NLWJC - Kagan

DPC - Box 026 - Folder 006

Family - Family Planning

HOGAN_L @ A1
01/14/97 01:21:00 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc: Michelle Crisci, Kevin Moran, REED_B @ A1@CD@LNGTWY, MAYS_C @ A1@CD@LNGTWY
Subject: Message Meeting/President's Int'l Family Planning Report

Martha Foley asked me to put together a message meeting to discuss releasing the President's report on international family planning. The meeting is scheduled for Thursday, Jan. 16 from 2:30-3:30 in room 211 OEOB.

The President is due to submit his report to Congress no later than Feb. 1 and a vote on the report is likely to occur shortly thereafter. The report and the vote are expected to be controversial. In addition, the VP is scheduled to speak to NARAL on Jan. 22 (the Roe v. Wade and Mexico City policy anniversary) and he will likely have to field questions about the report and the upcoming vote, so we need to be clear on message as soon as possible.

We need to discuss the following questions:

1) Actual report release date (we have discussed Jan. 30)
2) Message
3) Release strategy (remarks, press release or what?)

A draft of the report will be distributed to you this evening.

State and USAID are making final edits to the report and are clearing it through Secretary designate Albright and others. The final report will be available Tuesday, Jan. 21.

Message Sent To:

Donald A. Baer
Barry J. Toiv
Lorraine A. Voles @ ovp@eop
Lisa Ross
Elena Kagan
Rahm Emanuel
Nancy A. Min
FOLEY_M @ A1@CD@LNGTWY
ABERNATHY_P @ A1@CD@LNGTWY
VELLENGA_T @ A1@CD@LNGTWY
MYERS_B @ A1@CD@LNGTWY

File

HOGAN_L @ A1
01/13/97 07:11:00 PM

Record Type: Record

To: Gordon Adams

cc: Elena Kagan
Subject: Int'l Population Program Funding

Gordon,

I've heard a couple of different versions of the decision made at last week's meeting on Int'l Population Program funding. (I've heard three versions of the funding agreement -- $400 mil, $425 mil, and $435 mil -- and that the original number asked for was $460 mil, the same amount requested last year.

Can you fill me on on the correct numbers and the reason for the decision?

Thanks.

Message Creation Date was at 13-JAN-1997 20:04:00

Thanks for the e-mail. AID Administrator Brian Atwood would like to request $400 m. for population under Development Assistance. With funding they have available under Economic Support Funding (Egypt) and New Independent States (Russia, etc.) for population activities, the total program activity would be roughly $430 m. This compares with $385 m. appropriated for FY 1997, but is $35 m. below the amount the administration requested for FY 1997.

The question is whether $400 m. is an adequate request. I would argue that it is - if we got it, it would be $45 m. higher than what Congress appropriated for FY 1997. Some program people (Wirth, Gillespie) would argue for $435 m. as the request. We will not get $435 m. (we may not even get $400 m.) from the Hill. But if we ask for $435 m. , AID will have to take it away from other program priorities they have in a shrunk development assistance budget. When the Hill takes the $35 m. (or more) away from that higher request, they will put the money into priorities AID would not choose.

I think the sensible Hill strategy is to ask for an increase over FY 1997 appropriated levels (the $400 m. AID wants to ask for), which will look reasonable to some on the hill, without affronting others. We get credit for an increase; they get credit for the cuts they will take anyway, and we have more money to work with.

I need a resolution on this tomorrow, as we have to close the budget books on the issue. I am happy to discuss it further with you.

Ekra -
FYI on Pop Prog
funding. This came
from Gordon Adams.
Lyn

- Martha Foley -

1)

C.F. - throw stuff together for MF

Fam Planning -

- Adequacy of request
- Have to make funding - program delineated

lowered #s on # of abortions - so pretty defensible

-

Have to do straight - And so as not to scare Republicans.

Report prob OK.

Beating on State/AID

Tactics - how to bring Ging in + get his help.

[illegible]

2) What # to put in for family planning.

385 m last yr - way below our request (460)

If ask for less than last yr (460), have trouble w/ IPI?

But if ask for that much, they'll take extra + put it places we don't want

AID pleading - take # down to 425 - so other accts don't get screwed.

spread rest around to other worthwhile programs.

~~NAM~~ Tim Wirth - wants to stay as hi as possible.

Realism - enacted level of 400 would be great

MF - splits between 425 - 460??

BRUCE REED

Daily Schedule for
Monday
January 13, 1997

9:30	Staff Meeting (Room 211)
10:15	Emily Bromberg (your office)
11:15	Social Security Admin. Mtg (Room 158)
12:00	Balanced Budget Strategy Meeting (Roosevelt Room)
1:00	Lunch with Ron Brownstein
3:00	Tom Freedman (your office)
5:00	Farewell for George (State Floor)
7:00– 10:00	Surprise Party for Peter Knight (B. Smith's)

REVISED SCHEDULE 1/13
10:30 a.m.

G. Lew Dunn
955-8500

Agenda

International Family Planning Meeting
Monday, January 13, 1997
2:00 p.m.
Room 211 OEOB

I. Report Discussion

--Questions, Comments, Concerns

II. Report Clearance

--USAID, State (Clearance final?)
--White House clearance

III. Report Release/Distribution

--Release date (Feb. 1 or earlier?)
--Message
--Release strategy (Press release, press conference?)

IV. Vote

The President will submit his findings by Feb. 1. For population program funds to be available by March 1, 1997, Congress must approve the President's findings by joint resolution no later than Feb. 28, 1997.

V. Important Dates/Events

Jan. 20
--Inauguration, Right-to-Life groups plan protests

Jan. 22
--Roe v. Wade anniversary
--Mexico City Policy anniversary
--VP and Mrs. Gore speak to NARAL

Jan. 29
--Rockefeller Foundation releases report on the importance of family planning, expect large press interest

Feb. 1
--President's findings due to Congress

Feb. 28

--Date by which vote on President's findings must occur

HOGAN_L @ A1
01/06/97 01:44:00 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc: Elena Kagan, REED_B @ A1@CD@LNGTWY
Subject: International Family Planning Meeting

To: Distribution (attached)
From: Lyn Hogan
Date: Jan. 6, 1997
Re: International Family Planning
Report Distribution

I have scheduled a meeting for Monday, Jan. 13 from 2:00 p.m.-3:15 p.m. in room 211 OEOB to discuss the international family planning report due from the President to Congress Feb. 1, 1997.

We will review the final draft of the report and discuss strategy for the draft report distribution.

A copy of the final draft report from AID and State will be distributed for your review prior to the meeting. Please bring your comments and questions to the meeting.

Please RSVP to me. I can be reached at 456-5567 or through e-mail.

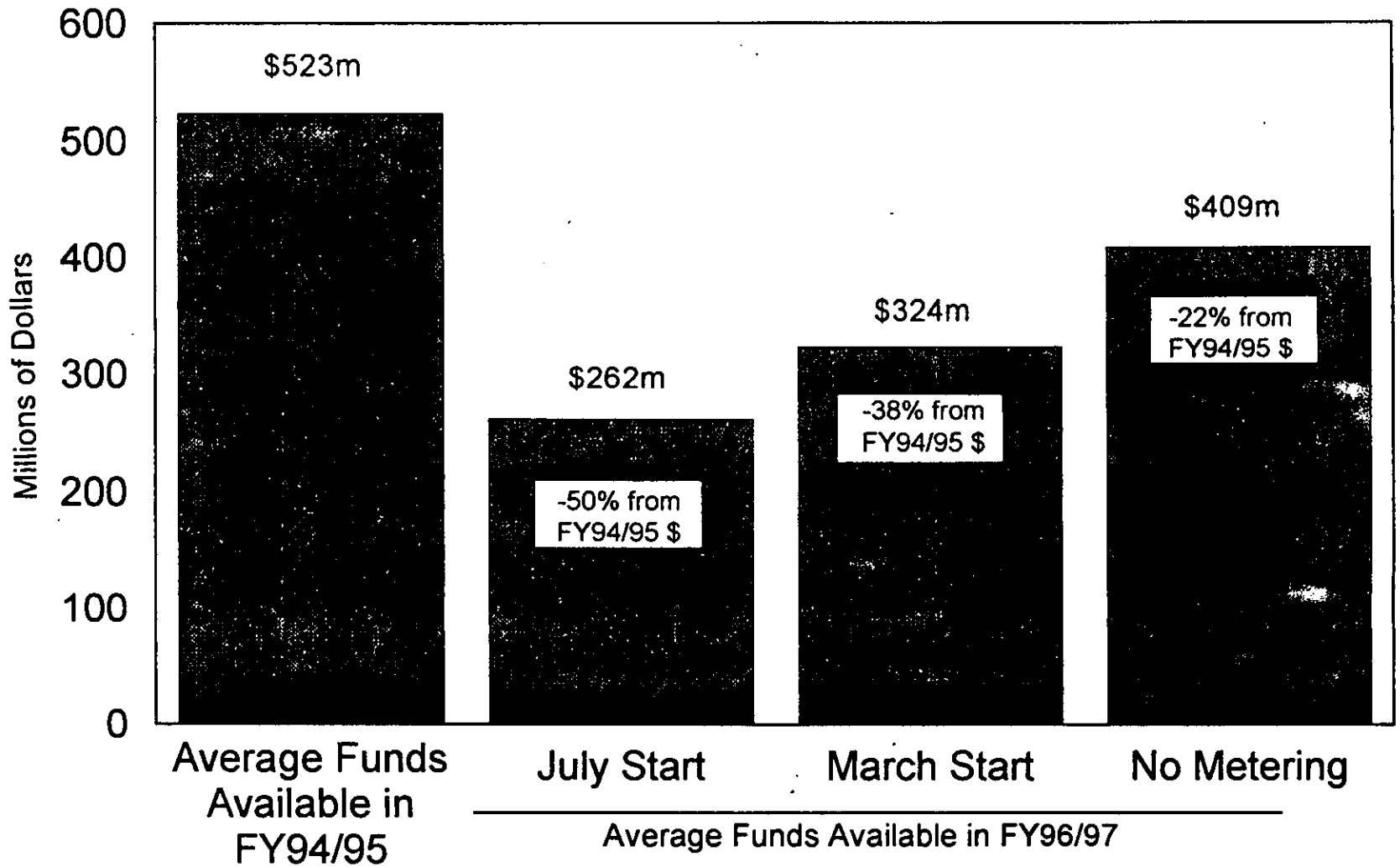
Thank you.

Distribution:

Gordon Adams, White House, OMB
Rodney Bent, White House, OMB
Jill Buckley, USAID
Mike Casella, White House, OMB
Bill Danvers, White House, NSC
Meg Donovan, State
Phil DuSault, White House, OMB
Debbie Fine, White House, DPC
Martha Foley, White House COF
Duff Gillespie, USAID
David Harwood, State
Robyn Leeds, Women's Office
Liz Maquire, USAID
Nancy-Ann Min, White House, OMB
Betsy Myers, White House, Women's Office

March vs July Start to Metering

Funds Available in FY96/97 compared to FY94/95



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FY96-97 POPULATION FUNDING RESTRICTIONS: SUMMARY

- **FY96 Appropriation:** $ 356m (35% cut from FY95)
  Added Prior-Year Funds: $ 76m
  Total $ 432m (21% cut from FY95)

- **FY97 Appropriation:** $ 385m (11% cut from FY96)
  (30% cut from FY95)

- **FY96 Metering:** 15 mos./$24m per mo./July start
  FY97 Metering: 12 mos./$31m per mo./March or July start

- Funding availability under:

JULY START TO METERING

Fiscal Year	Prior-Year Funds		Current-Year Funds		Total Available	Funds Deferred
FY94					$486m	$ 0
FY95					$560m	$ 0
FY96	$ 76m	+	$ 72m	=	$148m	$284m
FY97	$284m	+	$ 92m	=	$376m	$293m
FY98	$293m	+	$??	=	$??	$??

- **Funds available over the FY96/97 period average just $262m, representing a 50% cut from FY94/95 period average of $523m.**

MARCH START TO METERING

Fiscal Year	Prior-Year Funds		Current-Year Funds		Total Available	Funds Deferred
FY94					$486m	$ 0
FY95					$560m	$ 0
FY96	$ 76m	+	$ 72m	=	$148m	$284m
FY97	$284m	+	$216m	=	$500m	$169m
FY98	$169m	+	$??	=	$??	$??

- **Funds available over the FY96/97 period average $324m, representing a 38% cut from FY94/95.**

- **Had there been no metering, funds available over the FY96/97 period would have averaged $409m, a 22% cut from FY94/95.**

ONE HUNDRED FOURTH CONGRESS

CONGRESS OF THE UNITED STATES
COMMITTEE ON INTERNATIONAL RELATIONS
HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

TELEPHONE: (202) 225-5021
FAX (202) 225-2035

November 20, 1996

Hon. James F. Hinchman
Acting Comptroller General of the United States
General Accounting Office
441 G Street, N.W..
Washington, D.C. 20548

Re: Funding Restrictions on Voluntary Family Planning

Dear Mr. Hinchman:

As you know, Section 518 of the recently enacted Foreign Operations Appropriations bill for Fiscal Year ("FY") 1997 (P.L. 104-208) limited the spending of voluntary family planning funds spent by the President under the authority of section 104(b) of the Foreign Assistance Act.

Under this provision, Congress set a ceiling of $385 million that the President may make available for voluntary family planning activities in FY97. In addition, these funds may not be made available until July 1, 1997, and only then in increments of eight percent per month (*i.e.* $30.8 million per month).

Under the Act, the President may submit a certification to Congress by February 1, 1997, that these restrictions have a "negative impact on the proper functioning of the population planning program." If such a certification is made, the Act provides that Congress shall consider a resolution, under expedited procedures, to allow the President to begin spending voluntary family planning funds on March 1, 1997, at the same rate of eight percent per month. If the Congress approves this resolution, the President would be allowed to make voluntary family planning funds available four months earlier than would otherwise be the case.

Under current law, Foreign Assistance Act funds may not be used to support abortions or abortion-related services. Section 518 also prohibits these funds from being used to motivate or coerce any person to practice abortion, pay for involuntary sterilizations, perform research on

abortions/involuntary sterilization, or support governments or organizations which violate the prohibitions listed above.

With regard to these issues, GAO's objective review of the impact of these restrictions and the options before Congress under recent legislation on the program administered by AID would assist Members in considering the resolution to be voted upon in February. In this light, we would like GAO to answer the following questions with regard to AID's voluntary family planning program:

1. What is the effect of the FY97 $385 million limitation on AID's voluntary family planning program? If the limitation did not exist, what additional contracts, grants or cooperative agreements would AID support? What key countries or programs would receive funding without this limitation?

2. Is there a link between AID's programs providing voluntary family planning services and reductions in abortion? If the link exists, do the current funding limitations restrict AID's voluntary family planning programs from preventing further abortions?

3. What is the effect of the delay, until July 1, 1997, in the President's ability to provide FY97 voluntary family planning funds? If the limitation were advanced to March 1, 1997, what contracts, grants or cooperative agreements would the President be able to support?

Given the deadline of the President's certification under the Act, we would request that the GAO deliver the report by February 1, 1997.

With best wishes,

Sincerely,

BENJAMIN A. GILMAN
Chairman

LEE H. HAMILTON
Ranking Democratic Member

THE WHITE HOUSE
WASHINGTON

Elena

To: Distribution
From: Lyn Hogan
Date: Jan. 10, 1997
Re: International Family Planning Report

Attached please find a copy of the most recent draft of the USAID/State report on international family planning **for use in Monday's meeting at 2:00 p.m. in room 211.**

We will discuss the report content, message and roll out strategy as well as any other issues that emerge.

Thank you.

Elena -
Here is a copy of the Int'l Family Planning report for the meeting I mentioned to you early in the week.

You should come to this meeting if at all possible..

Lyn

DRAFT Presidential Determination on negative impact of obligation limits for FY97 population planning appropriation

Presidential Determination
No._____

SUBJECT: Presidential Finding on the Negative Impact of the Obligation Limitation on the Population Planning Program Administered with Funds Appropriated by title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1997

Pursuant to the authority vested in me by section 518A(d) of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1997, (the "Act"), I hereby find that the limitation on obligations imposed by subsection (a) of section 518A is having a negative impact on the proper functioning of the population planning program administered with funds appropriated by title II of the Act. Subject to a Congressional joint resolution of approval, to be adopted no later than February 28, 1997 as specified in section 518A(d) of the Act, funds for these activities may be made available beginning March 1, 1997, notwithstanding the July 1, 1997 limitation set forth in section 518A(a).

DRAFT JUSTIFICATION MEMORANDUM FOR THE PRESIDENT
NOT FOR CIRCULATION

MEMORANDUM FOR THE PRESIDENT

FROM: **A/AID, J. Brian Atwood**

SUBJECT: **Justification for a Presidential Determination on the Negative Impact of FY97 Obligation Limitations on the USAID Population Assistance Program**

Section 518A(a) of the FY97 foreign assistance appropriations act provides that USAID cannot obligate FY97 funds for population assistance until July 1, 1997. This provision also requires submission of a Presidential finding by February 1 concerning the impact of the funding delay. The provision further states that if the Presidential finding indicates that the limitation is having a negative impact on the proper functioning of the USAID population program, funds may be made available beginning March 1, 1997, if Congress approves such finding by adoption of a joint resolution no later than February 28, 1997.

This memorandum and the accompanying annex show that the funding delay would have severe negative impacts on the proper functioning of U.S.-supported international population programs and, most of all, on the health and well-being of women, men, and children who are beneficiaries of U.S. assistance. Increases in unintended pregnancies and abortions would be inevitable.

U.S. Population Assistance

Under your Administration, longstanding U.S. leadership on global population issues in the broader context of U.S. foreign policy has been reinvigorated through a comprehensive approach based on the following principles and objectives: 1) promoting the rights of couples and individuals to determine freely and responsibly the number and spacing of their children; 2) improving individual reproductive health, with special attention to the needs of women and young adults; and 3) reducing population growth rates to levels consistent with sustainable development. U.S. support for international programs emphasizes voluntary family planning as part of an integrated approach to population and development that includes complementary activities to promote health, the status of women, and strong families. As a matter of law and policy, U.S. funds may not be used either to fund abortions as a method of family planning or to motivate any person to have an abortion.

The Negative Impact of Delaying FY97 Funding From March Until July 1997

USAID has been the principal agency responsible for implementing U.S. global population programs for the last 30 years and currently provides assistance in more than 60 countries through 95 bilateral and worldwide programs. USAID's population program has already been seriously harmed by the 35 percent budget cut in FY96 and by restrictions that delayed access to new funds for nine months. The restrictions further required that population funds be made available only in small monthly installments ("metering"), beginning in July 1996. Implementation of the FY96 restrictions has caused programmatic disruption, inefficiencies, and higher costs for USAID and its development partners.

FY97 legislation continues these restrictions. A four-month delay in FY97 funding from March to July would translate into a reduction of $123 million in funds available during FY97 out of the total of $385 million appropriated by Congress. If funds are delayed, at least 17 bilateral and worldwide programs would need to suspend, defer, or terminate family planning service delivery and other critical supporting activities. The consequences of the four-month delay for women and men who need family planning services now would be significant, and could never be completely overcome. The consequences will be manifested in increased unintended pregnancies, more abortions, higher numbers of maternal and infant deaths, and in hundreds of thousands of additional births.

USAID has determined that urgent funding needs caused by the delay could be partially met by shifting some funds within the population program. Negative impacts would still be significant, however. In addition, shifting funds is a measure which itself would carry undesirable programmatic and political consequences, as well as significantly increased administrative costs. The management burden of coping with a possible delay in funding would be added to the administrative costs already resulting from the metering of funds, which has exceeded $1 million to U.S. taxpayers by the end of FY96.

Recommendation

Based on the information presented in this memorandum and accompanying annex, we recommend that you sign the attached determination and authorize its transmittal along with the accompanying report to Congress.

DRAFT DRAFT DRAFT DRAFT DRAFT DRAFT DRAFT

NOT FOR CIRCULATION
1/10/97

The Impact of Delaying USAID Population Funding from March to July 1997

Justification for a Presidential Determination on Section 518A(a) of the FY97 Foreign Operations, Export Financing and Related Programs Appropriations Act

January, 1997

Table of Contents

I. Summary

Background. Section 518A(a) of the FY97 foreign assistance appropriations act provides that USAID cannot obligate FY97 funds for population assistance until July 1, 1997. This provision also requires submission of a Presidential finding by February 1 concerning the impact of the funding delay. The provision further states that if the Presidential finding indicates that the limitation is having a negative impact on the proper functioning of the USAID population program, funds may be made available beginning March 1, 1997, if Congress approves such finding by adoption of a joint resolution no later than February 28, 1997. Reflecting the agreement reached by Congressional leadership and Administration negotiators on the FY 1997 omnibus appropriations act, section 518A(e) provides for expedited consideration of the joint resolution, the text of which is included in the section and is not amendable.

This justification shows that the funding delay would have severe negative impacts on the proper functioning of U.S.-supported international population programs and, most of all, on the health and well-being of women, men, and children who are beneficiaries of U.S. assistance. Programs with urgent funding needs during this period would have to suspend, defer, or terminate family planning activities. As a consequence, increases in unintended pregnancies and abortions would be inevitable.

The Role of Population Assistance in U.S. Foreign Policy. Progress toward global population stabilization has been recognized as vital to U.S. foreign policy interests for the past three decades. Rapid population growth undermines economic and social development in poor countries, damages the health of women and children, contributes to environmental degradation, and impedes improvements in the status of women. Countries around the world share these concerns, as reflected in consensus reports from a series of recent international conferences.

U.S. global population policy is based on the following principles and objectives: 1) promoting the rights of couples and individuals to determine freely and responsibly the number and spacing of their children; 2) improving individual reproductive health, with special attention to the needs of women and young adults; and 3) reducing population growth rates to levels consistent with sustainable development. To help achieve these goals domestically and internationally, U.S. programs emphasize voluntary family planning and complementary activities aimed at reducing child and maternal deaths; preventing the spread of HIV/AIDS and other sexually transmitted diseases;

improving the social, economic, and political status of women; strengthening the family unit; and improving educational opportunities for girls and boys.

Recent international data show that global population is growing at lower rates due to successful family planning and related health and development programs which the U.S. has led over the last thirty years. Unless these lower growth rates continue to be reduced further, however, world population will double to over 11 billion by 2050. U.S. leadership in addressing this critical global issue must not waver.

The USAID Population Assistance Program. USAID has been the principal agency responsible for implementing U.S. global population programs. With bipartisan political support over the course of three decades, USAID has built up a comprehensive population assistance program, financing voluntary family planning and closely related health efforts in more than 60 countries with a combined population of over 2.7 billion people. USAID provides assistance through 95 bilateral and worldwide programs, which contribute to all of the essential interdependent elements of an effective family planning effort, including service delivery, contraceptive supplies, training for medical and other personnel, information materials, strengthening management skills, policy support, and research.

As a matter of law and policy, USAID funds may not be used either to fund abortions as a method of family planning or to motivate any person to have an abortion. Both the Congress and the Executive Branch want to decrease the incidence of abortions, and voluntary family planning is the single most effective strategy to achieve this goal.

The Negative Impact of Delaying FY97 Funding From March Until July 1997. The U.S. government's international population program has already been severely affected by FY96 legislative restrictions that delayed access to newly appropriated funds for nine months. The restrictions further required that population funds be made available only in small monthly installments ("metering"), beginning in July 1996. FY97 legislation continues these restrictions. As documented in the accompanying annex and indicated below, a delay in availability of FY97 funds would further compound the negative consequences of FY96 restrictions.

A four-month delay in FY97 funding from March to July would translate into a reduction of $123 million in funds available during FY97 out of the total of $385 million appropriated by Congress. At least 17 bilateral and worldwide programs will have urgent funding needs in the March-June period, amounting to at least $35 million more than will be available from remaining FY96 funds. If FY97 funds are delayed, these programs would need to suspend, defer, or terminate family planning service delivery and other critical supporting activities.

The consequences of the four-month delay for women and men who need family planning services now are significant, and can never be completely overcome. The consequences will be manifested in increased unintended pregnancies, more abortions, higher numbers of maternal and infant deaths, and, of course, in more births.

USAID has determined that urgent funding needs caused by the delay could be partially met by shifting some funds within the population program. Negative impacts would still be significant, however. In addition, shifting funds would carry undesirable programmatic and political consequences, as well as significantly increased administrative costs. The management burden of coping with a possible delay in funding would be added to the administrative costs already resulting from the metering of funds, which have exceeded $1 million to U.S. taxpayers by the end of 1996.

II. U.S. Population Policy and Programs

1. Policy overview. Rapid population growth undermines economic and social development in poor countries, outpaces investment in human capacity and infrastructure, damages the health of women and children, contributes to environmental degradation, and impedes improvements in the status of women. For three decades, the United States has encouraged international cooperation to address this issue around the world. With bipartisan support, these efforts have been aimed at contributing to a number of interrelated foreign policy objectives: protecting the Earth's environment, encouraging worldwide realization of basic human rights and standards of health; encouraging global economic progress and opportunities for exporting American goods and services; promoting international stability; and reducing pressures that lead to refugee flows and migration.

Under the Clinton Administration, the United States has worked to strengthen international consensus on behalf of an integrated and comprehensive policy approach to population stabilization. This approach stresses the interrelated nature of free and informed choice about contraception; provision of services to improve women's reproductive health; reduction of maternal and child deaths; prevention of the spread of AIDS; improvement of the social, economic and political status of women; strengthening of the family unit; and improvement of educational opportunities for girls and boys.

This integrated approach was the principal outcome of the broad consensus reached by 180 countries at the 1994 International Conference on Population and Development, in which the U.S. government was an active participant. At this conference, the global community also agreed for the first time on the urgent need to mobilize substantially increased donor and developing country resources on behalf of population stabilization, within the context of national laws.

The overriding objective of these efforts has been to help families determine freely and responsibly the number and spacing of their children through support for voluntary family planning programs and related health services. These programs play a critical role in improving maternal and child health and reducing fertility, thus helping countries buy time to address other development challenges and improve their citizens' standards of living.

Recent international data show that global population is growing at lower rates due to successful family planning and related health programs which the U.S. has led over the last thirty years. Unless these lower growth rates continue to be reduced further, however, world population growth will double to over 11 billion by 2050. U.S. leadership in addressing this critical global issue continues to be essential.

2. **Program overview.** The U.S. has been the leading donor for family planning in developing countries for over thirty years. USAID population programs currently benefit families in over 60 countries with a combined population of over 2.7 billion people. (See Appendix 1 for a current list of USAID-assisted countries.) The developing countries in the group account for over three-fourths of the developing world population outside of China.[1]

USAID's program is built on principles of voluntarism and informed choice and supports access to a full range of safe, reliable, modern family planning methods which have all been approved by the U.S. Food and Drug Administration for use in the United States. Since 1983, USAID has also been the principal donor in support of natural family planning. As a matter of law and policy, USAID funds may not be used either to fund abortions as a method of family planning or to motivate any person to have an abortion.

USAID population assistance is provided through two main channels: 36 bilateral programs, each designed around the needs of a particular country, and approximately 59 worldwide (or regional) programs, which provide a wide range of technical assistance, commodities, and other support across countries.

3. **Program impact.** The program has enabled millions of couples to choose the number and spacing of their children and has helped to slow population growth worldwide, as confirmed by recent international data. Principal beneficiaries of the program have been poor women and men with virtually no prior access to family planning services. By expanding the availability and accessibility of modern contraceptive methods, the program has reduced abortions and high-risk pregnancies, helping to save the lives of hundreds of thousands of women. Specifically, since the start of the program:

- The average number of children per woman in the developing world has fallen from six to four, in large part due to the efforts of organized family planning programs. As the largest bilateral donor, USAID has played a significant role in this achievement.

- Modern contraceptive use in developing countries has risen from under 10% to 35% today.

Experts estimate that without the organized family planning programs of the last three decades, there would be 500 million

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[1] In this report, China is excluded from analysis because it does not receive U.S. assistance and because its size would distort the apparent effect of global efforts. All references to the "developing world" exclude China.

more people in the world today--almost twice the population of the United States. (Figure 1) In spite of this progress, over 100 million couples still have unmet needs for family planning services, and the momentum of population growth requires continued global cooperation in support of family planning efforts. (See Appendix 2)

4. The consequences of reducing access to family planning services. Access to family planning is universally recognized as a key strategy to improving the health and survival of women and children. In addition, evidence from countries in all regions of the world shows that **increased contraceptive use, by reducing unintended pregnancies, plays a major role in reducing abortions.**

- This relationship has been well documented in the United States and other industrialized countries, South Korea, Chile, and Hungary. Analysts are now finding a reduction in the rate of abortion as a result of increased contraceptive use in countries such as Russia, the Central Asian Republics, Mexico, and Colombia. In Russia, for example, use of contraceptives increased from 19 to 24 percent of women between 1990 and 1994, and resulted in a drop in the annual abortion rate from 109 per 1000 women to 76 in the same time period, a thirty percent decrease.

Based on the well-established causal links between family planning and the health and survival of women and children, any reduction in access (or quality) of family planning services is likely to result not only in an increase in unintended pregnancies, but also in increases in abortions and maternal and child deaths. Even a temporary loss of services for women exposed to the risk of unintended pregnancy implies lasting consequences. As the remainder of this report documents, disruptions in family planning services and other critical supporting activities would occur if FY97 funding for USAID-supported programs is delayed from March to July.

III. FY96 Population Funding

1. FY96 population funding. For 30 years, U.S.-funded population assistance has enjoyed bipartisan political support. Funding for USAID's population assistance program reached a peak of $548 million in FY95. As part of its deficit reduction package, the 104th Congress reduced FY96 funding for population by 35 percent, to $356 million. In addition, unrelated to deficit reduction, Congress took the unprecedented steps of delaying access to these funds until July 1996--nine months into the fiscal year--and further restricting the availability of funding to $24 million/month (6.7 percent per month) over a 15-month period.

2. **Program consolidation.** During 1995 and 1996, in response to FY96 and FY97 budget reductions, USAID began to reshape the population program through consolidating and cutting activities. Setting priorities for making cuts was facilitated by the completion during 1995 of strategic plans for most Agency units, including clearly articulated objectives and results for USAID-funded population programs.

- The Agency began consolidating worldwide programs in a number of key areas such as: support for family planning through PVO partnerships; breastfeeding; increased involvement of the private commercial sector; operations research; and data collection and evaluation.

- Activities within programs closely related to service delivery were protected, while disproportionate cuts were made in social science research, publications, regional initiatives, and other activities with fewer immediate consequences for service delivery.

- Funding for multilateral activities was cut, and several smaller projects were designated for phase-out without renewal.

- Worldwide contracts and grants with U.S. institutions which provide essential technical support of field programs were protected.

- All programs were required to undertake and report on administrative economies. Staff cuts and hiring freezes were instituted by USAID implementing partners. Other measures taken include consolidating trips, moving offices to less expensive space, sharing field office support staff, and cutting back on mailing and other communications costs.

- A number of country development programs were already in the process of being closed or severely cut back for reasons associated with Agency downsizing and political circumstances in certain countries.

3. **Delay and monthly metering of FY96 funds.** In order to reduce disruption of critical programs as a result of the delayed access to FY96 funds, USAID made available prior year funds to meet urgent population program needs before July 1996. In addition, to address the monthly metering provision, USAID disbursed funds to each of its population programs on a quarterly rather than annual basis. This was designed to minimize disruption of program activities, but it was accomplished at a significant administrative cost.

As a result of the FY96 population funding restrictions, only a limited number of programs can be funded each month. Programs therefore have had to draw down on reserves, and many are left with very limited cash balances or "pipelines."

- Average pipelines for worldwide population programs have declined from 14 months of funding available at the end of FY95 to 8 months at the end of FY96. They are projected to be at only 5 months by the beginning of July 1997, a dangerously low level and certainly below the minimal levels required for effective planning and management.

- For bilateral programs the decline is from an average of 19 months of funding remaining at the end of FY95 to 13 months at the end of FY96. Pipelines will average 7 months at the beginning of July 1997, which is also less than what is required to maintain commitments to developing country institutions.

As a direct consequence of this reduction in the availability of appropriated funds, a number of USAID-funded program managers have had to lay off service-related staff and avoid subcontracts and other long-term commitments.

- Pathfinder, for example, the largest worldwide family planning service provider funded by USAID, cut back on long-term agreements with host country partners in FY96.

- AVSC International (Access to Voluntary and Safe Contraception), the second largest service provider among USAID cooperating agencies, reduced subcontracts with developing country partner institutions by more than 50 percent in FY96, and reduced short-term technical assistance activities by a comparable amount.

Bulk purchases of equipment, commodities, and supplies have been reduced, with attendant higher unit costs for the U.S. government. All programs have had to allocate more funds to management of metering, thereby reducing funds available for services.

The full impacts of the FY96 restrictions are just beginning to be felt. The lag reflects the time that elapses between USAID's funding of programs, expenditures by program managers for activities, and use of expanded or improved services by clients and other beneficiaries at the country level. Still, the impacts of restrictions are emerging and will become increasingly apparent over time.

- For example, in Bolivia and Peru, countries with dynamic family planning programs, key USAID-funded service delivery activities have been reduced or frozen in place because of metering.

4. Increased inefficiencies and costs to the U.S. government of FY96 restrictions. The FY96 monthly metering restrictions on USAID population assistance are believed to be unprecedented in the administration of government funds. While they might appear at first to contribute to closer oversight and more careful management of government funds, in reality they do not. The metering actually undermines effective program management; jeopardizes the availability and use of family planning services; introduces political and programmatic vulnerabilities, and imposes unnecessary costs on U.S. taxpayers and USAID implementing partners.

- The number of separate funding actions has nearly tripled, from an average of 100 in a year to nearly 300. Each funding action involves dozens of communications among the various participants, including USAID country missions, USAID/Washington regional, technical, and procurement offices, and host country as well as U.S.-based implementing partners.

- USAID officers in the country missions are less able to focus on their technical oversight functions, which include responsibility for the Agency's child survival and other health programs. The population and health officer in Uganda, for example, estimates that because of metering provisions he spent several hundred hours last year working with computerized funding tables to manage population funding flows to the various components of the integrated population and health programs he oversees. This substantially reduced the time he could devote to critical AIDS prevention programs.

- In Bolivia and the Ukraine, progress on planned activities has been more rapid than anticipated, allowing more clients to be reached and served. USAID may not be able to take advantage of this success, however, because with metering there is no "pipeline" to permit a flexible response to changing field needs.

By a conservative estimate, developing and implementing the funding plan for FY96 alone required the equivalent of 27 full-time people's effort, representing an opportunity cost to the government (and taxpayers) exceeding one million dollars. This estimate does not include the substantial additional costs of managing metering for the many U.S. universities, PVOs and commercial firms which are USAID's implementing partners.

- One U.S.-based implementing partner, AVSC International estimates that administrative costs have increased by 12.5 percent as a result of metering. In the words of the President of AVSC, this effective organization is in danger of becoming "a showcase for bad management" as a direct consequence of these metering provisions.

IV. The Negative Impact of a Delay in FY97 Population Funding

1. Urgent funding needs. As is clear from the discussion of the FY96 program, USAID's population programs have drastically reduced funding reserves. If no FY97 funds were received until July, the population program would have available $123 million less to obligate during FY97 than if funds became available in March.

While some programs will be able to continue with FY96 metered funds, USAID estimates that there is a shortfall of at least $35 million in the March-June period which would make it necessary to cut or defer obligations to at least 17 out of the approximate total of 95 bilateral and worldwide programs. These 17 programs would need to suspend, defer, or terminate service delivery and other important supporting activities, directly affecting millions of clients. U.S.-based PVOs with worldwide service delivery programs will be among those most seriously affected, as will country programs in every region.

Many programs beyond those caught in the delay of funds would be damaged. If FY97 funds are first made available in July, a number of programs will not receive their funds until considerably later than July because of the metering. In addition, programs other than those with urgent needs in the March-June period will have important funding needs that must be met in July, August, and September. These programs would also be jeopardized if some of the metered funds that become available in the July-September period have to be used to make up the shortfall in the preceding four months. Finally, many more programs would continue to work with very constrained budgets and financial uncertainty, affecting their ability to respond to emergency needs such as contraceptive shortages, to plan ahead and make commitments for technical assistance and training, and to take advantage of unanticipated opportunities where a small expenditure could have a large payoff.

2. Impact at the country level. As noted earlier, while the combined effect of reduced overall levels, deferred budgets and metering is taking its toll on the entire program, there are a number of programs for which the FY97 restrictions are especially harmful. The following is a brief summary of the impact of funding delays until July on these programs. With a few exceptions, all of the countries listed below are experiencing rapid population growth, with annual rates of growth exceeding 2

percent. The exceptions are Turkey, where the annual growth rate is 1.6 percent, and Russia and the Ukraine, which both have low fertility but extremely high abortion rates.

Bolivia - Early in this decade, the Bolivian government made a strong commitment to expand access to family planning. With USAID funding, both the government and non-governmental organizations (NGOs) greatly expanded their delivery of family planning services between 1989 and 1994, resulting in a 50 percent increase in use of family planning methods. If funding is delayed until July 1997, USAID would have to defer ongoing population assistance to the National Social Security Medical System, jeopardizing services for 20 percent of Bolivia's population, and reduce support to local organizations providing family planning services to an additional 30 percent of Bolivia's rural population.

Haiti - By May 1997, the NGOs supported by the USAID population assistance program would need to start laying off staff, leaving thousands of poor Haitian women and men without family planning services. If funds are not available, the process of integrating family planning into CARE's child health and maternal care program and reorienting its well-established humanitarian relief program to development assistance would be delayed and possibly canceled.

Mexico - USAID helps support improved access and quality of care in public and private family planning programs in ten states. If funds are delayed, USAID-funded training in the public sector would be severely curtailed and NGO clinics potentially would close. One of the affected states would be Chiapas, where USAID-supported programs serve 70,000 people annually. Chiapas is the poorest state in Mexico and second highest in level of unmet need for family planning services. Under the current binational agreement, the government of Mexico has fulfilled its commitments to increase support for family planning, despite the economic crisis. If USAID cannot meet its funding commitments, not only would programs suffer, but US credibility would be damaged as would US ability to leverage Mexican resources in the future.

Guatemala - USAID is by far the largest family planning donor in Guatemala, and the only one providing contraceptives. If funding is delayed until July, many USAID partners, including the largest private provider, would have to reduce their family planning services. This provider would close down its rural health promoter program, greatly reducing access to services for rural, indigenous women and children with the greatest health problems. In addition, USAID would be unable to fulfill its part of an

agreement reached with the Guatemalan government to support its program to reduce maternal mortality by 50 percent. This program is a key component of the accord to end a 36-year civil war.

El Salvador - As a result of FY 96 funding delays and metering, the Salvadoran Demographic Association, a major USAID partner in reaching the poorest segments of the population, has had to reduce its family planning and maternal/child health services. Staff have been cut back, paid health promoters have been transformed into "volunteers," and a full service clinic has been downgraded to a satellite clinic. If further funding delays occur in FY97, these cutbacks would continue, crippling programs that served some 800,000 people between 1990-1994.

Dominican Republic - The FY96 funding delays forced USAID to reduce approved funding to four organizations that deliver the bulk of family planning services. The organizations have had to cut back a total of $350,000 (10% of planned expenditures). Opportunities to increase male involvement in family planning programs and to train staff in institutional strengthening have been lost. Even the current lower levels of service delivery could not be maintained if funds are not available before July 1997.

Russia - Historically, abortion has been the major means of restricting family size in Russia, with the average Russian woman having between two to three abortions in her lifetime. Data for 1990-1994 show an increase in contraceptive use from 19 to 24 percent, while abortions have dropped from 3.6 million to 2.8 million. Continuation of these encouraging trends depends on further progress in support of training of service providers and introduction of modern contraceptive methods. Two of the largest organizations providing this support would run out of USAID funds between March and June 1997, jeopardizing the access of 1.7 million couples to trained service providers and to modern family planning methods as an alternative to abortion.

Ukraine - Because of budget cuts in FY96, progress has already been slowed in reducing abortion rates through increased use of modern contraception. If FY97 population funds are also delayed, the program of training in clinical reproductive health, contraceptive counseling, and prevention of sexually transmitted diseases would not be able to expand as planned from Odessa to other major cities in the country.

The Philippines - Programs that would have to be deferred if there is a funding delay include training of government health personnel in natural family planning by Georgetown

University and technical assistance for voluntary surgical contraception at 200 sites across the country provided by AVSC International. In addition, agreements with three local manufacturers providing oral contraceptives at reduced prices for social marketing might have to be deferred, making contraceptives less affordable to low-income couples.

Egypt - Rapid population growth is viewed by Egyptians as one of the principal obstacles to social and economic development. Egypt's national family planning program, where USAID has been the primary donor, has been extremely successful, increasing use of family planning to 48 percent of couples in 1995 from 30 percent in 1984. If there is no access to population funds before July 1997, USAID's technical and financial support for the program would have to be drastically curtailed. This disruption would not only affect the thousands of women and men now served, but would damage a program crucial to the future development and stability of Egypt.

Jordan - The Government of Jordan recognizes the need to make family planning services available to contain its rapidly growing population. To this end, the Government entered into an agreement with USAID for expansion of family planning services. Several important activities would run out of funding before June 1997. These activities include mass media information campaigns on the availability of family planning and the establishment of model family planning centers in the twelve governorates of the country. Approximately 500,000 couples who are current and expected users of family planning would be left with lower quality services and less access to correct information about family planning methods.

Turkey - USAID is planning to phase out its support for Turkey's family planning program in 1999. Training activities are critical to the sustainability of the program and its ability to expand family planning services for the over four million couples in Turkey who are not currently served. Johns Hopkins University is poised to provide additional training of trainers for nurses and midwives to expand greatly access to a full range of family planning methods. If funding is delayed until July or later, the resulting shortage of trained providers would delay access to services for couples who need and want them, and threaten an orderly phase-out of USAID support.

Mozambique - The public sector network of health facilities in Mozambique has been devastated by 17 years of civil war. Mozambique has some of the highest maternal mortality levels in the world. The almost 4 million women of reproductive age and their families desperately need family planning

services. The delayed funding would substantially reduce activities in four focus provinces with a combined population of over 6 million, including nurse training and development of more effective delivery of family planning and maternal-child health services.

Uganda - If FY97 funds are delayed, programs implemented by Pathfinder through four local NGOs will have to be suspended. These programs have recently begun to provide basic family planning services and community-level education on family planning, HIV/AIDS, and maternal health among a population of about 1.5 million. Programs to train and supervise 900 nurses and midwives implemented by Pathfinder International, the University of North Carolina and CARE in 13 districts comprising about 35 percent of the population of Uganda may also have to be suspended, as would information and communications programs implemented by Johns Hopkins University in 10 of these districts. In all these instances, if staff salaries cannot be paid while activities are suspended, staff are likely to leave, effectively terminating the programs. Supervision of voluntary surgical contraception activities supported by AVSC would also be seriously curtailed, as would the contraceptive social marketing program--the major source of condoms for the country.

Zimbabwe - Zimbabwe's population program is one of the most successful programs in Africa, with forty-two percent of women using modern contraception, principally injectables and pills. Although USAID is phasing out of funding contraceptives in Zimbabwe, it remains the largest donor. If funds are delayed, USAID-funded contraceptives would not be delivered on schedule, resulting in stock-outs for clinics and community-based distributors.

3. **Impact across countries.** The funding delay would force difficult choices for U.S.-based private voluntary organizations (PVOs), universities, and commercial firms that provide technical support as well as funding and commodities to many different USAID-supported family planning programs.

Service delivery - Support for family planning service delivery activities is the core of USAID's population assistance, accounting for the largest share of all population expenditures in FY95. Critical PVO service delivery programs, including CARE and Pathfinder International, would have to shut down key activities if no FY97 funding is provided to them until July or later.

USAID's natural family planning program, which has been implemented through a five-year cooperative agreement with Georgetown University, ends on June 30, 1997. If the

funding delay is not reversed, the planned new agreement could not begin soon enough to prevent loss of Georgetown's trained staff and suspension of programs serving over 700,000 people annually, including in Bolivia, the Philippines, and Ecuador. USAID's natural family planning program, initiated in 1983, is the only significant program of its kind in developing countries funded by any donor.

Contraceptive supplies - Five U.S. manufacturers and their many subcontractors across the country have continuous production lines dedicated to the supply of contraceptive commodities to USAID family planning and HIV/AIDS prevention programs around the world. As the largest bilateral donor of contraceptive methods, USAID provided $53.2 million worth of contraceptives to 80 countries in 1995. If a nine-month funding delay occurs in FY97, there could be serious contraceptive shortages across a number of countries in 1998--a gap of up to 50 million condoms, 4.8 million cycles of oral pills, and 500,000 intra-uterine devices (IUDs)--as well as potential loss of jobs at one or more of USAID's contraceptive manufacturers in Alabama, Michigan, New Jersey, New York, and Pennsylvania.

USAID's large-volume advance purchases enable it to procure contraceptives at low prices. The delivery of products for a given calendar year requires that contracts be funded in the previous fiscal year. Through careful management of metered funds in FY96, 1997 contracts have been funded to ensure continuous supplies of contraceptives through the year.

However, if FY97 funds are not available until July or later, USAID would not be able to fund all of the contracts for deliveries needed beginning in January 1998 without terminating additional field programs. The most directly and immediately affected would be the planned September 1997 contract for condoms. The $8 million in population funds needed to fully fund that contract would constitute one-quarter of the metered funds available in September. If less than $8 million were available because of the pressing needs of other programs, USAID would be faced with three undesirable options:

- A first option would be to delay the contract by one or two months until adequate metered funds were available. That would result in disruptions in condom shipments to field programs and require the manufacturer to lay off most of the 200 workers dedicated to USAID contract production.

- A second option would be to renegotiate the contract to allow for shorter-term, lower volume

purchases. This option could result in higher unit costs and a loss of up to $3 million to the U.S. government.

- A third option would be to fund the contract at the expense of funding other programs that are also critical for accessible, high quality family planning services.

Training - Training programs supported by USAID play an essential role in making services accessible, safe, and responsive to client needs. Many training activities would be indefinitely deferred if there is a funding delay in FY97, including training by the University of North Carolina, Johns Hopkins University, Georgetown University, and Pathfinder International of over 4,500 service providers in Bolivia, Nicaragua, Brazil, Peru, Tanzania, Uganda, India, the Philippines, Turkey, and the Central Asian Republics.

Information and communications - Accurate and timely information is fundamental to informed decisionmaking by couples and to the success of family planning efforts at all levels. Potential family planning users need to know where to obtain services and how to use contraceptives correctly. If there is a delay in funding, however, information campaigns designed to reach millions of women in Bolivia, Ukraine, the Philippines, Kenya, and other countries would be slowed.

Research - Although contraceptive research and development (R&D) constitutes less than 5 percent of USAID's total population assistance program, it is critical to providing new and improved methods, achieving better understanding of current methods, and increasing the overall use of family planning. Research has shown that increasing the number of contraceptive methods available results in increasing use of family planning. USAID's research program is thus an integral element of USAID's comprehensive population program, and it contributes directly to reducing unintended pregnancies and abortions.

USAID has played a unique role among donors in support of contraceptive R&D and has been the primary donor agency concerned about methods appropriate for use in developing country settings, which private drug companies are not prepared to pursue because of the limited profit potential and issues related to product liability. The U.S. National Institutes of Health, understandably, focuses on methods for the U.S. consumer. While aimed primarily at methods for developing countries, USAID research has had direct and important benefits for American women and men, including the

availability of the female condom, improved methods of sterilization for men and women, and extending the use-life of the Cu-380A IUD to 10 years.

Contraceptive R&D, especially the development of better technology, is a long-term investment that relies on consistent and continual funding, and long-term planning. The consequences of cutting off funding to ongoing projects would be felt for many years to come. For example, a simple funding delay to July 1997 would halt the initiation of a large scale clinical trial needed for US FDA approval of a new female-controlled barrier method and would slow down work on several other current leads, including methods that also provide protection against HIV infection and other sexually transmitted diseases. Furthermore, if some ongoing clinical trials need to be suspended because of funding delays, they would have to start over, wasting years of prior investment and the willing participation of participating physicians and study volunteers.

4. The human consequences. In reporting on global and country level consequences of funding delays, it is easy to lose sight of the human dimension. But clearly, the consequences for the clients of many service delivery programs supported by USAID would be immediate. Millions of men and women are served through these programs, and the burden would fall most heavily on impoverished women and men who rely on these services, often with no alternatives.

5. Consequences for U.S. leadership and credibility. A significant delay in funding for a second year in a row would have an impact far beyond USAID's own programs because of the leadership role the U.S. has played. Even more than in other areas of development, other donors look to U.S. leadership in making their own commitments to population activities. In recent years, with U.S. urging, other donors such as Japan, Germany, and the European Union, have begun to take on additional commitments for international population efforts, although their programs are limited in size and scope. There is a real danger that if U.S. programs are curtailed by the delay in funding and other restrictions, other donors will follow the U.S. lead and downgrade the relative importance assigned to international cooperation on population matters.

6. Increased inefficiencies and costs to the U.S. government of the FY97 funding delay. Because of a tighter overall budget in FY97, construction and implementation of a metering plan would be likely to result in even higher levels of management burden than in FY96 as well as continued diversion of attention from technical program oversight. With or without the delay, the effort required to keep programs going under "metering on top of metering" is enormous, and the risk of severe

disruption of program activities at all levels is high. If FY97 funding is delayed, however, there would be even less capacity to shift funds among programs to make the FY97 metering plan workable. This would add further to the considerable administrative costs already incurred by USAID and its development partners.

V. Mitigation Measures

Recognizing the severity of the impact of a delay in FY97 population funding detailed above, USAID has explored every option to mitigate the impact of the legislation on the millions of people whose health depends on the services provided through USAID's population programs. These include: (1) shifting funds on a temporary basis among selected Agency population programs; (2) shifting funds from other development programs; (3) further termination of programs; and (4) approaching other donors to step in to meet urgent program needs.

1. Shifting funds on a temporary basis among selected USAID population programs. USAID has analyzed the current funds on hand of each of these programs; many have reserves that are already dangerously low compared to previous years. The Agency review of pipelines identified only $15 million which could be shifted temporarily--through de-obligations or adjustments in FY 96 commitments--without immediate negative program impact. Funds shifted would have to be "repaid" later, however, so as not to jeopardize bilateral commitments. There could, of course, be political impacts as even temporary shifting of funds could damage relationships with host governments and institutions as well as USAID's ability to negotiate future commitments.

2. Shifting funds from other USAID development programs. Pursuing this approach would not be possible because of the large cuts in USAID's overall budget in recent years. Prior year, de-obligated funds for non-population programs have already been reallocated to meet urgent needs in other sectors.

3. Further termination of programs. USAID, as noted in earlier sections of this report, has already made significant adjustments in its population assistance program to reflect new budgetary realities while continuing to provide the high quality, comprehensive population assistance program that has had such an impact on health and fertility to date. Congress has set a level of funding of $385 million for FY97, and USAID has budgeted for effective use of this amount. Further termination of activities which would be supported at the Congressionally-approved $385 million level simply to accommodate funding delays is unwise.

4. Approaching other donors. With the State Department, USAID has undertaken concerted efforts since 1993 to work more closely with other donors and encourage them to allocate more

resources to population-related assistance. While there has been some program expansion by several other donors recently, only a few of the 21 donors are currently projecting any substantial increases. And, while USAID has been working closely with donors to coordinate programs, especially in countries where USAID is or will be terminating its assistance, no donor is able to provide the emergency funding needed by USAID programs which are most immediately affected by the funding delay.

VI. Conclusion

USAID wants to implement the $385 million program which Congress has approved for FY97, and it wants to do so in the most efficient and effective manner possible. The evidence presented here demonstrates the significant harm that would be caused by a delay of FY97 population funding until July 1997. The impact of reduced obligations in the period between March and July 1997 would fall heavily on those countries and programs where funds are running short -- and most heavily on the individuals immediately served by those programs. The delay in funding would also affect worldwide activities such as training, communications, contraceptive procurement, and research, thereby having a ripple effect throughout the program. Further, the delay contributes to the administrative burden and greatly increased costs already experienced at all levels of the population program in coping with the monthly metering of funds, and with no discernible benefit.

No alternative measures exist to eliminate the negative impact of this delay other than the legislative remedy created in the FY97 appropriations bill. Temporarily moving funds out of other programs would reduce the shortfall in funding somewhat, but would carry its own negative consequences. Harm to the individual women and men served by USAID-funded programs would be inevitable.

Advancing the monthly disbursement of population funds from July to March 1997 would make an additional $123 million already provided by Congress available for obligation to the population program during FY97. A March start to metering would make adequate funds available to meet the urgent funding needs of a number of critical programs and allow all programs to avoid the delays, reductions, and suspensions of activities that they would otherwise carry out. In addition, earlier funding would enable managers to plan and make commitments to the partner organizations that are responsible for programs in the field.

USAID has demonstrated that it has the expertise and the experience to help meet the global population challenge and enable millions of couples in poor countries to build better

lives for themselves and their children. The key missing ingredient is access to appropriated funds on a timely basis.

Appendix 1
Recipients of USAID Population Assistance in FY96

Africa
Benin
Botswana
Cote d'Ivoire
Eritrea*
Ethiopia*
Ghana*
Guinea
Guinea-Bissau
Kenya*
Madagascar*
Malawi*
Mali*
Mozambique*
Niger*
Nigeria
Senegal*
South Africa*
Tanzania*
Uganda*
Zambia*
Zimbabwe*
Population Subtotal:
426 million

Asia/Near East
Bangladesh*
Cambodia*
Egypt*
India*
Indonesia*
Jordan*
Morocco*
Nepal*
Oman
Philippines*
Sri Lanka
Yemen*

Population Subtotal:
1.508 billion

*Bilateral population programs. A number are part of larger integrated bilateral health programs. Remaining countries on this list receive assistance through worldwide and regional programs.

Europe/Newly Independent States

Albania
Belarus
Central Asian Republics:
  Kazakhstan
  Kyrgyztan
  Tajikistan
  Turkmenistan
  Uzbekistan
Caucasus
Moldova
Poland
Romania
Russia
Slovakia
Turkey
Ukraine

Population Subtotal:
419 million

Latin America & Caribbean

Bolivia*
Brazil
Colombia
Dominican Republic*
Ecuador*
El Salvador*
Guatemala*
Haiti*
Honduras*
Jamaica*
Mexico
Nicaragua*
Paraguay
Peru*

Population Subtotal:
386 million

Total Population Size in Countries Receiving USAID Population Assistance: 2.739 billion

Appendix 2

The challenge ahead

Despite the progress that has been made, the need for population assistance continues to increase. Although the world population growth rate has declined, about 81 million people are added to the world population each year. Developing countries are still growing at close to 1.8 percent annually -- a rate which, if continued, would double their population in 38 years. Both the United Nations and the U.S. Census Bureau project that without continued **declines** in the growth rate, the world population, currently 5.8 billion, will double to over 11 billion by 2050.

Without significant fertility decline now, there will be large increases in the number of people and dramatic effects on their quality of life later on. The global community thus faces a dual challenge.

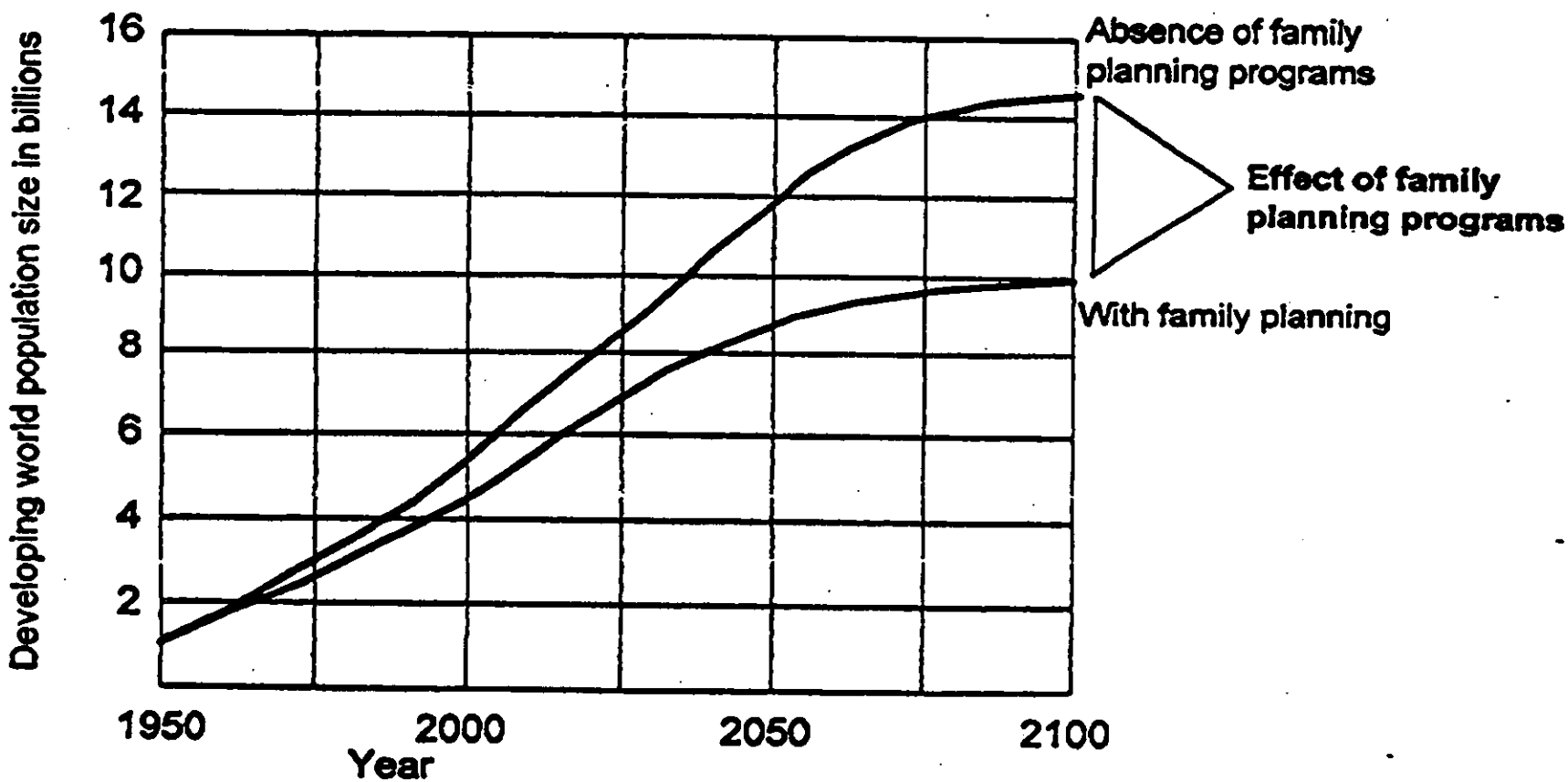
The first challenge is to **catch up with the current need for family planning.** Survey data show that over 100 million women in the developing world (excluding China) want to space or limit childbearing but are not using contraception, largely because of lack of access to quality family planning services.

The second challenge is to **keep up with emerging needs for family planning.** The number of women of childbearing age in the developing world (excluding China) **is growing by 21 million women per year**--roughly the total number of women of childbearing age in the states of California, Texas, New York, and Florida combined. As a consequence, the number of individuals at the peak of their reproductive years is the largest in human history, with serious consequences for population growth over the next generation.

Equally important are the health consequences of lack of access to family planning services and high fertility. Data from Demographic and Health Surveys show that on average, infants born less than two years after a previous birth are twice as likely to die as those born after intervals of two or more years. According to the World Health Organization (WHO), almost 600,000 women die annually of causes related to pregnancy and childbirth, mostly in the developing world. Of the 190 million pregnancies worldwide each year, a high proportion are unintended. Surveys indicate that many women in every country -- more than 50 percent in some -- say their last birth was unwanted or mistimed. According to WHO, every year approximately 50 million of these unintended pregnancies, mostly in the developing world, end in abortion.

FIGURE 1

Slowing Population Growth by Meeting Family Planning Needs, 1950-2100



C · R · L · P

THE CENTER FOR REPRODUCTIVE LAW AND POLICY

File: Family planning

February 20, 1997

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The Honorable William Jefferson Clinton
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Dear Mr. President:

On behalf of the Center for Reproductive Law and Policy (CRLP), the nation's only public interest legal organization committed solely to protecting women's reproductive rights and health, I write to offer our recommendations for a forward thinking reproductive rights agenda for the next four years. We firmly believe that the cornerstone of that agenda is universal access to safe, effective and affordable contraception for American women as well as women around the world.

Unfortunately, like many other aspects of women's health care, contraception is neither accessible nor affordable for many American women. For example, although ninety-seven percent of large group health plans generally cover prescription drugs and devices, only thirty-seven percent cover oral contraceptives. At the same time, a significant percentage of low-income women who are uninsured or underinsured, as well as many women who receive their health care through plans controlled by religious institutions, have limited access to safe and effective contraception. For women covered by Medicaid, one of the most comprehensive federal health programs, the guarantee of access to family planning services has been undermined by lack of adequate information about contraceptive options, and the transition to managed care. Finally, even when health care plans provide contraceptive coverage, American women have far fewer contraceptive choices than women in the rest of the industrialized world. Relentless pressure from antichoice forces and the realities of current product liability law have dramatically curtailed research and development of new contraceptive products. Yet access to safe and effective contraception remains an urgent -- but generally unrecognized -- public health need for women worldwide.

Meaningful access to contraceptives and reproductive health services is even further from reality for women living in low-income countries. In the more than sixty countries that have received U.S. AID family planning funds, many men

and women have virtually no access to contraceptives apart from those provided pursuant to U.S.-supported programs. Even with these programs, over 100 million couples around the world still have unmet needs for family planning services. The inability of women in these low-income countries to obtain modern contraceptive methods leads to shockingly high rates of unintended pregnancy, abortion, and death during pregnancy and childbirth.[1] Access to contraception and reproductive health services is thus essential to improving the health and survival of women and children around the world.

The Administration has already demonstrated its strong support for family planning -- lifting the gag rule, supporting early release of international population assistance, and backing increases in Title X. But we believe it is now time to address the problem of inadequate access to contraceptives in a more comprehensive and focused manner. Below we set out a number of recommendations that range from mandated contraceptive coverage in private insurance to the extension of Medicaid coverage for contraception for new mothers. We ask that you work with us to refine these proposals and then put the imprimatur and the power of the Presidency behind them.

The advancement of a comprehensive agenda in support of universal access to safe and effective contraception is consistent with this Administration's longstanding efforts to provide universal health care, as well as with the Democratic platform's goals "to make abortion less necessary and more rare, not more difficult and dangerous," and to support "contraceptive research, family planning and efforts to reduce unintended pregnancy." Not only is that agenda consistent with the consensus reached by over 150 countries at the International Conference on Population and Development in Cairo in 1994 and the Fourth World Conference on Women in Beijing last year, it has the overwhelming support of the American people.

We remain extremely grateful for your veto of H.R. 1833, the "Partial Birth Abortion Ban Act" of 1996, and we urge you to remain steadfast in your opposition to this onerous legislation. We further urge you to continue to oppose legislative restrictions on abortion funding in federal programs, and to continue vigorous enforcement of the Freedom of Access to Clinic Entrances Act to ensure that women can obtain reproductive health services free of coercion and violence. We recognize that the assaults on reproductive rights and health will persist, and we will continue to fight aggressively against them. But we cannot wait for those assaults to come to an end before returning to the critical task of fulfilling *Roe*'s

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[1]See ALAN GUTTMACHER INSTITUTE, ENDANGERED: U.S. AID FOR FAMILY PLANNING OVERSEAS 2 (1996).

promise of women's equal participation "in the economic and social life of the Nation."[2] We believe that our proposals for ensuring universal access to contraceptive care are a significant step toward that goal.

We look forward to discussing these proposals with you and members of your Administration.

Sincerely,

Janet Benshoof

[2]Planned Parenthood v. Casey, 505 U.S. 833, 856 (1992).

TABLE OF CONTENTS

ENSURING UNIVERSAL ACCESS TO COMPREHENSIVE CONTRACEPTIVE SERVICES

We urge the Administration to take all possible measures to ensure that every woman of childbearing age has meaningful access to all medical services related to contraception, including sterilization, and all FDA-approved, prescription contraceptive drugs and devices.[1] Each year about sixty percent of the 5.5 million pregnancies that occur in the United States -- 3.3 million pregnancies -- are unintended. Worldwide, millions of women each year experience an unwanted pregnancy.[2] Many of these unintended pregnancies exact tragic tolls on pregnant women and their families and burden society as a whole. Increasing the availability and use of contraception is a crucial step toward preventing unwanted pregnancies; protecting against sexually transmitted infections; lowering the rates of infant mortality and low birthweight births;[3] reducing high school drop out rates and the incidence of child abuse and neglect; and minimizing long-term dependence on welfare.[4] Ensuring that all women have meaningful access to all

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[1]The following are currently FDA-approved prescription contraceptive drugs and devices: all regimes of oral contraceptives, injectable contraceptives, contraceptive implants, IUDs, diaphragms and cervical caps.

[2]U.N. DEP'T FOR ECON. & SOCIAL INFO. & POLICY ANALYSIS, THE WORLD'S WOMEN 1995: TRENDS AND STATISTICS, at 79, U.N. Doc. ST/ESA/STAT/SER.K/12, U.N. Sales No. E.95.XVII.2 (1995).

[3]Kenneth J. Meier & Deborah R. McFarlane, *State Family Planning and Abortion Expenditures: Their Effect on Public Health*, Vol. 84, No. 9 AM. J. OF PUB. HEALTH 1468, 1471 (1994).

[4]Approximately half of the adolescents who give birth before the age of eighteen receive welfare within five years of giving birth. COMMITTEE ON UNINTENDED PREGNANCY, INSTITUTE OF

(continued...)

medical services related to contraception and all FDA-approved, prescription contraceptive drugs and devices is also the most efficacious means of fulfilling this Administration's promise to make abortion "safe, legal, and rare." It is undeniable, however, that all contraceptives sometimes fail. Thus, this Administration must forthrightly acknowledge that every pregnant woman must be given full information about her options and access to either prenatal, abortion, or adoption services -- whichever she chooses.

The failure to assure women access to the complete range of contraception is both discriminatory, and medically and fiscally unsound. As the United States Supreme Court noted in *Planned Parenthood v. Casey*, "[t]he ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives."[5] Unwanted childbearing, in many cases, curtails a woman's educational and work opportunities, constricts her social role, and excludes her from full participation in the "marketplace and the world of ideas."[6] In our view, exclusion of any medical service related to contraception or of any FDA-approved, prescription contraceptive drug or device from health insurance coverage that otherwise covers medical services and/or prescription drugs and devices constitutes impermissible gender-based discrimination in violation of the Equal Protection

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(...continued)
MEDICINE, THE BEST INTENTION: UNINTENDED PREGNANCY AND THE WELL-BEING OF CHILDREN AND FAMILIES, 56-58 (Sarah S. Brown & Leon Eisenberg eds., 1995).

[5]505 U.S. 833, 856 (1992).

[6]*See* Stanton v. Stanton, 421 U.S. 7, 14-15 (1975).

Clause of the U.S. Constitution, and (with respect to employer-provided health insurance) Title VII of the Civil Rights Act of 1964. Moreover, such an exclusion from federal grant programs that cover family planning services -- such as Medicaid, Title X, and international family planning programs -- is similarly discriminatory. In addition, we hold that individuals have an international human right to health care, including family planning. Such a human right is contravened when women and men are not provided with a full range of medical services relating to contraception.

The exclusion of FDA-approved, prescription contraceptives or medical services related to contraception from health insurance coverage (whether private or supplied by the federal government through CHAMPUS or FEHBA) is based on outdated sex role stereotypes reflecting the unconstitutional assumption that women's "natural" role is to bear and raise children, as well as the assumption that the burden of preventing pregnancy should be the exclusive responsibility of women. The exclusion also carries on the insurance industry's history of discrimination against women.[7]

Further, excluding insurance coverage for medically appropriate prescriptions and

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[7]*See, e.g.*, Newport News Shipbuilding and Dry Dock Co., 462 U.S. 669 (1983) (health insurance plan that provided less extensive pregnancy benefits for spouses of male employees than for female employees unlawfully discriminated on the basis of sex); E.E.O.C. v. South Dakota Wheat Growers Ass'n, 683 F. Supp. 1302 (D.S.D. 1988) (exclusion of pregnancy-related costs from health benefit plans constituted unlawful sex discrimination); *cf.* Arizona Governing Committee for Tax Deferred Annuity and Deferred Compensation Plans, 463 U.S. 1073 (1983) (state pension plan which paid women lower monthly retirement benefits than men who made same monthly contributions unlawfully discriminated on the basis of sex).

devices needed exclusively by women while covering all medically appropriate prescriptions and devices needed by men is an impermissible gender-based classification. Although the Supreme Court has permitted pregnancy/gender-based classifications that purportedly equalize the sexes,[8] the Court has never sanctioned the imposition of burdens on women alone because of their unique procreative abilities.[9] Moreover, this exclusion, when sanctioned by the federal government through the use of federal funds, also violates the obligation of government to remain neutral as to reproductive decision making and to avoid use of its largesse to coerce women into one reproductive decision over another.

Not only is it legally required that health insurance benefits and federally funded programs cover all medical services related to contraception and all FDA-approved, prescription contraceptive drugs and devices, sound medical practice also so dictates. As the Institute of Medicine of the National Academy of Sciences noted in a recent report:

> there is the virtually undisputed reality that no existing contraceptive method can meet the requirements, intentions, and preferences of all individuals in all circumstances over entire reproductive lifetimes. Nor can any method be totally without side effects, risks, or trade-offs in terms of safety, efficacy, convenience, usability, and appropriateness (Fathalla 1992). . . . Furthermore, for many women it is also important, even vital, that their contraceptive method be "user-controlled," that is, that it permit them to be the primary decision-makers about

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[8]*See, e.g.*, Geduldig v. Aiello, 417 U.S. 484 (1974); Michael M. v. Sonoma County Super. Court, 450 U.S. 464 (1981).

[9]*See, e.g.*, Int'l Union, United Automobile, Aerospace and Agriculture Implement Workers of America, UAW v. Johnson Controls, 499 U.S. 187 (1991).

utilization. All this argues for the broadest possible range of available options.[10] Women with medical conditions that require them to avoid pregnancy have a particularly urgent need for access to all medical services related to contraception and all FDA-approved, prescription contraceptive drugs and devices because their medical conditions often preclude use of one or more contraceptive methods.

Finally, increasing the availability of effective contraception would create a substantial fiscal savings, as well as improve the health and well-being of women and children. A recent study by the Alan Guttmacher Institute concludes that every tax dollar spent for contraceptive services saves an average of $3.00 in Medicaid costs alone for pregnancy-related health care and medical care for newborns.[11] On an international level, United States government efforts to expand the availability of contraception help to improve the health and survival of women and children and to enable governments to link population to larger issues of development.[12]

A. PROPOSED ACTION: CONTRACEPTIVE COVERAGE IN PRIVATE INSURANCE

Despite the dictates of law, public health, and economics, coverage of contraceptives by

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[10]COMMITTEE ON CONTRACEPTIVE RESEARCH AND DEVELOPMENT, CONTRACEPTIVE RESEARCH AND DEVELOPMENT: LOOKING TO THE FUTURE 1-2 (Polly F. Harrison & Allan Rosenfield, eds., 1996).

[11]Jacqueline D. Forrest and Renee Samara, *Impact of Publicly Funded Contraceptive Services on Unintended Pregnancies and Implications for Medicaid Expenditures*, Vol. 28 No. 5 FAM. PLAN. PERSP. 188 (1996).

[12]U.S. AID, THE IMPACT OF DELAYING U.S. AID POPULATION FUNDING FROM MARCH TO JULY 1997: JUSTIFICATION FOR A PRESIDENTIAL DETERMINATION ON SECTION 518(A) OF THE FY97 FOREIGN OPERATIONS, EXPORT FINANCING AND RELATED PROGRAMS APPROPRIATIONS ACT 5-6 (Jan. 1997).

private insurance is woefully inadequate. According to a recent study by the Alan Guttmacher Institute ("the AGI insurance study") of private insurance coverage, 49 percent of large-group plans do not routinely cover any contraceptive method at all.[13] In fact, oral contraceptives, the most commonly used reversible contraceptive method in the United States, are routinely covered by only 33 percent of large-group plans, although 97 percent of those plans provide prescription coverage for other drugs.[14] Similarly, while 92 percent of typical large-group plans routinely cover medical devices in general, only 18 percent routinely cover IUDs, 15 percent cover diaphragms and 24 percent cover the Norplant device.[15] A recent study by the Women's Research and Education Institute reveals that women between the ages of 15 and 44 pay 68 percent more in out-of-pocket expenditures for health care services than men, and reproductive health services account for much of that difference.[16] Indeed, almost 5 million privately insured women have out-of-pocket health care expenses in excess of 10 percent of their income.[17] Yet the majority of health plans fail to cover drugs and devices used by over 21 million women each

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[13]THE ALAN GUTTMACHER INSTITUTE, UNEVEN AND UNEQUAL, INSURANCE COVERAGE AND REPRODUCTIVE HEALTH SERVICES 12 (1995).

[14]*Id.* at 17.

[15]*Id.*

[16]WOMEN'S RESEARCH AND EDUCATION INSTITUTE, WOMEN'S HEALTH INSURANCE COSTS AND EXPERIENCES 2-3 (1994).

[17]*Id.* at 2.

year.[18]

The ad hoc system of contraceptive coverage and exclusion is irrational as well as discriminatory. For example, according to the AGI insurance study, 26 percent of large group plans covered IUD insertion, but only 18 percent of those plans covered the IUD device; 28 percent covered Norplant insertion, but only 24 percent covered the Norplant device.[19] Notably, 32 percent covered Norplant removal.[20] In addition, of those large group plans, despite the low levels of coverage for reversible contraception, approximately 66 percent pay for abortion and approximately 86 percent pay for male and female sterilization.[21]

Exclusion of contraceptive coverage from private insurance can create real financial burdens for low-income, working class and even middle-class women. In 1993, the total cost of Norplant insertion was approximately $700, the total cost of an IUD insertion was approximately $400, and a year's supply of oral contraceptives and the associated physical exam cost approximately $300.[22] In a period of just a few years, many women will spend thousands of dollars in unreimbursed prescription drug and device health care costs as a result of the exclusion

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[18]*Impact of Publicly Funded Contraceptive Services on Unintended Pregnancies, supra* note 11 at 189.

[19]UNEVEN AND UNEQUAL, *supra* note 13 at 9.

[20]*Id.*

[21]*Id.*

[22]James Trussell, et al., *The Economic Value of Contraception: A Comparison of 15 Methods*, Vol. 85, No. 4 AM. J. OF PUB. HEALTH 495-96 (1995).

of contraceptives from their private insurance. From the insurer's perspective, however, contraceptive coverage is far more cost-effective than paying the costs of maternity care.

Not only do health insurers disserve their beneficiaries by failing to cover the complete range of contraceptive services, they do so by failing to assure confidentiality of contraceptive services. Confidentiality is of the utmost importance to women and adolescents seeking insurance coverage for contraceptive services. The concern about confidentiality is particularly acute for women because they are far more likely than men to depend on someone else's insurance,[23] and thus to risk disclosure of medical information to the person (usually a spouse or parent) on whose insurance they rely. The AGI insurance study documented that among those private insurance plans that do cover some contraceptives, many fail to ensure the confidentiality of medical information.[24] According to the AGI insurance study, in 88 percent of large group plans (and similar proportions of PPOs and POS networks), the employee must submit the claim and/or receive the Explanation of Benefits (EOB) form, even if the services were obtained by the employee's spouse or nonspouse dependents.[25] The EOB contains information about services provided and/or the name of the practitioner or medical institution, which in the case of

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[23]In 1990, while 55% of men aged 18-64 were insured through their own employers, only 37% of women in this age group had direct coverage. INSTITUTE FOR WOMEN'S POLICY RESEARCH, WOMEN'S ACCESS TO HEALTH INSURANCE 7 (1994).

[24]UNEVEN AND UNEQUAL, *supra* note 13 at 21-24.

[25]*Id.* at 22.

reproductive health providers could easily reveal the type of service obtained.[26] Thus, for many women who receive indirect insurance coverage, the billing and claims processing procedures deprive them of the ability to confidentially seek insurance coverage for contraceptive care.

Thus, we urge the Administration to take the following steps:

1. Direct the Equal Employment Opportunity Commission ("EEOC") to amend its Guidelines on Discrimination Because of Sex to define the exclusion of any medical services related to contraception (including sterilization) or any FDA-approved, prescription contraceptive drugs or devices from private health insurance that otherwise covers prescription drugs and devices as an unlawful employment practice because it discriminates between men and women with regard to fringe benefits, and thus constitutes "discrimination on the basis of sex" in violation of Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e. *See* proposed regulatory language in Appendix A-I.

2. Direct the EEOC to amend its Guidelines on Discrimination Because of Sex to state that the failure of employer-sponsored health insurance plans to ensure that everyone covered by the plan, including those covered indirectly, can receive insurance coverage for contraceptive services without risking disclosure of private medical information constitutes "discrimination on the basis of sex" in violation of Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e, because it has a disparately adverse impact on women seeking to obtain constitutionally protected medical services. *See* proposed regulatory language in Appendix A-I.

3. Direct the Department of Health and Human Services ("HHS") to promulgate regulations under the Health Maintenance Organizations subchapter of the Public Health Service Act, mandating that "voluntary family planning services" within the meaning of the Act, 42 U.S.C. § 300e-1(1)(H)(iv), include all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices. *See* proposed regulatory language in Appendix A-II.

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[26] *Id.*

B. PROPOSED ACTION: CONTRACEPTIVE COVERAGE IN FEDERAL INSURANCE PROGRAMS

Non-military federal employees are eligible to receive health insurance in accordance with the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901, *et seq.* Pursuant to FEHBA, the Office of Personnel Management ("OPM") oversees the Federal Employees Health Benefits Program ("FEHBP"). Commercial insurance carriers and other organizations that wish to sponsor health plans for federal employees must apply to OPM, which reviews the applications and decides who may offer a FEHBP health plan. OPM enters into annual federal procurement contracts with approved applicants, and has final authority over all benefits, exclusions, and limitations in FEHBP plans. OPM is authorized to contract for such benefits, limitations, and exclusion as it "considers necessary or desirable." 5 U.S.C. § 8902(d).

Federal employees can choose from among any of the health plans offered to them. As with other plans offered by private insurance companies, some of the insurance plans offered to federal employees do not include coverage for all medical services related to contraception (including sterilization) or all FDA-approved, prescription contraceptive drugs and devices. Mandating coverage for these services in FEHBP health plans would greatly benefit federal employees and their dependents. In addition, such a mandate in the largest insurance program in the country would constitute a significant step toward changing the standard benefit package offered to non-federal employees.

Members of the uniformed services and their dependents are eligible to receive health insurance through the Civilian Health and Medical Program of the Uniformed Services

("CHAMPUS"), 10 U.S.C. §§ 1071, *et seq*. Pursuant to regulations promulgated to implement CHAMPUS, some family planning services are specifically covered by CHAMPUS. *See* 32 C.F.R. § 199.4(e)(3)(i). Current regulations, however, do not include coverage for Norplant insertion and removal, cervical caps, or Depo Provera, even though these are FDA-approved contraceptives. In addition, because the regulation is worded so as to exclude from coverage any contraceptive method that is not specifically included, any new contraceptive methods will not be covered unless the regulation is specifically amended.

We urge the Administration to:

1. Direct OPM to change the Request for Proposals for entities applying to provide FEHBP health benefit plans to require that every such plan provide insurance coverage for all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices, and that every such plan ensure that everyone covered by the plan, including those covered indirectly, can receive insurance coverage for contraceptive services without risking disclosure of private medical information to third parties.

2. Promulgate regulations under FEHBA mandating that any health plan offered by a private carrier pursuant to an annual procurement contract with OPM to provide health benefits to federal employees must provide coverage for all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices. *See* proposed regulatory language in Appendix B-I.

3. Direct OPM to notify participants in FEHBP health benefit plans, including dependents and spouses, that all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices are covered by the plan and can be obtained without risking disclosure of private medical information to third parties.

4. Amend the current CHAMPUS regulation to ensure that the CHAMPUS family planning benefit includes coverage for all medical services related to contraception (including sterilization) and all FDA-approved, prescription

contraceptive drugs and devices. *See* proposed regulatory language in Appendix B-II.

5. Amend the current CHAMPUS regulation to provide that all persons covered by CHAMPUS, including dependents and spouses, may receive coverage for contraceptive services without risking disclosure of private medical information to third parties. *See* proposed regulatory language in Appendix B-II.

6. Direct the Secretary of Defense, the Secretary of Transportation, and the Secretary of HHS to notify all individuals covered by CHAMPUS, including dependents and spouses, that all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices are covered by CHAMPUS and can be obtained without risking disclosure of private medical information to third parties.

C. PROPOSED ACTION: CONTRACEPTIVE COVERAGE IN FEDERAL GRANT PROGRAMS

Almost one in four of the 21 million women in the United States who use some form of reversible contraception rely on public funds for their contraceptive care.[27] According to the Alan Guttmacher Institute, each year publicly funded family planning helps 1.3 million women in the United States alone avoid an unintended pregnancy.[28] If not prevented, 632,300 of these pregnancies would be terminated by abortion and 533,800 would result in unintended births.[29] Moreover, expenditures for contraceptive services are highly cost-effective. For example, had there been no public-sector expenditures for contraceptive services in 1987, the federal and state governments would have spent an additional $1.2 billion that year through their Medicaid

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[27] *Impact of Publicly Funded Contraceptive Services on Unintended Pregnancies*, *supra* note 11 at 189.

[28] *Id at 192.*

[29] *Id.* at 193.

programs for expenses associated with unplanned births and abortions.[30]

In the United States, direct federal support for subsidized contraceptive services and supplies is available through two major sources:[31] Title X of the Public Health Services Act[32] and Medicaid.[33] Additional federal funding is provided for family planning services with funds appropriated for migrant health centers,[34] community health centers,[35] rural health clinics,[36] Indian health services,[37] health services for the homeless,[38] the Refugee Medical Assistance portion of the Refugee Assistance Program,[39] and others.

In the international arena, substantial direct federal support for contraceptive services and supplies are provided through the U.S. Agency for International Development ("U.S. AID")

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[30]*Id.*

[31]Many states also use significant amounts of federal funds for contraceptive services by using parts of their Maternal and Child Health Block Grant (Title V of the Social Security Act ("SSA")) and Social Services Block Grant (Title XX of the SSA) for family planning services.

[32]42 U.S.C. §§ 300 *et seq.*

[33]42 U.S.C. §§ 1396 *et seq.*

[34]42 U.S.C. § 254b(a)(6)(C).

[35]42 U.S.C. § 254c(b)(1)(C).

[36]42 C.F.R. § 405.2448(b)(9).

[37]25 U.S.C. § 1603(k)(5).

[38]42 U.S.C. § 256(r)(6).

[39]8 U.S.C. § 1522; 45 C.F.R. § 400.105.

assistance for family planning projects overseas[40] and assistance for refugees in countries outside the United States.[41] The Foreign Assistance Act of 1961, as amended,[42] authorizes the President to provide financial assistance for voluntary population planning and health programs in nations around the world. These programs have been administered by U.S. AID. U.S. AID population programs currently benefit families in over sixty countries with a combined population of over 2.7 billion people.[43]

It is imperative that the hundreds of thousands of women who seek contraceptive services and supplies through these federally funded programs be provided with all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices so that they are not forced into using medically inappropriate contraception, or denied contraception altogether due to the unavailability of the contraception of their choice.[44] In addition, women must be given the ability to choose a method that best meets their personal needs whether the contraceptive method be available by prescription or over-the-

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[40]22 U.S.C. §§ 2151b and 2362c.

[41]22 U.S.C. § 2601(b).

[42]22 U.S.C. § 2151(a).

[43]THE IMPACT OF DELAYING U.S. AID POPULATION FUNDING FROM MARCH TO JULY 1997, *supra* note 12 at 5.

[44]For example, in 1995, over fifty percent of publicly-funded family planning agencies failed to provide the IUD, emergency contraception, the female condom, sterilization, or the cervical cap. Jennifer F. Frost & Michele Bolzon, *The Provision of Public-Sector Services by Family Planning Agencies in 1995*, 29 FAM. PLAN. PERSP. 6 (1997). A smaller percentage also failed to offer diaphragms or implants. *Id.*

counter. Accordingly, the Administration should take steps to ensure that women who rely on federal grant programs for family planning services have access to all forms of contraception.

Thus, we urge the Administration to:

1. Amend existing regulations and promulgate a new regulation pursuant to Title X, making clear that Title X's requirement that "family planning projects . . . offer a broad range of acceptable and effective family planning methods and services . . . ," 42 U.S.C. § 300(a), mandates that grantees provide *comprehensive* family planning services, including all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices. This meaning is consistent with Congressional intent "to establish a nationwide program with the express purpose of making comprehensive family planning services readily available to all persons desiring such services.'" *See Planned Parenthood Federation of America v. Heckler,* 712 F.2d 650, 651 (D.C. Cir. 1983), quoting Pub. L. No. 91-572, § 2, 84 Stat. 1506 (1970) (emphasis added) (statement of the "purpose of this Act"). *See* proposed regulatory language in Appendix C-I.

2. Amend existing Medicaid regulations and promulgate new regulations under the Medicaid Act to make clear that Medicaid recipients are entitled to coverage for all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices. *See* proposed regulatory language in Appendix C-II.

3. Amend existing regulations and promulgate new regulations requiring all other non-block-granted federally funded programs that provide family planning services in the United States to provide coverage for all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices. *See* proposed regulatory language in Appendix C-III.

3. Amend existing regulations and promulgate new regulations requiring all federally funded programs that provide family planning services outside the United States to provide coverage for all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices. *See* proposed regulatory language in Appendix C-IV.

4. Direct HHS to purchase in bulk non-prescription, medically effective, legally

available contraceptives (including male and female condoms, and spermicides) and to distribute them at no cost to all Title X projects, Medicaid managed care providers, and other providers of federally-funded family planning services for distribution to their patients.

D. PROPOSED ACTION: EXPANSION OF MEDICAID COVERAGE FOR FAMILY PLANNING SERVICES

Between 1984 and 1990, Congress enacted a set of laws that extended Medicaid eligibility to poor pregnant women, regardless of whether they meet other eligibility requirements for Medicaid benefits (the "expanded Medicaid program").[45] Under current Medicaid law, all pregnant women whose income is less than 133 percent of the federal poverty level are eligible to receive Medicaid benefits, and states have the option of extending eligibility to women whose income is higher. Federal matching funds are available for Medicaid benefits for poor pregnant women whose income is less than 185 percent of the federal poverty level. Under current law, the expanded Medicaid program for pregnant women covers post-pregnancy family planning services, but that eligibility terminates 60 days after birth unless the woman qualifies for benefits under the regular Medicaid rules.

This 60-day window for obtaining Medicaid-covered post-pregnancy family planning services is too short, especially given the fact that for medical reasons women usually must wait at least six weeks after giving birth before beginning a contraceptive method.[46] As a result, many

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[45]*See* 42 U.S.C. §§ 1396a(l)(1)(A) and 1396(l)(2)(A)(i).

[46]Several states have extended or have sought to extend the period of eligibility for post-pregnancy family planning services benefits pursuant to § 1115 waivers. As of September 1996, (continued...)

genuinely poor women have few or no means by which to obtain family planning services after a pregnancy. Not only would extending the time-period in which the expanded Medicaid program covers post-pregnancy family planning services greatly assist poor women's ability to space their pregnancies, it would likely reduce the number of low-birth-weight and premature deliveries, and infant deaths attributable to closely spaced pregnancies among women whose poverty limits their access to health services.[47]

While federal matching funds are now available for states that provide Medicaid benefits to pregnant women with incomes up to 185 percent of the federal poverty level, several states have elected to provide Medicaid benefits to pregnant women whose incomes exceed that level, but who are still poor.[48] These states have recognized that most women whose income is 200 percent of the poverty level are unlikely to be able to afford prenatal care or post-pregnancy family planning services without Medicaid benefits.[49] They have thus determined that both as a matter of public health policy and fiscal policy, it makes sense to provide these women with pregnancy-related medical benefits and post-pregnancy family planning services.

(...continued)
the waivers for Illinois, Maryland, Rhode Island and South Carolina were approved; applications were pending from Missouri, New York, and Washington.

[47]*State Family Planning and Abortion Expenditures, supra* note 3.

[48]For example, Rhode Island covers pregnant women whose income is up to 250% of poverty, Missouri covers pregnant women up to 200% of poverty.

[49]As of 1996, federal guidelines defined poverty for a family of one as $7,740, and for a family of three as $12,980. *See* 61 Fed. Reg. 8286 (Mar. 4, 1996).

Accordingly, we urge the Administration to take the following steps:

1. Require states, as a term and condition of approval of any future § 1115 Medicaid waiver application (including renewals and extensions), to extend eligibility under the expanded Medicaid program exclusively for purposes of receiving post-pregnancy family planning services from 60 days post-pregnancy to 60 months.

2. Require states, as a term and condition of approval of any future § 1115 Medicaid waiver application (including renewals and extensions), to establish meaningful procedures to inform eligible women of the extended post-pregnancy Medicaid coverage for family planning services.

3. Require states, as a term and condition of approval of any future § 1115 Medicaid waiver application (including renewals and extensions), to extend pregnancy-related Medicaid eligibility, including an extended period of coverage for post-pregnancy family planning services, to women whose family income is up to 200 percent of the federal poverty level.

E. PROPOSED ACTION: PRESERVATION OF MEANINGFUL ACCESS TO CONTRACEPTIVE SERVICES IN MEDICAID MANAGED CARE PLANS

Ensuring meaningful access to all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices for Medicaid managed care enrollees poses special concerns because primary care "gatekeepers" and prior authorization requirements for referrals can be a significant detriment to timely, confidential care. Not only does a gatekeeper requirement necessitate an extra doctor's visit before obtaining family planning services, some primary care providers or "gatekeepers" refuse to provide or refer for the services for religious or conscientious reasons. Moreover, those gatekeepers that do provide family planning services may refuse to refer patients to specialized providers even though for some women, especially for those women with special need for privacy and a supportive environment, family planning clinics are best able to meet their special needs. For

these reasons, access to family planning services is greatly enhanced if women are allowed to go to the family planning provider of their choice, even if their choice of all other medical providers is limited by a managed care system.[50]

Waivers from the general Medicaid requirement that enrollees have freedom to choose their own providers[51] may be granted under either § 1115, 42 U.S.C. § 1315(a), or § 1915(b), 42 U.S.C. § 1396n(b), of the Social Security Act. When originally enacted, the Secretary had discretion under § 1915(b) to waive the choice of provider requirement for all mandated services including family planning services. In recognition of the special access concerns surrounding family planning services, however, Congress enacted legislation in the mid-1980s that exempts family planning services from otherwise applicable restrictions on the ability of Medicaid managed care enrollees to select the provider of their choice. *See* 42 U.S.C. §§ 1396a(23)(B) and 1396n(b); 42 C.F.R. § 431.51(a)(3). Pursuant to this "family planning free access rule," § 1915(b) managed care enrollees are free to self-refer to any provider to receive family planning services. By its terms, however, the free access rule applies only to § 1915(b) Medicaid managed care programs. Although sound legal and policy arguments support the view that the free access rule must also apply to Medicaid managed care waivers granted pursuant to § 1115,[52] this

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[50]*See* CENTER FOR REPRODUCTIVE LAW AND POLICY, REMOVING BARRIERS, IMPROVING CHOICES: A CASE STUDY IN REPRODUCTIVE HEALTH SERVICES IN MANAGED CARE (1995).

[51]42 U.S.C. § 1396a(23)(A).

[52]*See* letter from Center for Reproductive Law and Policy to Bruce Vladeck, dated November 29, 1994, commenting on the proposed § 1115 OhioCare Medicaid waiver.

Administration has repeatedly granted § 1115 waivers without conditioning the waiver on enrollees' ability to self-refer to the family planning provider of their choice.

Therefore, we urge the Administration to:

1. Mandate a free access policy for family planning services as a term and condition of approval of all future § 1115 Medicaid managed care freedom of choice waivers (including renewals and extensions).

2. Require states, as a term and condition of approval of all future § 1115 Medicaid managed care waivers (including renewals and extensions), to educate case workers, providers and patients regarding patients' right to seek family planning services at their provider of choice.

F. PROPOSED ACTION: EMERGENCY CONTRACEPTION

Although emergency contraception is among the FDA-approved, prescription contraceptive drugs and devices that, as discussed above, must be covered in all private insurance plans, federal insurance programs, and federal grant programs funding contraceptive services, the Administration should take additional measures to increase women's access to these safe and efficacious prescriptions.

There are more than fifty brands of oral contraceptives produced by nine pharmaceutical companies approved for daily use in the United States. Of these, six brands --- Ovral, Lo/Ovral, Nordette, Triphasil, Levlen and Tri-Levlen --- are effective as emergency postcoital contraception.[53] Although oral contraceptives have been approved for use as emergency contraception in Europe for several decades, drug manufacturers in the United States have failed

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[53]In addition, insertion of an IUD is also a medically effective and safe form of emergency contraception.

to label or market their products for this use, citing in part fear of political retaliation from antichoice forces. Yet, clinical studies have proven that postcoital contraception reduces the risk of pregnancy by approximately seventy-five percent.[54] In the United States, relabeling and broader access to emergency contraception could decrease the number of unintended pregnancies by as much as 1.7 to 2.3 million each year.[55] Consequently, an estimated one million abortions could be avoided each year through the use of emergency contraception.[56]

Until very recently the FDA stood silent while the pharmaceutical manufacturers refused to relabel oral contraceptives to provide information about safe and effective emergency contraception. Relatively few health care providers in the United States are aware of emergency contraception and many of those providers are reluctant to prescribe oral contraceptives for an "off label" use. For the most part, use of emergency contraception has been limited to university health centers, emergency rooms that treat rape victims and family planning clinics.

In 1994, on behalf of nearly two dozen medical groups and health care providers, including the American Public Health Association, the American Medical Women's Association and Planned Parenthood of New York City, the CRLP filed a citizen's petition urging that the FDA mandate relabeling of certain oral contraceptives to indicate their use as emergency contraception. In response, the FDA convened a meeting of its Reproductive Health Drugs

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[54]James Trussell, et al., *Emergency Contraceptive Pills: A Simple Proposal to Reduce Unintended Pregnancies,* Vol. 24, No. 6 FAM. PLAN. PERSP. 269 (1992).

[55]*Id.* at 270.

[56]*Id.*

Advisory Committee to consider whether certain oral contraceptives were safe and effective for use in an "emergency" regime. After hearing testimony of a number of experts concerning the safety and efficacy of emergency contraceptive pills and the salutary effect that widespread access to emergency contraception would have on the rate of unintended pregnancy and abortion, the panel found that the oral contraceptives were safe and effective when used for emergency contraception. Although Commissioner Kessler announced that the FDA would publish a formal notice in the Federal Register by early fall of 1996 setting out the panel's finding, the register notice has yet to be published.

While the FDA panel's action provides a critical "stamp of approval" for those health care providers who currently prescribe oral contraceptives for emergency contraceptive use, it is only a first step. Ultimately, the pharmaceutical manufacturers must be required to relabel their products to make clear their emergency use. Thus far, the FDA has declined to issue such a mandate. Moreover, the FDA should require relevant companies to package and market oral contraceptives in "emergency" doses as is commonly done in Europe. Finally, the Administration should initiate research to determine whether emergency contraceptive pills can safely be provided on an over-the-counter basis. In addition to initiating actions to achieve these long term goals and the relevant changes advocated in sections A through E of this document, the Administration should take immediate action to ensure that all women have both greater access to and information about the option of emergency contraception.

Specifically, we urge the Administration to:

1. Publish the Federal Register notice regarding the use of oral contraceptives as emergency contraception without further delay.

2. Undertake a comprehensive education campaign to inform the medical profession of the safety and efficacy of emergency contraception. The FDA should prepare a letter signed by the Commissioner describing the action taken by the FDA, the protocol for the postcoital administration of oral contraceptives and the implications for reducing unintended pregnancy and abortion. That letter and the Federal Register notice should be distributed to every health care provider and professional medical association in the country, to every recipient of U.S. AID family planning funds, and to the Secretary of State insofar as she is responsible for medical care for refugees.

3. Prepare a patient information pamphlet about emergency contraception and widely disseminate the pamphlet to private practitioners and all providers of federally funded health care with particular attention to those programs where abortion services have been proscribed by law. Each provider of federally funded health care and family planning services, including recipients of U.S. AID family planning funds and those that serve refugees, should be required to disseminate the pamphlet to their patients.

4. Promulgate a regulation under the federal Crime Awareness and Campus Security Act mandating that the notification of services provided to victims of sexual assault must include information on the effective use of emergency contraception, as well as information on where emergency contraception may be obtained. *See* proposed regulation language in Appendix D.

G. PROPOSED ACTION: CONTRACEPTIVE RESEARCH AND DEVELOPMENT

Today, American women have fewer contraceptive options than women in Europe and much of the industrialized world. Moreover, American women must pay substantially more than their European counterparts for contraceptive services, drugs and devices. Nearly forty years after the "contraceptive revolution," combined political and commercial forces have stalled initiatives in both the public and the private sector. Public investment in contraceptive

development has remained static for some years. This inertia is partially due to both the political controversy surrounding reproductive rights and the lack of recognition of contraception as an urgent public health need. It is also due to the real and perceived fear of product liability law in the United States, which not only discourages development of contraceptives, but is exacerbated by the political climate around contraceptives. Private investment in contraceptive development by pharmaceutical manufacturers has diminished markedly over the past few decades. As a result, by the mid-1980s only one of the nine private U.S. firms that did research related to contraceptive drugs and devices in the 1960s continued to do that work.[57]

Private industry commonly rationalizes its failure to pursue contraceptive development by citing the state of products liability law in the United States. Manufacturers claim the law has made it too costly to pursue research and development in this area and forced some products off the market. The negative publicity and pressure from anti-choice factions has affected manufacturers willingness to pursue further development of contraceptives. The result for American women is severely diminished access to safe and efficacious contraceptive choices, which contributes to the three and a half million unintended pregnancies each year, half of which end in abortion. The Administration must address this by instituting private sector initiatives on research, such as the tax credit for orphan drugs.

The promise of universal access to safe, effective and practical contraception cannot be met unless the barriers now impeding the development and marketing of new contraceptives in

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[57] CONTRACEPTIVE RESEARCH AND DEVELOPMENT, *supra* note 10 at 4-1.

the United States are removed. Removal of barriers will have world-wide implications as all countries will benefit from new contraceptive methods developed here. The Administration should make the removal of obstacles to contraceptive research and development a public health priority.

Among other things, the Administration should:

1. Seek increased funding for contraceptive research and product development at the contraceptive research and development centers currently operating under the auspices of the National Institute of Child Health and Human development, as well as identify other research funds for this purpose.

2. Provide a tax credit -- similar to the credit for orphan drugs -- to private pharmaceutical firms conducting research on contraceptives.

3. Explore models for compensating individuals injured by contraceptive use that could serve as alternatives to traditional product liability litigation (possible models could include the National Childhood Vaccination Injury Act of 1986 or the European compensation system).

4. Convene a one day White House Conference to bring together pharmaceutical manufacturers, women's health advocates, health professionals, medical researchers and experts on product liability to explore new ways that contraceptive development can be encouraged while at the same time rigorously safeguarding women's health.

5. Develop a technology transfer package that would provide federal assistance with research costs to small manufacturers who have completed early stages of development on a new product or permit a partially government-developed drug to be transferred to a private distributor.

6. Examine proposals for the adoption of an "FDA" defense that would shield contraceptive manufacturers from liability or from punitive damages if they were in compliance with all applicable requirements of U.S. food and drug law.

APPENDIX A
Contraceptive Coverage in Private Insurance
Proposed Regulatory Language

I. PROPOSED EEOC REGULATION

The Equal Employment Opportunity Commission should amend 29 C.F.R. § 1604.9 to read as follows:

. . .

(g) It shall be an unlawful employment practice for an employer to:

(i) Provide employees medical insurance which covers any prescription drug, but which excludes or restricts coverage for any FDA-approved, prescription contraceptive drug or which imposes greater cost-sharing requirements or other limitations or conditions on contraceptive drugs than on other prescription drugs;

(ii) Provide employees medical insurance which covers any prescription device, but which excludes or restricts coverage for any FDA-approved, prescription contraceptive device or which imposes greater cost-sharing requirements or other limitations or conditions on contraceptive devices than on other prescription devices;

(iii) Provide employees medical insurance which covers medical services but which excludes or restricts benefits for medical services related to contraception (including sterilization) or which imposes greater cost-sharing requirements or other limitations or conditions on medical services related to contraception than on other medical services;

(iv) Provide employees medical insurance which does not ensure that every person covered by the medical insurance can receive any available coverage related to contraception without risking disclosure of private medical information by the insurance provider to the insured party (if other than self), the insured party's employer or any member of the person's family (except where state law requires the consent of a third party to medical treatment).

II. PROPOSED HHS REGULATION REGARDING HEALTH MAINTENANCE ORGANIZATIONS

The Department of Health and Human Services should promulgate the following regulation clarifying 42 U.S.C. § 300e-1(1)(H)(iv):

> The "voluntary family planning services" to which 42 U.S.C. § 300e-1(1)(H)(iv) refers include all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices.

APPENDIX B
Contraceptive Coverage in Federal Insurance Programs
Proposed Regulatory Language

I. PROPOSED FEHBA REGULATION

The Administration should promulgate a regulation amending 5 C.F.R. § 890.201(b) to read as follows:

Minimum standards for health benefit plans. . . .

(b) To be qualified to be approved by OPM and, once approved, to continue to be approved, a health benefits plan shall not: . . .

(6) Exclude or restrict benefits for:

(i) Any FDA-approved, prescription contraceptive drug, if the health benefits plan provides coverage for any prescription drug;

(ii) Any FDA-approved, prescription contraceptive device if the health benefits plan provides coverage for any prescriptive device;

(iii) Medical services related to contraception (including sterilization) if the health benefits plan provides coverage for any medical services.

(7) Nothing in paragraph (6) of this subsection shall be construed as preventing a health plan from imposing cost-sharing requirements or other limitations or conditions in connection with benefits for contraception; except that --

(i) any such cost-sharing requirements or other limitations or conditions on prescription contraceptive drugs may not be greater or more onerous than those for any other prescription drug; and

(ii) any such cost-sharing requirements or other limitations or conditions on prescription contraceptive devices may not be greater or more onerous than those for any other prescription device; and

(iii) any such cost-sharing requirements or other limitations or conditions on outpatient medical services related to contraception may not be greater or more

onerous than those for any other outpatient medical services; and

(iv) it shall not be a condition of coverage for prescription, contraceptive drugs or devices that they be obtained exclusively through mail order.

(8) Fail to ensure that every person covered by the health benefits plan can receive any available coverage related to contraception without risking disclosure of private medical information by the plan provider to the insured party (if other than self), the insured party's or person's employer or any member of the person's family (except where state law requires the consent of a third party to medical treatment).

II. PROPOSED CHAMPUS REGULATION

The Administration should promulgate a regulation amending 32 C.F.R. § 199.4(e)(3)(i)(A) to read as follows:

(3) *Family planning.* The scope of the CHAMPUS family planning benefit is as follows:

(i) *Birth control (such as contraception)* -- (A) *Benefits provided.* Except for the exclusions listed in paragraph (B) of this subsection, benefits are available for all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices. It shall not be a condition of coverage for prescription, contraceptive drugs or devices that they be obtained exclusively through mail order. Further, all persons covered by the CHAMPUS family planning benefit shall be able to receive coverage related to contraception without risking disclosure of private medical information by the benefit provider to the insured party (if other than self), the insured party's or person's employer or any member of the person's family (except where state law requires the consent of a third party to medical treatment). Benefits are available for services and supplies related to preventing conception, including the following:

~~(1) Surgical inserting, removal, or replacement of intrauterine devices.~~

~~(2) Measurement for, and purchase of, contraceptive diaphragms (and later remeasurement and replacement).~~

~~(3) Prescription contraceptives.~~

~~(4) Surgical sterilization (either male or female).~~

APPENDIX C
Contraceptive Coverage in Federal Grant Programs
Proposed Regulatory Language

I. TITLE X

A. Proposed Amendment of Existing Regulations

1. The Administration should amend 42 C.F.R. § 59.2 to read as follows:

. . .

Family planning means the process of establishing objectives for the number and spacing of one's children and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including all FDA-approved, prescription contraceptive drugs and devices contraceptive methods and all medical services related to contraception (including sterilization and natural family planning and abstinence) and the management of infertility (including adoption). Family planning services includes preconceptional counseling, education, and general reproductive health care (including diagnosis and treatment of infections which threaten reproductive capability). Family planning does not include pregnancy care (including obstetric or prenatal care). As required by section 1008 of the Act, abortion may not be included as a method of family planning in the title X project. Family planning, as supported under this subpart, should reduce the incidence of abortion. . . .

2. The Administration should amend 42 C.F.R. § 59.5(a)(1) to read as follows:

(a) Each project supported under this part must:

(1) Provide or provide referral to a broad range of acceptable and effective medically approved family planning methods (including all FDA-approved, prescription contraceptive drugs and devices and natural family planning methods) and services (including all medical services related to contraception, including sterilization, infertility services and services for adolescents). ~~If an organization offers only a single method of family planning, such as natural family planning, it may participate as part of a title X project as long as the entire title X project offers a broad range of family planning services.~~ For purposes of this subsection, referral means the process of: (1) directing an eligible person to a provider for a family planning method or service after it has been confirmed that the provider is accessible and can provide the method or service to that person without undue delay, (2) conducting a follow-up in a timely manner to determine whether the method or service was obtained and to provide an alternative referral if necessary, and (3) ensuring that the person receives the method or service from the provider at no

greater expense than he or she would have incurred had he or she received the method or service from the project.

B. Promulgation of Proposed New Regulation

The Administration should promulgate the following regulation clarifying 42 U.S.C. § 300(a):

> The "broad range of acceptable and effective family planning methods and services" to which 42 U.S.C. § 300(a) refers include all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices.

II. PROPOSED MEDICAID REGULATIONS

A. Proposed Amendment of Existing Regulations

The Administration should amend 42 C.F.R. § 440.210(a)(2)(i) to read as follows:

Required services for the categorically needy.

(a) A State plan must specify that, at a minimum, categorically needy recipients are furnished the following services: . . .

(2) Pregnancy-related services and services for other conditions that might complicate the pregnancy.

(i) Pregnancy-related services are those services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of the woman having been pregnant. These include, but are not limited to, prenatal care, delivery, postpartum care, and family planning services (including all medical services related to contraception, including sterilization, and all FDA-approved, prescription contraceptive drugs and devices). . . .

B. Promulgation of Proposed New Regulations

1. The Administration should promulgate the following regulation clarifying 42 U.S.C. § 1396b(a)(5):

The "family planning supplies and services" to which 42 U.S.C. § 1396b(a)(5) refers include all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices.

2. The Administration should promulgate the following regulation clarifying 42 U.S.C. § 1396d(a)(4)(C):

The "family planning services and supplies" to which 42 U.S.C. § 1396d(a)(4)(C) refers include all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices.

3. The Administration should promulgate the following regulation clarifying 42 U.S.C. § 1396o(a)(2)(D):

The "family planning services and supplies" to which 42 U.S.C. § 1396o(a)(2)(D) refers include all medical services related to contraception (including sterilization) and all FDA-approved,

prescription contraceptive drugs and devices.

III. PROPOSED REGULATIONS FOR OTHER NON-BLOCK-GRANTED FEDERALLY FUNDED PROGRAMS THAT PROVIDE FAMILY PLANNING SERVICES IN THE UNITED STATES

A. Proposed Amendment of Existing Regulations

1. Medicare HMOs

The Administration should amend 42 C.F.R. § 417.101(a)(8)(i) to read as follows:

(a) An HMO must provide or arrange for the provision of basic health services to its enrollees as needed and without limitations as to time and cost other than those proscribed in the PHS Act and these regulations, as follows: . . .

(8) Preventative health services, which must be made available to members and must include at least the following:

(i) A broad range of voluntary family planning services (including all medical services related to contraception, including sterilization, and all FDA-approved, prescription contraceptive drugs and devices); . . .

2. Rural Health Clinics

The Administration should amend 42 C.F.R. § 405.2448(b)(9) to read as follows:

(b) Preventative primary services which may be paid for when provided by Federally qualified health centers are the following: . . .

(9) Voluntary family planning services (including all medical services related to contraception, including sterilization, and all FDA-approved, prescription contraceptive drugs and devices). . . .

3. Migrant Health Services

The Administration should amend 42 C.F.R. § 56.102(l)(3) to read as follows:

(l) *Primary health services* means: . . .

(3) Preventive health services, including children's eye and ear

examinations, prenatal and post-partum care, perinatal services, well child care (including periodic screening), immunizations, and voluntary family planning services (including all medical services related to contraception, including sterilization, and all FDA-approved, prescription contraceptive drugs and devices); . . .

4. Community Health Services

The Administration should amend 42 C.F.R. § 51c.102(h)(3) to read as follows:

(h) *Primary health services* means: . . .

(3) Preventive health services, including medical social services, nutritional assessment and referral, preventive health education, children's eye and ear examinations, prenatal and post-partum care, prenatal services, well child care (including periodic screening), immunizations, and voluntary family planning services (including all medical services related to contraception, including sterilization, and all FDA-approved, prescription contraceptive drugs and devices); . . .

B. Promulgation of Proposed New Regulations

1. Migrant Health Centers

The Administration should promulgate the following regulation clarifying 42 U.S.C. § 254b(a)(6)(C):

The "family planning services" to which 42 U.S.C. § 254b(a)(6)(C) refers include all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices.

2. Community Health Centers

The Administration should promulgate the following regulation clarifying 42 U.S.C. § 254c(b)(1)(C):

The "family planning services" to which 42 U.S.C. § 254c(b)(1)(C) refers include all medical services related to contraception (including sterilization) and all FDA-

approved, prescription contraceptive drugs and devices.

3. Health Services for Homeless

The Administration should promulgate the following regulation clarifying 42 U.S.C. § 256(r)(6):

> The "family planning services" to which 42 U.S.C. § 256(r)(6) refers (by reference to 42 U.S.C. § 254c(b)(1)) include all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices.

4. Health Centers

The Administration should promulgate the following regulation clarifying the Health Centers Consolidation Act, Pub. L. No. 104-299, 110 Stat. 3626 § 330(b)(1)(A)(i)(III)(gg) (Oct. 11, 1996):

> The "voluntary family planning services" to which the Health Centers Consolidation Act, Pub. L. No. 104-299, 110 Stat. 3626 § 330(b)(1)(A)(i)(III)(gg) (Oct. 11, 1996), refers include all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices.

5. Indian Health Services

The Administration should promulgate the following regulation clarifying 25 U.S.C. § 1603(k)(5):

> The "family planning" to which 25 U.S.C. § 1603(k)(5) refers includes all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices.

IV. PROPOSED REGULATIONS FOR FEDERALLY FUNDED PROGRAMS THAT PROVIDE FAMILY PLANNING SERVICES OUTSIDE THE UNITED STATES

A. Proposed Amendment of Existing Regulations

1. Agency for International Development Funds

The Administration should amend 48 C.F.R. § 752.7016(a)(2) to read as follows:

> (2) Activities which provide family planning services or information to individuals financed in whole or in part under this contract, shall provide a broad range of family planning methods and services (including all medical services related to contraception, including sterilization, and all FDA-approved, prescription contraceptive drugs and devices) available in the country in which the activity is conducted or shall provide information to such individuals regarding where such methods and services may be obtained.

B. Promulgation of Proposed New Regulations

1. Foreign Assistance for Family Planning Projects

The Administration should promulgate the following regulation clarifying 22 U.S.C. § 2151b(b):

> The "voluntary population planning" and "family planning information and services" to which 22 U.S.C. § 2151b(b) refers include all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices.

2. Foreign Assistance for Family Planning Projects

The Administration should promulgate the following regulation clarifying 22 U.S.C. § 2362(c):

> The "voluntary family planning programs" to which 22 U.S.C. § 2362(c) refers include all medical services related to contraception (including sterilization) and all FDA-approved, prescription contraceptive drugs and devices.

3. Assistance to Refugess and Displaced Persons

The Administration should promulgate the following regulation clarifying the Foreign Relations Authorization Act, Fiscal Years 1994 and 1995, Pub. L. No. 1103-236 § 501(a)(5), 108 Stat. 382 (Apr. 30, 1994) (United States Policy Concerning Oversees Assistance to Refugees and Displaced Persons):

> The "services in reproductive health and birth spacing" to which Pub. L. No. 1103-236 § 501(a)(5), 108 Stat. 382 (Apr. 30, 1994) (United States Policy Concerning Oversees Assistance to Refugees and Displaced Persons) refers include all medical services related to contraception and all FDA-approved, prescription contraceptive drugs and devices.

APPENDIX D
Emergency Contraception
Proposed Regulatory Language

The Administration should promulgate the following regulation clarifying 20 U.S.C. § 1092(f)(7)(B)(vi):

> The "notification of students of existing counseling, mental health or student services for victims of sexual assault" to which 20 U.S.C. § 1092(f)(7)(B)(vi) refers shall include information regarding the effective use of emergency contraception, as well as information on where emergency contraception may be obtained (either on-campus or in the community) in a timely manner.