion laws typically record higher abortion rates than countries with less restrictive laws.

The U.S. should use diplomatic engagement and foreign assistance to promote access to quality, comprehensive sexual and reproductive health care services for all people; this includes safe, legal, and accessible abortion. Stated U.S. policy should promote access to safe and legal abortion throughout the world, as a part of U.S. efforts to advance health and human rights through the following actions:

- Congress should legislatively repeal the Helms Amendment, and replace it with endorsement of using U.S. funding for safe abortion services worldwide.
- The President should champion the permanent repeal of the Helms Amendment. While working
with Congress to pass legislation to this end, the President should work to mitigate the harms of the Helms Amendment.

- Congress should modify the Siljander Amendment in the State and Foreign Operations appropriations bill to only prohibit the use of U.S. funds to lobby against abortion. Foreign policy funding decisions – particularly those around health – should be grounded in science and fact, and the evidence is clear that safe abortion access saves lives.

- The State Department should make an affirmative statement that the U.S. supports the decriminalization of abortion – including self-managed abortion – around the world. U.S. diplomats should carry this message throughout the world, and the U.S. should use multilateral spaces to promote normative guidance urging the decriminalization of abortion.

**Policymakers should promote and ensure improved access to medication abortion.**

Ever since mifepristone was approved for use in the United States nearly 20 years ago, it has offered those who want to end their pregnancies a way to do so in a setting where they may feel most comfortable. Medication abortion accounts for 45% of all abortions before nine weeks of gestation in the U.S.26 Unfortunately, medication abortion has been subject to laws that limit access, and those limits – combined with medically unnecessary regulatory restrictions imposed at the time of approval – have inhibited access to the highest standard of care for medication abortion.

- HHS should encourage and pursue policies that support evidence-based protocols and implement programs that will improve access to this safe, private, and non-invasive option.

- The Department of Health and Human Services should proactively work with the World Health Organization’s (WHO) Expert Committee on the Selection and Use of Essential Medicines to remove the disclaimer notes attached to the combination use of mifepristone and misoprostol on the WHO’s List of Essential Medicines.

“Reproductive Justice is built on the foundation of Human Rights. The framework of “Reproductive Justice” requires that the most vulnerable populations be kept in the center of our lens, not at the margins.”

– Loretta Ross

The Administration should create and support public health resources used to increase people’s knowledge of the full range of abortion options, including self-managed abortion.

Both clinic-based and non-clinical abortion options should be safe, affordable, and free from stigma or punishment for the people who need them. Clinic-based abortions are an essential component of abortion care; nevertheless, some pregnant people need abortions outside of the formal health care system. Non-clinical abortion, such as a self-managed abortion, occurs most commonly in the privacy and safety of one’s home and with the help of a caregiver, friend, or family member. Self-managed abortion may include the use of medication abortion pills (mifepristone and/or misoprostol), traditional herbs, or other means to end a pregnancy.

Self-managed abortion (SMA) is generally safe and effective, especially when people have access to information and back up medical care if needed. There is no legitimate public health reason to prevent people from having access to the means to self-manage their abortion. Increased awareness about self-managed abortion, safe methods, and means of access—achieved through culturally competent communications accessible to people of all educational levels—will help destigmatize self-managed abortion. Destigmatization will, in turn, ensure that people who end their own pregnancies will feel safe to seek medical care, and it will lessen the likelihood of criminalization.

Criminalization of self-managed and supported non-clinical abortion poses serious threats to people’s health. The likelihood, or even possibility, of being turned in to law enforcement erodes trust in the medical system, making people less likely to seek medical help when they need it. Most of the people arrested for self-managing an abortion came to the attention of law enforcement when they sought emergency medical help. Public health resources could educate healthcare providers, patients, and the public at large about SMA, debunking myths with facts and overcoming stigma through normalization.

- Materials for pregnant people, created or supported by HHS, should include information about how self-managed abortion with pills works, what the common side effects are, and under what conditions a person may need to seek medical help following a medication abortion or miscarriage.

- Materials geared toward health care providers, first responders, and social workers, created or supported by HHS and DOJ, should make clear that mandatory reporting laws do not apply to people who SMA and emphasize a harm reduction approach to treating patients in a supportive, non-stigmatizing manner.

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States have used a variety of criminal laws – the vast majority of which were never intended to be used against people who ended their own pregnancies – to prosecute people for self-managed abortion. There are as many as 40 different types of laws across the country that could be misused by a prosecutor intent on punishing a person for ending or losing a pregnancy. Specifically, there are six states with laws directly criminalizing self-managed abortion, as well as ten states with fetal harm laws and 14 states with criminal abortion laws that have been and could be misapplied to people who self-manage. There are various other laws that have been deployed when no other legal authorization to punish someone can be found, ranging from unlawful practice of medicine to child abuse to concealing a birth. In states throughout the country, even where fetal homicide laws expressly exempt pregnant people from prosecution, prosecutors have used other laws to target people who have self-managed abortion.

“For too long, women in this country have been denied abortion coverage just because of their source of insurance or level of income. We know that these restrictions are nothing more than attempts to bully, shame, and punish those seeking abortion care. I remain resolved as ever to see the Hyde amendment dismantled once and for all.”

– Rep. Barbara Lee
Access to respectful, high-quality, holistic pregnancy-related health services is a fundamental human right. Pregnancy care should fit the patient’s needs and preferences, regardless of race, ethnicity, socioeconomic status, immigration status, language, gender, gender identity, sexual orientation, marital status, family structure, disability status, age, source of insurance, or intent to parent. It is the government’s duty to respect, protect, and fulfill this human right. Further, the opportunity to improve maternal health outcomes begins years before pregnancy and requires continued support and access to non-discriminatory health care and wraparound services throughout the individual’s lifespan, including the pregnancy and postpartum period. Increased access to primary care throughout one’s life, as well as family planning, pre-pregnancy counseling, postpartum care, and necessary wraparound services are crucial to ensuring the best health outcomes for both pregnant individuals and infants.

In order to support healthy pregnancies and ensure the best outcomes, it is critical to address rising maternal mortality and morbidity, and long-standing health inequities that disproportionately harm Black and Native American communities. The U.S. is the only wealthy country in the world where maternal mortality is increasing, and Black women are between three to four times more likely to suffer maternal death, and twice as likely to suffer maternal morbidity as white women are. American Indian and Alaskan Native women are also 2.5 times more likely to die from pregnancy complications as white women. Disparities in pregnancy and birth outcomes are also tied to income and geographic location, but they do not explain the racial disparities that affect Black and Native women.

Pregnant individuals have the right to culturally competent, quality care that prioritizes their health care needs and preferences, and covers the full-range of services that research has proven to decrease their risk of maternal death and severe morbidity.

- To ensure comprehensive and holistic care for pregnant and parenting individuals, the administration must increase access to supports and services across the reproductive health continuum – including before, during, after, and between pregnancies.

- Further, the administration must encourage the development of a culture of equity, dignity, respect, and empowerment in health care systems, whereby accountability mechanisms are encouraged and implemented across systems to address discriminatory care, disrespect, mistreatment, and abuse of pregnant individuals based on race, age, gender identity, sexual orientation, immigration status, insurance coverage, perceived socioeconomic status, and other factors.

The Administration must clarify and mandate minimum standards of pregnancy care in insurance coverage.

The Affordable Care Act made maternity care and newborn services one of the ten Essential Health Benefits that every federally qualified health plan sold in the marketplaces must offer. However, the Affordable Care Act did not define what is included in maternity care. Thus, maternity care varies widely depending on your health plan, level of coverage, geographic region, and other factors.

- HHS should issue regulations establishing a minimum threshold for maternity care that specifically defines which services health plans must provide to ensure adequate, equitable pregnancy care coverage.

- All health plans including pregnancy care should cover care for uncomplicated pregnancies, without cost sharing, at a minimum of the number of prenatal appointments as well-woman visits recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. This means a visit every four weeks for the first 28 weeks of pregnancy, a visit every two weeks until 36 weeks of pregnancy, and weekly visits thereafter.

- For complicated pregnancies, the number of prenatal visits covered under pregnancy care would be increased. All prenatal screenings and ultrasounds should be included without cost sharing. Individuals who have just given birth should also have insurance coverage, without cost sharing, for an appointment with their OB-GYN, midwife, or other provider within the first three weeks postpartum, and similar coverage for a comprehensive postpartum visit no later than 12 weeks after birth.

Policymakers must improve access to insurance coverage for pregnant individuals by establishing a special enrollment period.

Many pregnant individuals find they lack the coverage needed to be able to access timely and comprehensive health care that meets their needs. Many live in states that did not expand Medicaid and may not be eligible for their state’s Medicaid pregnancy coverage. For this and many other reasons, they might turn to their state’s marketplaces to gain coverage. There, they might find they are unable to enroll simply because they missed the designated period for enrollment. Without coverage, many individuals forgo critical services such as prenatal care, with Black and Native American women
being more likely than other racial groups to receive late or no prenatal care during pregnancy.\textsuperscript{30} As mentioned previously, Black and Native American women are also more likely to experience severe morbidity and/or die from pregnancy-related causes.

- To improve access to critical services essential to healthy pregnancies, CMS should establish a special enrollment period for pregnant individuals to allow them to enroll in Marketplace coverage for at least 60 days after presentation of pregnancy or as established by the Secretary of HHS.

Congress should extend postpartum coverage to one year postpartum for individuals with pregnancy coverage under Medicaid and CHIP.

Although many pregnant individuals may not meet income requirements to qualify as a traditional enrollee of the Medicaid program, especially in non-expansion states, they are more likely to be eligible for their state’s Medicaid pregnancy coverage. Although the income threshold needed to qualify varies across states, pregnancy coverage is usually set at a higher percentage of the federal poverty line than the traditional program’s income requirements, with all states allowing pregnant individuals with incomes at or below 138 percent of the FPL to qualify for Medicaid pregnancy coverage. While this coverage helps millions of pregnant individuals, many states end coverage at sixty days following childbirth.

Extension of coverage for a full year beyond the end of pregnancy could help address the fact that many pregnancy-related complications that lead to maternal deaths, such as postpartum hemorrhage and peripartum cardiomyopathy, take place after the 60–90 day postpartum period. In fact, as many as two in three maternal deaths occur after childbirth, with 33 percent occurring between one week to one year postpartum.\textsuperscript{31} In addition to extending coverage, the next administration and Congress should ensure eligibility standards are maintained or expanded. Prior to the end of the one-year postpartum period, assistance should be provided to Medicaid and CHIP enrollees to help them enroll and transition to private insurance.

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Pregnant and birthing individuals must be able to meaningfully exercise their rights to access maternity care and maintain bodily autonomy by deciding where and with whom they will give birth. To improve access to maternity care, providers must ensure that people giving birth have options. This includes the federal government expanding access to birthing centers and midwifery care.

- Medicaid, Marketplace plans, and private insurance plans should be required to designate midwifery care and freestanding birth center services as a covered benefit.
- Midwives that meet U.S. accredited education standards, and licensed and accredited freestanding birth centers must explicitly be included in managed care plans.
- Managed care enrollees must be affirmatively informed about and offered the services of midwives and freestanding birth centers.
- Medicaid, Marketplace, and private insurance plans should be required to pay certified nurse midwives licensed in the jurisdiction at 100% of the physician payment for providing the same service.

Congress should pass legislation that expands access to doula support for pregnant individuals.

Numerous studies demonstrate that doulas can help reduce the impacts of racism and racial bias in health care on pregnant people of color by providing culturally appropriate and patient-centered care and advocacy. Research indicates that individuals receiving doula care have experienced improved health outcomes for both themselves and their infants, including shorter labors and lower cesarean rates. While access to doula care would benefit underserved populations, including people of color, immigrants, LGBTQ+ individuals, and individuals and families with low incomes, oftentimes members of these communities cannot afford to pay out of pocket for doula care.

- Congress should require that Medicaid, Marketplace plans, and private insurance plans expand access to doula care as a covered benefit. This should include: Coverage of full spectrum, culturally-congruent doula support during
pregnancy, labor and birth, and the postpartum period, and around the time of miscarriage and abortion support.

- CMS should promote Medicaid coverage of doula support and provide guidance to the states on how best to set up an efficient and effective Medicaid coverage program for doula care that helps build a culturally competent doula workforce, reimburses doulas with a living wage, and gives specific guidance to state agencies on reimbursement mechanisms, billing codes, and ensuring network adequacy and access for all managed care enrollees.

- Doulas must explicitly be included in managed care plans. Managed care enrollees who are pregnant must be affirmatively informed about and offered doula services.

Women, particularly women of color with low incomes, regularly face the threat of criminal penalties for actions taken during pregnancy and for pregnancy outcomes. These policies drive women away from seeking prenatal care and other social services, and they drive poor maternal or infant health outcomes.32 Additionally, no one who uses illicit drugs or licit substances such as alcohol, prescription opioids, or medication assisted treatment while pregnant should be subject to additional criminal penalties just because they are pregnant.

- DOJ should end policies and practices that place people at risk of criminal charges for failing to seek medical help when they miscarry, have a stillbirth, or use illicit substances during pregnancy.

- DOJ should also urge states to repeal existing policies criminalizing pregnant people, which discourage people from seeking care.

- DOJ should also furnish states with the resources they need to provide comprehensive medical treatment to pregnant and postpartum individuals with substance use disorders and/or mental health conditions and ensure that treatment for substance use disorders is available and accessible to pregnant and parenting people.

Policymakers must discourage states from using substance use during pregnancy as grounds for prosecution or incarceration.

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Policymakers should require all public and private insurance to cover all types of breast pumps, including double electric breast pumps.

According to the CDC, breast milk provides the best source of nourishment for most babies, and may even provide additional health benefits for both mother and infant protecting them from both short- and long-term illnesses. Breastfeeding puts babies at a lower risk for developing asthma, type 2 diabetes, infections, sudden infant death syndrome (SIDS), and other health conditions that could result in infant mortality. Mothers who breastfeed have a lower risk of developing breast and ovarian cancers, type 2 diabetes and high blood pressure. The ability to breastfeed should be accessible, autonomous, simple and convenient.

The ACA has made substantial progress for maternal and infant health by requiring that most private insurers cover breast pumps; however, significant gaps still remain. While the ACA mandates that private health plans provide breastfeeding support, counseling and equipment with no cost sharing, plans have discretion over which type of breast pump they will cover, and there is no guaranteed access to equipment for traditional (non-expansion) Medicaid enrollees at all. The Centers for Medicare and Medicaid Services (CMS) should issue a rule requiring all public and private plans:

- Cover all of the three main types of breast pumps, including manual, battery-powered, and electric, as well as single and double pumps, for all individuals if requested;
- Ensure access to the selected equipment for at least one month prior to the individual’s scheduled delivery date;
- Clarify that a lactating individual may have access to a new breast pump if the one originally selected does not suit their needs;
- Lengthen the covered rental period for breast pumps to one full year postpartum

“You cannot have maternal health without reproductive health. And reproductive health includes contraception and family planning and access to legal, safe abortion”

Hillary Clinton, former US Secretary of State

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33 The Department of Health and Human Services, Center for Disease Control and Prevention, Breastfeeding Recommendations and Benefits, 2018.
Ensure Access to Qualified Providers

Politicians shouldn’t interfere with health care providers and their patients in the U.S. or around the world. Yet policies like the domestic and global gag rules violate this trusted relationship by blocking qualified providers from participating in critical health programs in the U.S. and around the world. They also deny people the ability to get comprehensive information and care at their provider of choice.

Policymakers must ensure there is robust access to family planning services and providers who provide evidence-based sexual and reproductive health services domestically and globally.

While the Affordable Care Act (ACA) has produced unmatched improvements in access to affordable reproductive health care in the United States and there has been hardfought global progress on addressing both rights and access issues through innovative and persistent advocacy, there are individuals and communities who continue to face barriers to services that are essential to achieving full sexual and reproductive health, autonomy, and well-being. We must strengthen and expand access to the providers and programs that deliver these essential forms of health services in accordance with recognized standards of care, and ensure that services and supplies are available to all who seek them by strengthening the Title X, global health, and Medicaid programs.

“I raise up my voice – not so I can shout, but so that those without a voice can be heard...we cannot succeed when half of us are held back.”

– Malala Yousafzai
Every year, millions of U.S. adults and young people rely on safety-net providers supported by the Title X family planning program. Title X sites serve as critical sources of care, particularly for the uninsured, underserved, and other individuals in need of publicly-funded family planning services, which include contraceptive services and supplies, STI screening and treatment, cancer screening, sexual and reproductive health education, pregnancy options counseling, and basic infertility services. Of the approximately 4 million people served through Title X funded health centers in 2017, 31% (1.2 million) self-identified with at least one of the Office of Management and Budget’s nonwhite race categories: Black or African American, Asian, Native Hawaiian or Pacific Islander, American Indian or Alaska Native, or more than one race. Thirty-three percent (1.3 million) of Title X patients identified as Hispanic or Latino. Importantly, the life-saving care of Title X clinics also extends throughout the U.S. territories; for example, in Puerto Rico, 15,172 people were served in 2017. LGBTQ+ people also rely heavily on Title X centers for culturally competent family planning and preventative care and for gender-affirming health care services. For many individuals, particularly those who have low incomes, are under- or uninsured, or are adolescents, Title X is their main access point to obtain affordable and confidential contraception, cancer screenings, STI testing and treatment, complete and medically accurate information about their family planning options, and other basic care. In fact, a 2017 study found six in ten women seeking contraceptive services at a Title X-funded health center saw no other health care providers that year. Access to the family planning safety net must be protected and expanded – particularly in the face of recent ideological attacks on these providers and the funding streams that support them.

As the nation’s only federal grant program focused exclusively on family planning and sexual health care, the Title X program should be modernized to reflect and continue to keep pace with best practices in the delivery of compassionate, comprehensive care. In order to better serve our communities, the program should
be implemented according to nationally recognized standards of care and administered consistently, while still allowing providers to respond to local and regional health needs. Title X must support the inclusive delivery of care for all patients, especially those who are low-income.

• The administration should rescind the entirety of the Title X final rule, sometimes referred to as the “gag rule,” and protect the ability of highly qualified providers to participate in Title X, regardless of the non-Title X services they also offer.

• The administration should reaffirm that all providers receiving Title X funding are bound by the program’s fundamental tenets and congressional intent for the program, including providing confidential care, access to a broad range of contraceptive methods and counseling on all methods, and nondirective options counseling for patients with a positive pregnancy test.

• The administration should support advances in service delivery through the promotion of clinical standards, namely Providing Quality Family Planning Services: Recommendations of the CDC and the US Office of Population Affairs; through the development of quality measures, especially for contraceptive care; through providers’ consistent collection of metrics to track trends in service delivery; and through providers’ leveraging of existing and emerging technologies, with a focus on patient-centered care.

• Congress should increase investments in the Title X family planning program to $737 million. In spite of the critical importance of equitable access to family planning services for all people, regardless of their income or insurance status, Title X remains woefully underfunded.

The U.S. should end the Global Gag Rule.

It is wrong for the U.S. to force a health care provider in another country to choose between limiting the information and/or care they can give to patients and keeping critical funding. Yet, for 35 years, the global gag rule has played politics with people’s health and lives around the world, and now President Trump has put in place an unprecedented version of the policy, which extends its harm to even more people and communities. In its current expanded version, it prohibits foreign organizations from receiving any U.S. global health assistance if they provide information, referrals, or services for legal abortion, advocate for the legalization of abortion in their country, or fund organizations that undertake these activities, even if these activities are supported solely with non-U.S. funds.

Health care providers pledge to do no harm. By forcing health care providers to deny legal health services and/or withhold information about legal health services, the global gag rule violates the trusted relationships between an individual and their provider—sometimes at the cost of their life.

The expanded global gag rule blocks health care access, stifles local advocacy efforts, and undermines reproductive rights worldwide. This policy creates mass fear and confusion and puts lifesaving services out of reach for communities who already face systematic barriers to care.

- Congress must legislatively repeal the global gag rule and block any future President from reinstating it by passing the Global Health, Empowerment and Rights (HER) Act.

- The President should champion the permanent repeal of the global gag rule and proactively work to restore relationships with communities and organizations who have been harmed by the policy.
  - Rescind the presidential memorandum reinstating and expanding the global gag rule.
  - Vocally support the Global Health, Empowerment and Rights (HER) Act and other legislative efforts to permanently repeal the policy, including through appropriations.

- Provide clear and proactive communication to all agencies that administer global health programs and U.S. Missions that the global gag rule is no longer in place and direction to update all relevant training, compliance, contracts, requests for proposals, and related materials.

- Develop a plan to proactively reach out to organizations previously impacted by the global gag rule to make sure they know U.S. policy has changed, understand the gaps and harm created by the global gag rule to inform future funding and programmatic decisions, and ensure that they are aware of future opportunities to collaborate with the U.S. government, including by applying for U.S. global health funding.

- Stand with other governments who are committed to funding comprehensive sexual and reproductive health and rights, including through SheDecides.

The Administration should require state Medicaid programs to sufficiently reimburse providers for all services and supplies to ensure that Medicaid enrollees have timely access to all covered services from the provider of their choice.

Medicaid and CHIP are essential to the U.S. health care system, covering more than 72.5 million people, including one in five women of reproductive age. LGBTQ+ people are almost twice as likely as the overall U.S. population to receive Medicaid benefits. Providers participating in Medicaid and CHIP offer high-quality care, including sexual and reproductive health care. Yet, they are typically reimbursed considerably lower than for other services.

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37 The Department of Health and Human Services, Center for Medicaid and Medicare Services (CMS), Medicaid Eligibility, 2019.
less for their services than by other types of public and private health insurance—often significantly less than the actual cost of service.⁴⁰ For safety-net providers that do not turn away patients in need, low reimbursement rates hinder provider capacity to accept new patients, limit the number of available providers in a community, and cause appointment delays that can be troublesome for patients needing time-sensitive care.⁴¹ The administration should:

- Issue regulations that require Medicaid and CHIP reimbursement rates, whether fee-for-service or managed care, be at least equal to Medicare reimbursement.
- Support any congressional effort to boost the federal share of rate increases for a range of providers.
- Clarify and implement policies that ensure providers have access to discounted drugs. This is necessary to ensure that Medicaid and CHIP enrollees have access to timely, high-quality care and services.

> “Of all the forms of inequality, injustice in health is the most shocking and inhumane.”

– Dr. Martin Luther King, Jr.

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⁴¹ Ibid.
Policymakers must ensure that all federally-supported health programs are operated in a manner that does not discriminate against or otherwise limit the participation of reproductive health providers for reasons unrelated to their qualifications; and expand the scope of health care providers that are covered under health programs and insurance options.

Increasingly, state governments have tried to deny or restrict the participation of reproductive health providers that provide comprehensive services in federally supported health programs. These attacks put access to care at risk, particularly for low-income and underserved populations, and thereby threaten to compromise public health and prevention goals. In order to have timely access to quality health care, patients must be able to use their health coverage or leverage publicly-funded programs to see the sexual and reproductive health care providers that they trust. However, health care access, particularly for people of color and people with low incomes, has increasingly been put at risk by state efforts to deny the participation of qualified, reputable providers in federally-supported health programs. Congress and the administration must ensure that certain providers of sexual and reproductive health care are not discriminated against, and must expand access to the providers that people trust.

This includes:

- Ensuring that qualified providers of reproductive health care are not prevented from participating in public health programs – including in key programs that provide access to birth control, STI/HIV prevention, cancer screenings, and sexual health education – for reasons unrelated to their qualifications.

- Leveraging the administration’s full authority to issue strong rules that ensure reproductive health providers can continue to participate in the range of federally supported health programs.
Congress should pursue policies that incentivize the creation of a larger and more diverse network of reproductive health care providers. More specifically, Congress should encourage broader diversity of race, ethnicity, language proficiency, gender, sexual orientation, and provider type to expand access to comprehensive reproductive health care, increase culturally competent care, reduce health disparities, and ensure that providers reflect the populations they serve.

- **Congress should create a Reproductive Health Care Provider Service Corps.** There are not enough reproductive health care providers to meet current needs. This program, which would include advanced practice clinicians (APCs), would incentivize providers to provide the full range of reproductive health care, including abortion, in underserved areas. The program should emphasize enrollment of providers of color and bilingual providers, offer loan forgiveness, and provide resources on how to manage the pressures of providing reproductive health care.

- **Congress should increase Graduate Medical Education (GME) funding.** The demand for physicians continues to grow faster than supply, leading to a projected shortfall of between 42,600 and 121,300 physicians by 2030 with predicted shortages in both primary and specialty care. Physicians are a critical element of our health care workforce, and if we do not address this impending problem, patient access to care will continue to suffer. Medicare provides an important source of funding that helps offset some of the costs associated with educating residents. However there is a Congressionally imposed limit to the number of training slots Medicare can support. Lifting this antiquated cap on the number of slots for medical school graduates and increasing the available GME funding to Medicare would expand the number of providers available to provide reproductive health care.

- **Congress should commission a comprehensive study into barriers for people of color becoming health care providers and initiate a pilot program to create a pipeline for providers of color.** Studies have shown that there is a correlation between better health outcomes and patients having access to providers that come from similar backgrounds, including race, ethnicity, gender identity, sexual orientation, and religion. But the nation has continued to struggle with efforts to build a more diverse health care workforce. Impediments to the inclusion of more providers of color in the health care system start long before medical training or undergraduate education and are multivariable, so further research to better understand these barriers is needed.

- **Congress should encourage states to enter into compacts for state Medicaid programs.** Reproductive health care services can be out of reach for individuals that live far from Medicaid providers in their own states but close to providers in neighboring states. Congress should encourage states to facilitate providers in other states getting reimbursed by their Medicaid programs.
Policymakers must advance federal initiatives and support state efforts to protect the privacy and safety of reproductive health care providers and patients, and assess ways for the federal government to strengthen existing protections.

In a climate of escalating anti-abortion rhetoric, reports illustrate that reproductive health care facilities are experiencing an increase in vandalism, trespassing, hate mail, internet harassment, and obstruction of their entrances. Death threats and threats of harm directed at individual providers remain high. Reproductive health care providers face a barrage of harassment and intimidation at their workplaces, homes, in their communities, and online.

Additionally, many reproductive health care providers fear public disclosure of their identities or other personally identifiable information because this information has historically been used to target providers and their families with violence, harassment, and intimidation tactics, including at their homes, churches, and in their residential neighborhoods. Reproductive health care providers, like any other professional engaged in lawful business activities, should not be forced to live fearing for their safety or the safety of their loved ones. State legislators must be made aware of how their public licensing processes, and other state policies, may be putting the lives and safety of reproductive health care providers at risk.

• The administration must prioritize investigation and prosecution of those who target and commit acts of violence and harassment against reproductive health care providers, patients, staff, and others who support the right to access abortion care, and fully fund efforts to prevent violence against abortion providers.

• The administration should direct the Department of Justice to Monitor and Combat Violence Against Reproductive Health Providers to develop policies, protocols, and guidelines concerning the prevention, investigation, and prosecution of violence against abortion providers, patients, staff, and others who support access to abortion care.

• The federal government should, through grants and other technical assistance, support state efforts, like California’s Safe at Home program, to protect the home addresses of providers and others who fear harassment and violence from public disclosure through state records.

• The administration must find ways to leverage federal and state resources to collaborate between authorities, including training for state and local law enforcement, and support for state efforts to protect providers.